Auto No-Fault Bills Aim to Increase Insurance Company Profits at Taxpayers’ Expense

ALSO IN THIS ISSUE

• Driving Force: How Doctor Spanaki Scored a Win for Her Patients, Her Physician Colleagues & All Michigan Motorists
• Employers: Avoid Penalties Under Affordable Care Act
• Haveman 2.0: Rebooting Community Health, Expanding Partnerships & Showing Value
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**Question:**
Over the years, I have seen several patients who have conditions that, in my opinion, render them incapable of operating a motor vehicle safely. We have been told in the past that it would be a violation of the physician-patient privilege to report the identity of these patients and/or their conditions to the authorities. I have read recently the law has changed and physicians now may make such a report. Can you explain this change in the law?

**Answer:**
You heard correctly. Thanks to intense lobbying efforts led by MSMS, a favorable change in this area of the law has occurred. Effective December 13, 2012, the Michigan Legislature enacted Senate Bills 402 and 403. Senate Bill 402 added Section 5139 to Michigan’s Public Health Code, making clear that a physician or an optometrist has no affirmative obligation to but may voluntarily report to the Secretary of State or warn third parties regarding a patient’s mental and physical qualifications to operate a motor vehicle in a safe manner. Physicians and optometrists who chose to report or warn third parties in accordance with Section 5139 (the requirements are described below) are immune from any civil or criminal liability resulting from the report or warning. Importantly, new Section 5139 also makes clear that physicians and optometrists who chose not to make a report to the Secretary of State or warn third parties are also immune from criminal or civil liability that may arise from the failure to report.

New Section 5139 requires physicians and optometrists choosing to make a report to the Secretary of State for the purpose of initiating or contributing to an examination of a patient’s physical and mutual qualifications to operate a motor vehicle safely must recommend a period of suspension they determine appropriate as follows:

a) in the case of a patient holding an operator’s license, that the suspension be for at least six months or longer

b) in the case of a patient holding a commercial license, that the suspension be for at least twelve months or longer

The report must be made in “good faith” and “exercising due care,” which means the “episode” resulting in the report must be evidenced by documentation in the patient’s medical record. An episode as:

a) an experience derived from a condition that causes or contributes to loss of consciousness, blackout, seizure, a fainting spell, syncope or any other impairment of the level of consciences

b) an experience derived from a condition that causes an impairment of an individual’s driving judgment

c) an experience derived from an impairment of an individual’s vision

Therefore, patients relating to you any of these experiences who, in your judgment, should not be operating a motor vehicle may be reported by you to the Secretary of State, or you may warn third parties (e.g. spouses, children, others expected to be driven by the patient, etc.), provided that you have adequately documented in the patient’s medical record what you have been told by the patient and what you have learned through your diagnosis, without fear of civil or criminal liability. Conversely, if, in your judgment, a report is unnecessary, the failure to make a report will not result in civil or criminal liability.

The companion bill, Senate Bill 403, amended Section 309 of the Michigan Vehicle Code to provide that a written medical report and recommendation from either a physician or optometrist may be considered by the Secretary of State when assessing a person’s qualifications to operating motor vehicle it makes the report confidential.

Daniel J. Schulte, JD, MSMS Legal Counsel, is a member of Kerr, Russell and Weber, PLC.

**Editor’s Note:**
If you have legal questions you would like answered by MSMS legal counsel in this column, send them to: Jessy Sielski, Michigan Medicine, MSMS, 120 West Saginaw St., East Lansing, MI 48823, or at jsielski@msms.org.
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**Evaluation and Management (E/M) Services: Complying with Documentation Requirements** is an MLN educational tool. It describes common CERT Program errors and provides information on the documentation needed to support certain claims to Medicare.

n the 2011-12 legislative session, insurance companies promoted legislation that sparked a statewide debate on the future of Michigan’s no-fault auto insurance system. On one side, the insurance industry argued the current no-fault system is costly and unsustainable. The other side was led by the Coalition Protecting Auto No-Fault (CPAN), of which MSMS is a member, along with other health care providers, consumer advocates, patients and the legal community. Together, CPAN advocated that Michigan’s no-fault system provides the best insurance value in the country and needs to be maintained.

Once again, however, auto insurance is shaping up to be a hotly debated topic for the new legislature in 2013. Unbeknownst to many is the fact that this legislative debate is not years old, but decades old. Since the early 1990s, insurance companies have been attempting to impose strict cost controls, reduce benefits and promote other reforms that would eliminate no-fault insurance as it is known in Michigan today. Each attempt has ended with the same result: with lawmakers and the public reaffirming their support for a system that provides quality benefits at a value that is second to none.

History of Auto No-Fault in Michigan
Michigan’s current auto insurance system was adopted by the Michigan Legislature in 1972 under the guidance of Gov. William Milliken and went into effect in October of 1973. This law was created to achieve three basic goals:
1. To help injured persons achieve maximum recovery after accidents;
2. To ensure that auto accident victims were reimbursed promptly for costs related to their accidents; and
3. To reduce legal and administrative costs by avoiding time-consuming and unnecessary lawsuits.

In exchange for these generous benefits, Michigan motorists gave up the right to sue the at-fault driver except in the case of death or severe injury.

