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DETAILS PAGE  6
Hospitalists.

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Along with many hospitals across the country, Manatee Memorial Hospital has developed a program centered on the care of their hospitalized patients. A physician who specializes in the care of hospitalized patients, a hospitalist has no outpatient practice. Most patients who are cared for by hospitalists are referred by their primary care physician or they are admitted through the Emergency Department.

Dr. Jennifer Bermudez is a hospitalist who devotes her practice to the care of patients in the inpatient unit of The Center for Behavioral Health at Manatee Memorial. Dr. Bermudez is board certified by the American Board of Psychiatry and Neurology. She treats patients who suffer from mental illness, substance abuse disorders and dual diagnoses.

For more information about the Hospitalist Program at Manatee Memorial Hospital, please call 941-725-0822.

The Center for Behavioral Health at Manatee Memorial Hospital
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From: Tim Stapleton,  
FMA Vice President

Tallahassee—Florida Medical Association President Madelyn E. Butler, M.D., released the following statement May 5, 2011:

“The FMA is extremely pleased with the passage of HB479. We have been working to pass expert witness reform for over a decade and we consider the passage of this legislation to be a major step forward in making Florida a more friendly place to practice medicine. The physicians of Florida are grateful to the bill sponsors, Representative Mike Horner and Senator Alan Hays, and to all of the legislators who supported this landmark bill.”

The bill that passed late last evening, HB 479, includes the following provisions:

- Requires MD, DO, or DDS, licensed in another state, to obtain an expert witness certificate before being able to provide expert testimony in Florida.

- Gives the Boards of Medicine, Osteopathic Medicine, and Dentistry the specific authority to discipline any expert witness, both those licensed in state and those with an expert witness certificate, who provide deceptive or fraudulent expert witness testimony.

- Requires the BOM and the BOOM to create a standard informed consent form that sets forth the recognized risks related to cataract surgery. Provides that an incident resulting from a recognized specific risk is not considered an adverse incident.

- Deletes the provision in current law that prohibits an insurance company from selling a malpractice insurance policy to a physician that gives the physician the authority to control settlement decisions.

- Excludes from evidence in any medical negligence action any information regarding an insurer’s reimbursement policies or reimbursement determinations.

- Provides that the breach of, or failure to comply with, any federal requirement is not admissible as evidence in a medical negligence case.

- Provides that the expert witness who submits the pre-suit verified expert medical opinion is no longer immune from discipline.

- Provides that volunteer team physicians are immune from suit when gratuitously rendering care at a school athletic event.

In addition, a separate bill supported by the FMA passed yesterday that extends sovereign immunity protection for faculty physicians at teaching hospitals. This was a major priority of the University of Miami Miller College of Medicine.
In 2012, millions of Americans who get health care coverage through their employer will start to see some big changes to offset rising medical costs and new expenses tied to health reform. According to a new report from human resources consulting firm Towers Watson, companies will be charging higher contributions for dependent coverage and dropping retiree accounts. Physicians will need to be more forward thinking to react to ongoing changes in patients’ insurance coverage as the unintended consequences of Obama Care manifest themselves.

1. There is falling optimism about providing health coverage. Employer confidence in offering health coverage ten years from now has fallen dramatically. In 2007, the Towers Watson survey of employers showed they were 73% confident that they’d be offering health insurance in a decade. That dropped sharply to 38% in 2010. The firm surveyed 588 employers between November 2010 and January 2011, with a total of 9.2 million full-time workers. "It is a reflection of uncertainty about how health reform will play out," said Julie Stone, senior consultant with Towers Watson.

2. More than a quarter of retiree health plans may be dropped. Stone said "This is one of the most critical findings of our survey." The report showed that more than a quarter of companies polled plan to drop retiree health plans in 2012 for some employees, such as new hires. 0:00 /2:48

3. Employees will have to pay more per dependent. Health reform mandates that insurers provide dependent coverage up to age 26 and employers have seen a sharp jump in dependents being added to their plans. The Towers Watson report says that 68% of companies polled said that they would raise employee contributions for each dependent that they covered in order to offset higher costs associated with the increase numbers of dependents being added to plans.

4. New surcharges may be added for spouse coverage. Health coverage for spouses can cost an employer about $5,000 annually. To offset that expense, the Towers Watson report says that companies are reacting by imposing penalties or surcharges on "ineligible" spouses. "We're seeing renewed interest in spouse surcharges," Stone said. If an employee's husband or wife has access to health insurance through their own job but refuses it to be added to his or her spouse's plan, a surcharge will be added.

5. Companies are getting serious about good health. More companies are thinking about getting tough on employees to encourage healthier lifestyles. Despite big investments in wellness programs, the report said employers have found it hard to get their workers to participate in voluntary disease management, smoking cessation or weight loss programs. "There is discussion among some employers about making a complete health risk assessment a requirement in order to get health benefits," Stone said.

6. Employees may be directed to pick “preferred” doctors. Stone said companies may get more involved in helping employees manage their health costs in 2012. "Many plans offer a tiered network of [medical] providers based on their performance," said Stone. Companies could tweak their plans next year to offer more coverage to employees if they pick a "high-quality" provider versus one with a lower performance score, she said.

xxxxxxx
The Gulf Coast Health Information Exchange (HIE) is currently offering a special 12-month Limited Membership to current Manatee County Medical Society members.

Benefits of the Limited Membership include the following:

- Set-up fee waived for one year ($250 savings)
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In order to qualify for this special Limited Membership, current MCMS members must submit a Participation Registration Application and Agreement to the Gulf Coast HIE. Applications are subject to review and approval by the Executive Director or other designee approved by the Board of Governors.

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Darin Pierce, CFP®  Don Westerhoff
Financial Planning Steps to Prepare Your Child for College

By Karin A. Grablin, CPA, CFP®

It seems like just yesterday they were learning how to walk, or riding a bike or attending their first scout meeting. And now, with less than a month to go, you expect to see them walking across the stage to accept their diploma! How did this all happen so fast? More importantly, do you feel confident you have them prepared for what lies ahead?

If your son or daughter is planning to attend college soon, there seem to be thousands of “to do’s” to just get them there. But as a financial planner, I often see some preparation steps not thought about soon enough or skipped altogether and I’m always wary to counsel clients on what they need to do to get their child “financially” ready for their next educational endeavor.

Issues to consider as part of your college prep “to do” list:

1. **Set a budget with them**
   
   This is often easier said than done. You’ll do a lot of guessing at first. A good place to start is to purchase the school’s meal plan: at least your child will have access to nutritious food (if not taken advantage of) and that part of the budget will be accounted for. Sit down with your child and review his likely expenses and how much he’ll have to put toward them. Then create a list of categories, like "Supplies," "Housing and Utilities" (if he’s living off campus), "Transportation," "Entertainment," "School Fees," etc and allocate a dollar amount to each. Remind your child to log his expenses regularly, and that a little deviation isn’t necessarily a bad thing as long as he returns to the plan you’ve created together.

2. **Work out their banking arrangements**
   
   It’s important to clearly establish how your teen will access his spending money. If you’re contributing to his/her everyday funds, open a joint savings or checking account so you both have access. Choose a bank with branches at home and on campus, or at least strong online access. Well before orientation, walk him or her through check-writing (have your child write a few for you, that you then sign and send), depositing and withdrawing money, bill-paying, and keeping track of debit card expenditures. They should learn about how to protect their accounts, check their statements, balance their checkbooks, and keep copies of financial records before they go to school. Help them to understand what fees are incurred for bouncing checks.

3. **Emphasize prompt payments**
   
   Let your kids know how important it is that they pay their bills on time. After all, skipping payments can cause problems with their credit rating, in addition to late fees: consequences most college students don’t consider.

4. **Consider their credit card options**
   
   If you want to ease your child into the credit card world, you can get your student a re-loadable prepaid credit card. This allows you to monitor their spending (in some cases, with real-time e-mails and text messages) and not have to worry about overspending or overdrafts. This won’t do as much for establishing a credit history for them, but it is a good way to enable, but control spending.

Eventually, building good credit is a must: It will help the student qualify for loans, auto insurance, rental applications, cell phone plans, and can even affect whether or not they get a job. For a student is going off to college, unless the parent is 100% sure they’re responsible, the first regular credit card that student should have is the parent’s credit card. The teen can be an authorized user on the parent’s account with a separate spending limit on his/her card so that the adult can monitor the child’s spending. If the child is responsible, he could try applying for one credit card with a low balance limit (say $300) in his own name. If received and this card balance is paid off regularly, this will help to build a positive credit history for your child.
Con’t Financial Planning Steps to Prepare Your Child for College

Educate your child to ignore all those special credit card offers he or she may get in the mail. There is no need at this stage to have multiple credit cards. The only one they should have is one that you control together!

Back up their financial & other important information

Have your child make photocopies of the contents of their wallet and keep a copy with you at home. If you think they can keep this information secure, they should also take a copy with them to school. For each important “card” being copied, write down the phone numbers or websites of the places to contact if that card is lost or stolen right above the copy of the card. That way, you have a quick way to get replacements, if need be.

Consider their healthcare

When your kid gets sick at school, you won't be there to nurse her back to health. That means she needs to know when to call the health center, where it is, and how it works. Sit down with your teen and visit the center's website.

Look into health insurance early. First determine what's available and covered on campus—college and university health centers vary in the scope of the medical problems they treat. (The information should be in your student's orientation packet; if it isn't, contact the admissions office.) Some services may be covered by tuition or a prepaid fee, while others may be out-of-pocket or have to go to your insurance. You also might want to research which doctors' practices near the school offer what the college doesn't or that insurance won't cover at the health center.

If your child takes regular meds and will be in charge for the first time, there's no time like the present to let him or her take over. Explain the importance of setting up regular habits and keeping the medication in a safe, secure location that's easy to remember and access. If your teen doesn't already schedule doctor's appointments or fill prescriptions on her own, explain the basics (and have her make appointments or go to the drugstore herself if it comes up) and remind her to always carry her insurance card.

be hampered by such “red tape.” (Remember the Virginia Tech massacre several years ago? Parents frantically calling local hospitals to find out about their child could not be told anything without such forms on file).

Consult your attorney

In addition to HIPPA forms, if your child is over 18, it’s a good idea to visit with your estate planning attorney and see what other basic documents they might need before heading off to college. While they may still be too young to have a will (with few assets to distribute), they should have power of attorney documents and healthcare directives (health care power of attorney, living will) executed and on file with you before they go off to college, just in case you need to step in and act on their behalf should they be unable to.

Just as their first steps to walk were important back then, these financial steps toward independence (as they prepare to leave for college) are equally significant right now. If you need help getting organized around these issues, be sure to consult a Certified Financial Planner® practitioner for further guidance.

Karin Grablin, CPA, CFP®, MBA is with SRQ Wealth Management, Two N. Tamiami Trail, #410 in Sarasota (941-556-9004) karin@srqwealth.com and is a registered representative & investment advisory representative with, and securities are offered through, LPL Financial, Member FINRA/SIPC. LPL Financial Representatives offer access to Trust Services through Private Trust Company, N.A. an affiliate of LPL Financial.

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<th>Babette Pachence, MD</th>
<th>Lori Taylor, MD</th>
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<tr>
<td>Myra Carreon, MD</td>
<td>Bradenton Internal Medicine</td>
<td>Manatee Diagnostic Center</td>
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<td>Kidney Disease Consultants</td>
<td>941-744-0024</td>
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<td>Ronald Smith, Jr, MD</td>
<td>Riverview Cardiac Surgery</td>
<td>941-744-2640</td>
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<tr>
<td>Melissa Themar-Geck, MD</td>
<td>MDC</td>
<td>941-747-3034</td>
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Dr. Jack Jawitz has served as a “Legislative Doctor of the Day” for the past 8 years. He has enjoyed it tremendously and states that the experience is incredible!

It is 5:00AM, and one could wonder why a Dermatologist is awake at that hour, but like the previous eight years I was on my way to Tallahassee. Grab a quick breakfast, a short drive to Dolphin Aviation at SRQ and an early morning departure in N5082W, my Cessna 172. It was still dark at only 5:45Am, before sunrise and I was off the ground before the tower opened at 6AM, a routine done many times before.

The Doctor of the Day program started in both legislative bodies in the 1960s by Representative Walter Sackett MD, a physician legislator. His vision was to have physician presence in both the house and senate chamber to remind the legislators of the medical community in Florida. Doctors from every specialty volunteer to see patients in the Legislative Medical Clinic, seeing mostly sore throats, allergies, flu symptoms, asthma and BP checks. Patients come to the clinic are legislators, aids, assistants, workers in any job in the legislative buildings and even lobbyists and guests to the capitol. Nobody is turned down from the medical clinic for a screening.

This was my eighth year as a volunteer “Doctor of the Day.” Since 2002 I have been sponsored by Senator Mike Bennett and attended session in the Senate Chamber, but this year I asked and was sponsored by our new Representative Jim Boyd.

I landed Tallahassee after a beautiful and invigorating sunrise flight and a quick cab ride got me to the capitol at about 8:15AM. My first stop was to the Medical Clinic where I was embraced by Nurses Michele Fijman and Carole Beckham who have been there to greet me and every volunteer since 2001. After joyful salutations like meeting long lost friends, I was given my “Doctor of the Day” Badge and headed off to see my sponsor and other representatives. First to see me was Representative Jim Boyd, our new legislator who, as my sponsor, invited me to sit in the House Chamber when session started at 1:30pm. He explained his legislative goals and expressed support of the FMA legislative agenda of Tort Reform. I was glad to see his enthusiasm in representing the people of west Manatee county. Next door was Representative Greg Stuebe of Lakewood Ranch. He too was glad to meet with me, and explained his legislative goals. He firmly endorsed the FMA Tort reform package, and as he sits on the Judicial Committee, invited me to attend the days committee session which was to include a debate on the FMA Tort Bill. This was to be the last committee it had to pass through prior to a vote of the entire House of Representatives. I confirmed my planned attendance and thought how fortunate Manatee county is to have such great representation by good people.

My next visit was to Senate Pro Temp Mike Bennett. Mike had sponsored me for the last eight years as Doctor of the day and I always appreciate getting a chance to speak with him about medical issues and this was no exception. I first thanked him for sponsoring me these last years, then thanked him for his positive vote in a recent committee meeting on the Senate Tort Reform Bill. He expressed to me that he wished the language could have been stronger. I was again happy he had the time to see me before his committee meeting.

Con’t next page
I would usually now spend time in the medical clinic doing a yearly skin cancer screening for the capitol employees, but I told Michele and Carol that I didn’t have time for the screening this year but promised to return over the summer and do the annual screening when it was less busy. My day was already planned full with the Judiciary Committee debate on Tort Reform and Legislative session beginning at 1:30pm.

I walked into the Judiciary committee meeting hearing room and before me was a huge table with 15 legislators, a witness podium and a visitor gallery half full with about fifty people. Witness after witness spoke in support of the Tort reform Bill. They were a wide coalition from business, school board, many medical groups and specialties, hospitals, pharmacies and municipalities. Then three lawyers spoke, two representing themselves as individuals and one for the trial bar. The testimony was emotional and intellectual with charts. The responses from the legislators was emotional and evidence based as well. I was totally impressed with the testimony from several Democrat Legislators who supported the bill against the advice of the party. One stated physicians cannot come to Florida because of the costs of malpractice and the other concerned for his constituents who cannot get the care they require so “the people who we care about the most are most being hurt.” In the end after almost two hours of debate a vote was taken and the FMA Tort Bill passed (15yea-2nay) the final committee and was on its way to the full legislating body for a future vote. Committee members, Representatives Greg Steube, Lakewood Ranch and Ray Pilon of Sarasota both voted yes, and I promptly thanked them both for their votes.

I then rushed to the start of the House of Representatives legislative session and a chair was places on the floor next to Jim Boyd’s chair. While in the senate I would sit on the sidelines, the House tradition is to sit on the floor next to your sponsor. I was introduced as Doctor of the Day to the House and after more introductions debate on the current business had begun. Jim Boyd was totally a gracious host, introducing me to all the legislators sitting nearby us. He was also sure to get me a souvenir photo of the day. I am indebted to him for his hospitality. While on the floor, I was also sure to thank as many members as I could for their earlier vote in the Judiciary committee, especially the Democrats.

I had to leave session a little early having a commitment to watch Charles Clapsaddle of METV present his award winning film “Through the Tunnel” during a special showing for the Sarasota Film Festival in Sarasota. I really do appreciate airplanes.

I previously thought about writing of my experiences as “doctor of the day.” Witnessing today’s legislative process in the judiciary committee, watching the Tort reform debate, watching and learning of the law making process, meeting with the fine people elected to serve, all became too much not to write about. Volunteering as ”Doctor of the Day” has been a teaching and learning experience that I hope one of you reading this account will consider doing in the future. I believe every little part has a place to make Florida a better place to practice medicine.

Addendum: The Tort Reform Bill was passed by both Legislative bodies and to be signed by Governor Rick Scott as of this printing.

If you are interested in serving as a “Doctor of the Day” for 2012 you can contact Althea Houston, at the Office of Legislative Services (850-488-6803) or Liz Gatlin at the Medical Society. Legislative Sessions begin early March—Early May.
Act Now to Avoid Financial Repercussions of Failing to Comply with ICD-10 Mandate

By Jennifer Shimek, COO
Doctor’s Administrative Solutions (DAS)

In just over two years, all physician practices – as well as hospitals and payers – must be utilizing the ICD-10 diagnosis code set. It’s not as much time to complete the transition as some may think. Because the switch will impact nearly every aspect of practice operations, projections are that full implementation will take more than two years to complete.

As such, planning should have been underway in January 2010. Yet few practices in Manatee County, or nationwide for that matter, are aggressively pursuing the transition from ICD-9 to the greatly expanded ICD-10 code set.

It is a lack of urgency that could have significant financial repercussions. The Centers for Medicare and Medicaid Services (CMS) has stated that, as of Oct. 1, 2013, claims that are not submitted using ICD-10 will be rejected. This could result in a negative impact on a practice’s cash flow and revenues.

A Costly Transition
It’s not just the impact on the revenue cycle that practices must be concerned with. There is also a significant cost associated with the transition, up to $83,000 for a typical three-physician practice and $2.7 million for a 100-physician practice.

These include hard costs for IT upgrades, changes to SuperBills and staff training. Soft costs include cash flow disruptions and a 20 percent increase in documentation activities.

The two main cost drivers are:
1. The expanded number of codes in the ICD-10 code set, which includes approximately 68,000 diagnosis codes versus ICD-9’s 13,000.
2. Structural differences between ICD-10, which features three to seven alpha-numeric digits, and ICD-9, with three or four numeric digits.

The increased granularity of ICD-10 may also result in changes to reimbursement patterns, while contract modifications by health plans may alter payment schedules. Both can potentially disrupt a practice’s cash flow.

Given the wide-ranging impact the switch to ICD-10 will have, practices that are not already deep into the planning stages may find themselves in trouble. But it’s not too late. The conversion may seem daunting, but a systematic approach can result in a smooth transition.

Transition Planning
The first step is to establish a project team to oversee the transition. Its first order of business should be a gap analysis to identify necessary changes to technology, business processes and workflows. This information will lay the foundation for a comprehensive project plan, including identifying necessary software and hardware upgrades, as well as impacted vendor and business relationships.

That latter information in particular is critical. Early engagement of billing services, clearinghouses and payers will determine the final transition timeline. It will also determine any required “work-arounds,” such as the ability to function in a dual ICD-9/ICD-10 environment.

Early involvement of IT vendors will determine how smoothly the transition goes. Availability of upgrades establishes when implementation must begin to ensure sufficient time for testing and hands-on training. Too, knowing whether there will be a charge for those upgrades or if they fall within existing maintenance contracts will factor into the final budget.

Once the gap analysis is complete, a comprehensive transition plan should be developed that encompasses all areas that will be impacted by the switch. This includes identification of any changes to reporting requirements, which may necessitate the collection of additional data, new reporting formats and/or adjustments in workflow and business processes.

Con’t Pg 20
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Healthcare providers are faced with a paradox that the more medicine advances, the greater the potential for error. While all undesired outcomes cannot be eliminated even by extremely well-qualified providers, today’s legal climate necessitates that physicians are familiar with longstanding, current, and evolving risk management practices.

There are a number of risk management issues which require a heightened awareness. These include the use of physician extenders and hospitalists and issues regarding internet defamation, patient identity theft, and regulatory requirements.

**Physician Extenders**

The number of physicians who support the use of physician extenders continues to escalate. Physician extenders can provide several benefits, including faster patient access to care, and increased physician time and focus. However, along with the increasing use of physician extenders is the spiraling frequency and severity of medical malpractice claims against physicians who are being exposed to the acts of physician extenders.

Malpractice claims attributed to PEs can often be traced to clinical and administrative factors that are easily identified and remedied. Consequently, there are precautions and assurances that the employing physicians should initiate. Determine that your PEs are not providing services beyond their capabilities or the scope of their licensing. Monitoring enables detection of misdiagnoses, delays in diagnoses, improper orders, or any other issues requiring attention. Physician extenders are the agents of their employers—their acts reflect directly upon the supervising physician.

Although the practical benefits of utilizing PEs are numerous, myriad legal doctrines hold the physician responsible for the acts and omissions of such employees. Implementing effective risk management measures will help ensure that the benefit of using physician extenders in your practice is not at the expense of increased liability exposure and malpractice claim development.

**Hospitalists**

Hospitalists have evolved into a medical specialty that is growing both in number and sophistication and is a rapidly increasing option for primary care physicians (PCP) and their patients. Hospitalists are beneficial because they specialize in inpatient care and treatment. They are very familiar with the workings of the hospitals and the staff who work there.

From a liability standpoint, inpatient and outpatient care inherent to the hospitalist model presents the greatest challenge, both in terms of continued erosion in the physician-patient relationship and the incidence of medical malpractice claims. While there are many types of hospitalist models, none possess a distinct risk management advantage over another.

The primary cause of claims related to hospitalists result from communication breakdowns and failure to follow up. Discontinuity of care encompasses such risks as abandonment, allegations of negligent referral, and patients lost to follow-up. However, perhaps the greatest risk is that of patients that are unaware or who do not understand the hospitalist model.

The hospitalist has a responsibility to notify the patient’s PCP of the diagnosis, clinical status, discharge plan and any necessary follow-up. To ensure an adequate exchange of clinical information, the PCP and hospitalist should maintain open dialogue and agree upon a “game plan” of periodic updates.
With a modicum of risk management effort, prevalent liability issues entailing a hospitalist model can be minimized. As is the case with most loss prevention measures, effective communication remains the chief caveat.

**Physician Internet Defamation**
There has been explosive growth of anonymous doctor rating sites available on the Internet with “hits” that number in the millions. These sites provide patients with the ability to post false and defamatory statements alleging physician negligence. Negative postings present potential risks to the professional reputations of doctors and their practices.

Currently, libel cases are difficult to resolve. Patient confidentiality laws and federal immunity laws granted to Internet Service Providers (ISP) limit the options for recourse, increasing the difficulty and expense.

On rating sites, patients, or people posing as patients – such as disgruntled employees, ex-spouses, and even competitors can damage a hard-earned reputation. In most instances, a doctor has little recourse. As an arcane nuance of cyberlaw, the websites are immune from accountability (Section 230 of the Communication Decency Act). Some sites have taken the position that they will not monitor or police such content.

As a physician, one of your most valuable assets is your reputation. Anonymous web postings by disgruntled patients can threaten your good name and practice. Most medical practices are built through word of mouth. It only takes one negative Internet posting to impact your livelihood.

**Patient Identity Theft**
Cases of patient identity theft continue to substantially increase every year. It is critical that all medical professionals acknowledge the emerging risk associated with this dilemma. Physician offices, clinics and hospitals are all prey to the possibility of compromising personal health information (PHI).

The PHI stolen from a medical office can be used to obtain credit cards, drain bank accounts, falsely bill Medicare and make e-transactions – globally. Physicians with sophisticated encrypted electronic files are no less vulnerable.

**Florida Practitioner Profiles**
Florida physicians are required by the Department of Health to update any change that is made to the following:

- education & training
- current practice & mailing addresses
- staff privileges & faculty appointments
- financial responsibility
- legal actions
- BOM final disciplinary action within previous 10-years
- liability claims which exceed $100,000 ($5,000 for podiatrists)

Physicians who do not comply with this requirement are subject to fines, penalties, and disciplinary action.

**Benefits of Risk Management Protection**
Although today’s legal and regulatory climate continues to present additional challenges to doctors, many cases can be prevented or reduced by simply utilizing risk reduction strategies and tools. To reduce the frequency of claims, exceptional risk management services are essential for any medical practice. The risk management benefits provided by FPIC are unmatched in the industry and are available at no additional cost to its policyholders.

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During some recent conversations with clients, we learned that a few of them were considering changing their business models in search of tax and medical liability relief. A good idea on the surface, but one that could have unintended consequences.

One client planned to move his firm into a Limited Liability Company. While we of course defer to our friends in the legal profession to help people decide what type of entity best suits their needs, we would point out one area of caution.

In Florida, all practices with four or more employees (full and part time) must purchase workers’ compensation insurance. If you are an “S” or “C” Corporation you are allowed to exempt yourself as an “employee” from this count. In a Limited Liability Company, according to the State of Florida you will always be considered an “Employee” (see section 440.02(15)(a)). However, Florida defers to the insurance carriers and labor attorneys to make the distinction whether to include or exclude you in workers’ compensation.

We took a poll of insurance carriers, and the conclusion is that they will not oppose what the State of Florida deems is an “Employee,” and therefore will charge the practice the same $.40/$100 of payroll as all other physician and clerical on payroll. The minimum compensation that a carrier must charge according to the National Council on Compensation Insurance is $18,200 to a max of $119,600.

While moving to an LLC may still be the right move for your practice, the point is we want you to be knowledgeable about any extra costs. Consult your attorney and accountant—and your insurance agent—as you go through your cost-and-benefit analysis.

Another pitfall we hear horror stories about is neglecting to update beneficiaries as needed. In one case, a gentleman purchased an annuity policy for his two daughters. Year later he decided to put the same annuity into a charitable trust, but neglected to change the beneficiary on the annuity. As you might have guest costly legal battles ensued between the daughters and the charitable organization. Changing a beneficiary on insurance, annuities and investments is very easy as long as you are the owner or grantor. Just give us a call.

Don’t let yourself fall into any of these pitfalls. We’re happy to review your current coverages with you and help you consider your options. Please call myself Taylor Collins or my partner Jim Tollerton at 941/957-1310.

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At the May 24, 2011 Manatee County Medical Society Meeting, I will have the privilege of presenting and talking about one of the most important topics today – the future of health care and medicine in America. I will be talking about the pressing questions on everyone’s minds: What will health care look like going forward? What new structures will emerge? How will our thinking about health care delivery alter? How will health care delivery be different? What changes are coming to the economics of health care?

In response to recent transformational times, I have partnered with a world-recognized futurist, David Houle, to co-author a book, *The New Health Age: The Future of Health Care in America*. David speaks regularly to professionals and business leaders all over the world, advising them about future trends and directions. Combine David’s knowledge about the future with my perspectives about the health care industry and health care reform and the result is a book that David and I believe shapes all the chaos and chatter around health care and places it into helpful and accurate “context.” We “make sense” out of all of the confusing “content” that hits us on a daily basis.

We will release the Professional Edition of the book in early June, and we will publish the Public Edition later this summer. At the May 24th meeting, I will present to the Manatee County Medical Society certain sections from our book.

The thrust of the book is simple – we detail the dramatic changes, incredible breakthroughs and totally altered thinking about health, medicine and health care delivery that will occur during the twenty-first century. The years to 2020 will be filled with an altering of how Americans think about health, how medicine is practiced and how health care is delivered. These years will set the stage for a fifty-year period that will be viewed as The New Health Age. Future generations will look back and thank us for what we accomplished and initiated in this brilliant new age.

Massive change is ahead. The migration, however, will not be easy. A new age is beginning. We are at an inflection point in the history of medicine and health care. Such times are triggered by multiple dynamics and forces that occur simultaneously to birth us into a new place, a new time and a new reality. The most important thing to realize is that it is not just one force, but many at the same time that are converging with historical imperative to move us all into the new landscape of medicine and health care.

The majority of humanity gets uneasy when confronted with change. It is human nature to identify with the way things are. So change, in and of itself, creates a sense of anxiety. This is accentuated when the direction and shape of the change is not readily apparent. If we all knew that The New Health Age would be better for each of us, for all of us, for the benefit of America, we would excitedly anticipate it. Those who expect to benefit, embrace the change. Those that fear that the change will hurt them economically, resist the change. Both of these positions, while understandable, are way too narrow perceptively to have any accuracy or depth. Self-interest has always been a primary driver in human endeavor. The problem with looking at the impending shift from a narrow point of view, or through the lens of legacy thinking, is that this huge historical shift encompasses a multitude of converging forces that transcend simple self-interest.

History shows us that new centuries and new ages bring about the birth of new institutions and reorganization of existing ones. What was the norm in one century or age is replaced by a new norm. The New Health Age will be no different. The existing structures of the health care delivery system in the United States were largely established in the Industrial Age during the twentieth century. Some of these structures and institutions will survive in The New Health Age, but in altered form. Others will cease to exist. There will also be entirely new structures that will reshape, reorder, reorient and lower costs in the American health care delivery system.

Con’t next page
Five new fundamental health care structures that will profoundly reshape and dominate the health care landscape throughout The New Health Age are:

1. Integrated Delivery Systems (IDS);
2. Accountable Care Organizations (ACOs);
3. Employer Accountable Care Organizations (EACOs);
4. Medical Homes; and
5. Health Insurance Exchanges.

There will be more new structures going forward, but the above five will exist at the core of new health care.

Simply stated, an IDS is a network of health care providers and organizations which provides or arranges to provide a coordinated continuum of services to a defined population and is willing to be held clinically and fiscally accountable for the clinical outcomes and health status of the population served.

ACOs have recently come about as an integral part of health care reform laws; and is defined as a structure of health care providers established for the purpose of achieving quality thresholds and as an instrument to share in the related cost savings to the Medicare program. ACOs must be accountable for the overall care of their Medicare beneficiaries, have adequate participation of primary care physicians, and define processes to promote evidence-based medicine and report on quality and costs and coordinate care.

An ACO was defined recently in a Health Affairs article entitled “A National Strategy to Put Accountable Care into Practice” as follows:

ACOs consist of providers who are jointly held accountable for achieving measured … per capita improvements in quality and cost … ACOs should have … accountability for achieving these improvements while caring for a defined population of patients.

ACOs may involve a variety of provider configurations, ranging from integrated delivery systems and primary care medical groups to hospital-based systems and virtual networks of physicians, such as independent practice associations.

As futurists, David and I brand named “Employer Accountable Care Organization – EACOs.” We think that EACOs will be one of the most significant and influential structures in The New Health Age. Large employers, or aggregations of smaller sized employers, will create their own EACOs, replicating the ACO model but designed exclusively for their own employees. This way, the payers - both employee and employer - create entirely contained ACOs that operate the same way that an ACO would, benefiting from all of the integrated thinking described and defined later in the EACO chapter of our book.

Kaiser Permanente, CEO George Halverson, defines “medical homes” as organizations “where designated caregivers can coordinate and support all of the care needs of a given patient … contrasted to uncoordinated, unlinked, unconnected, incident-based patterns of care.”

Health care reform laws define health insurance exchanges as state-regulated and standardized health care plans, from which individuals and small businesses may purchase health insurance, with government subsidies in limited cases.

Those are the concise definitions, but what does it all mean and how will these new structures function during The New Health Age? Come to the Manatee County Medical Society meeting on May 24th and learn more. If you can’t make it, please feel free to contact me at jfleece@blalockwalters.com and I will add you to the list of people who are interested in reading our new book. I will let everyone know as soon as it is released.

More to come! Until then, be well.
Early identification of training needs is also important, as proper staff training will accelerate the learning curve and reduce productivity disruptions. The transition plan should also include running tests with any business partners with which data is exchanged to ensure transactions flow appropriately.

Finally, an effective communication plan should be established. In addition to practice leadership and staff, the plan should include communications with any external stakeholders and business partners that may impact the final outcome.

**The Clock is Ticking**

Ultimately, failure to comply with the ICD-10 mandate will result in rejected claims and lost revenues. Further, as the deadline draws closer, demand for hardware and software and support for implementation and training will quickly exceed supply.

As such, practices need to start their transition planning now. Given the resources necessary to manage the project, a good option is to seek out the assistance of experts in ICD-10 who can alleviate some of the burdens involved with the gap analysis, communications and workflow modifications.

Regardless of whether they go at it alone or seek outside help, practices must take immediate and aggressive action on their transition plans. Procrastination is no longer an option.

Jennifer Shimek (JenniferS@Dr-Solutions.com), COO of Doctor’s Administrative Solutions (DAS), is an authority on all aspects of physician practice operations and administration. She is a certified professional coder and active member of the American Academy of Professional Coders, Medical Group Management Association and American Medical Group Association.

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Save the Date - Casino Night 2012

Casino Night 2012
a collaborative fundraiser for We Care Manatee and the
Manatee County Medical Society
Saturday, February 4, 2012
6:00-10:00 pm at IMG Golf & Country Club

Since 1996, the Manatee County Medical Society has been working to guard and foster the mutual interest of their member physicians and to promote high quality health care for patients in this community. In 1999, they had the vision to address the ever increasing problem of access to specialty medical services. It was from this foresight that We Care Manatee, Inc. was created. Today the vision continues serving over 1,000 people annually with over $400,000 worth of medical services donated through their programs.

In an effort to streamlines the fundraising goals, the Manatee County Medical Society and We Care Manatee are joining forces. The proceeds from Casino Night 2012 will be equally distributed to help continue the Manatee County Medical Society and We Care Manatee’s programs and services. Please join us!

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All Meetings Mattison’s Riverside Grill—6:00 pm

May 24, 2011

The New Health Age: The Future of Health Care in America
By: Jonathan Fleece, Esq.
Board Certified Health Law
ACOs, Medical Homes and How to Succeed
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Aug 30, 2011

“Legislative Update from Capitol Hill”
Rep Jim Boyd, Rep Greg Steube & FMA Chair of Legislation—John N. Katopodis, MD
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Nov 29, 2011

“10 tips to lower your practice overhead and increase your earnings & Year End Tax Tips”
Kathy Hargreaves, CPA/CFP

May 8th

HAPPY MOTHER’S DAY

June 19th

HAPPY FATHER’S DAY
Electronic remittance advice, you, and your vendor/clearinghouse

Do you think you are ineligible for electronic remittance advice (ERA) since you submit claims through a vendor/clearinghouse? Think again.

Even if you contract with a vendor or clearinghouse, you may still be eligible to receive the electronic remittance advice. In addition, if your vendor or clearinghouse is still receiving standard paper remittance (SPR) they may be eligible for ERA as well.

First Coast Service Options (FCSO) understands that each provider’s billing situation may be different. However, the vast benefits of ERA are worth the time and effort of researching and determining if it is a possibility for your situation.

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- More detailed information; and
- Free software.

Contact the Electronic Data Interchange (EDI) department at FCSO for further information on your situation and the availability of ERA for your office.

To assist in the transition from SPR to ERA, FCSO will allow you to receive both (SPR and ERA) for a period of time. This will ensure there are no interruptions in posting of payments for processed claims during the transition period. You or your vendor/clearinghouse would have the SPR to rely on until it is confirmed that your retrieval and printing of the ERA is working properly.

The Centers for Medicare & Medicaid Services (CMS) even offers free software for Part A and Part B providers for use in viewing and printing duplicate copies of ERA whenever you wish. If you currently submit your claims electronically and are not set up for electronic remittance, please complete the electronic data request form found at http://medicare.fcsolo.com/EDI_forms/130245.pdf prior to downloading the free software.

If you or your vendor/clearinghouse is eligible, how do you get the free software?

- For Part A providers, download PC-Print Software found at http://medicare.fcsolo.com/PC-print_software/.
- For Part B providers, download MREP Software found at http://medicare.fcsolo.com/MREP/.

A few minutes of research now may save you time and frustration later.
Your Chamber of Commerce is committed to supporting and enhancing healthcare quality, access and affordability in Manatee County.

To us, it’s a quality of life issue that affects businesses, employees and visitors, alike.

We thank the Manatee County Medical Society and its members for their support of our ongoing healthcare priorities:

- Manatee Chamber Healthcare Committee
- Manatee Chamber Medical Tourism Task Force
- Manatee Chamber Business Wellness Task Force
- Manatee Chamber’s Legislative Platform Healthcare Priorities
- Creating and Enhancing www.ManateeHealth.com
- Formation of the Manatee Healthcare Alliance
- Successfully Advocating for a Medical Residency Program
- Successfully Advocating for the Reduction of County Impact Fees for Medical Buildings

For information on how you can be involved or how the Manatee Chamber of Commerce can help your practice become an even stronger business, contact Marie Pender at 941-748-4842, ext. 121.

You will also find us online at www.ManateeChamber.com.
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U.S. House of Congress
Congressman Vern Buchanan (R)
District 13, covers Manatee, Sarasota, Hardee, Desoto, and Charlotte counties.
Local Address: 235 N. Orange St., Suite 201, Sarasota, FL 34236
(941)951-6643, Fax: 641-951-2972
Washington Address: 221 Cannon., Washington, DC, 20515
(202)225-5015, Fax: (202) 226-0828
http://www.buchanan.house.gov/contact.shtml

State Legislatures

Representative Jim Boyd (R)
District 68, cover western portion of Manatee County
Local Address: 717 Manatee Avenue West, Suite 100
Bradenton, FL 34205
(941) 708-4968, Fax: (941)708-4970
Tallahassee Address: 1102 The Capitol, 402 South Monroe Street,
Tallahassee, FL 32399-1300
(850)488-4086

Representative Greg Stuebe (R)
District 67
Local Address: 5800 LWR Blvd S. , Sarasota, FL 34240
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Representative Ray Pilon (D)
District 69, covers southern Manatee, University Parkway, Sarasota
Local Address: 1660 Ringling Blvd, Suite 310-311, Sarasota, FL 34236
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Senator Marco Rubio (R-FL)
United States Senate
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Washington, DC 20510
Phone: (202) 224-3041
Fax: (202-228-0285)
Tampa (813) 977-6450

Senator Bill Nelson (D-FL)
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Washington, DC, 20510
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Toll Free: 888-671-4091 Tampa: 813-225-7040
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Senator Mike Bennett (R)
District 21, covers parts of Charlotte, Desoto, Lee, Manatee and Sarasota Counties.
Local Address: 3653 Cortez Road West, Bradenton, FL 34210
(941) 727-6349
Fax: (941) 727-6352
Tallahassee Address: 216 Senate Office Building, 404 South Monroe Street, Tallahassee, FL 32399-1100
(850) 487-5078, Fax: 800-500-1239
Email: bennett.mike.web@flsenate.gov

Senator Nancy Detert (R)
District 23, covers parts of Charlotte, Manatee and Sarasota Counties
Local Address: 1521 Tamiami Trail #303, Venice, FL 34285
(941)486-2032, District wide: (888) 349-3042
Fax: (941)486-2050
Tallahassee Address: 412 Senate Office Building, 404 South Monroe Street, Tallahassee, FL 32399-1100
(850) 487-5081, Fax: 850-487-5406
Email: carlton.lisa.web@flsenate.gov

Senator Arthenia Joyner (D)
District 18, covers parts of Hillsborough, Pinellas and Manatee
Local Address: 508 W. Dr. Martin Luther King Jr. Blvd
Tampa, FL 33603-3415
(813) 233-4277
Fax: (813) 233-4280
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