Under this no-fault system, all drivers are required by law to carry three basic forms of insurance:
- Personal Injury Protection (PIP): This part of an auto insurance policy pays all medical costs related to an auto accident. There are no caps on PIP benefits, commonly referred to as “no-fault benefits,” but insurance companies are only required to pay for “reasonable and necessary” medical treatments and expenses. PIP also pays up to three years of lost wages that an injured person would have earned had he or she not been hurt.
- Property Protection Insurance (PPI): This coverage pays up to $1 million for damage the driver’s vehicle does in Michigan to other people’s property, such as buildings or fences.
- Residual Liability and Property Damage Liability (RI/PD): In the few cases where a driver is found to be at fault in Michigan, this coverage pays for defense costs and any damages for which the driver is found liable.

Because Michigan’s PIP insurance is not capped but rather a lifetime benefit, the legislature created the Michigan Catastrophic Claims Association (MCCA) in 1978 as a fund that would reimburse auto insurance companies for claims that exceed a certain amount, which is currently set at $500,000. This reinsurance fund, which currently covers about 13,000 severely injured accident survivors, is critical to the functionality and sustainability of the Michigan no-fault system.

To fund the MCCA, insurance companies are charged an annual assessment on every vehicle they insure in the state of Michigan. That assessment has ranged from $110 in 1992 to $175 per vehicle today. Insurance companies pass this assessment on to policyholders.

The MCCA is managed by a five-member board of directors made up entirely of insurance companies, with the Michigan Insurance Commissioner serving as a non-voting, ex-officio member. And although it was created by an act of the Michigan Legislature, the MCCA contends it is not subject to the Open Meetings or Freedom of Information Acts.

Michigan No-Fault: The Best Value in the Nation
The most recent data from National Association of Insurance Commissioners ranks the average cost of a Michigan auto insurance policy as the eighth highest in the country. However, when examining at each portion of the costs of an insurance policy, it becomes clear that no-fault is not the driving factor.

The average uncapped, lifetime PIP benefit costs Michigan drivers $544.20 per year, just $60 above the national average of $484.03. In fact, the most expensive portion of an auto insurance policy in Michigan is collision, not PIP. States like New York,
where PIP benefits are capped at $50,000 (some cap benefits even lower), actually pay more for medical benefits than drivers in Michigan. Given Michigan’s far superior medical benefits, it’s clear that our auto insurance system does a good job of providing the care needed at a reasonable cost.

Michigan is also one of the few states in the country where an accident survivor can be assured to receive immediate care. In all other states, surviving accident victims must either sue to gain reimbursement for care or they end up on Medicaid because the PIP caps are so low, which does not cover the post-acute rehabilitation benefits needed by many auto accident victims.

In Michigan, however, lifetime injury benefits are paid for by drivers through fees paid into the MCCA.

Colorado is an example of a state that realized the benefits of auto no-fault too late. In 2003, its legislature, in an effort to lower the cost of auto insurance, switched from a no-fault to a tort system. Five years later, the costs to taxpayers and health care providers were devastating. Medicaid costs in Colorado increased a staggering 205 percent from care resulting from motor vehicle accidents alone.

The Current No-Fault Proposal

Despite the lessons learned from Colorado and the nation-leading value of Michigan’s auto insurance system, auto insurance companies continue their attempts to end auto no-fault in Michigan.

Recently, Senators Joe Hune (R-Howell) and Virgil Smith (D-Detroit) introduced Senate Bill 251, which would cap PIP benefits at $50,000 and eliminate the MCCA. Senator Smith contends this legislation would reduce costs for drivers, despite the fact that insurance companies have also refused to guarantee any savings would be passed on to Michigan drivers if the legislation is approved.

While lawmakers such as Sen. Smith want to reduce costs for drivers, the insurance industry is advocating for this and similar yet-to-be-introduced proposals, such as applying a workers’ compensation fee schedule to no-fault claims. Insurers argue these changes are needed to keep the MCCA financially viable, but they have yet to disclose the economic and actuarial assumptions on which the MCCA’s projections are based.

The Need for MCCA Transparency

Because the insurance industry is basing its arguments for no-fault reform on information from the MCCA that cannot be publically verified, CPAN and the Brain Injury Association of Michigan have engaged in a legal battle with the MCCA to disclose the fund’s financial information.

The combined lawsuit argues that the MCCA is subject to the Freedom of Information Act and should be considered a public body because it was created by an act of the Michigan Legislature and is funded by Michigan drivers through assessments on their auto insurance policies. CPAN’s position was supported by two excellent amicus curiae briefs, including a joint brief by the Michigan State Medical Society, the Michigan Osteopathic Association, the Michigan Orthopedic Society, and the Michigan Association of Chiropractors.

“A well-functioning MCCA is critical to the existence of our state’s auto insurance system and for the care of seriously injured accident victims,” said Michael Dabbs, president of the Brain Injury Association of Michigan. “The Circuit Court judge ruled in our favor and issued an order that would bring long-awaited transparency to the MCCA, but the MCCA filed to have the case heard in the Court of Appeals.”

He adds, “But until now insurance companies have kept the MCCA hidden from the public. There has been no way to verify whether drivers were being charged appropriate rates to sustain the MCCA or whether Michigan insurance companies were properly managing the more than $13 billion held in MCCA funds.”

The specific information CPAN is seeking from the MCCA includes economic projections, actuarial assumptions and calculations, and other information used by the MCCA to project its long-term financial needs. This information is critical to the public’s understanding of Michigan’s no-fault system and lawmakers’ ability to make sound public policy decisions on the subject.

Unintended Consequences of Proposed Reforms

While the proposed $50,000 PIP cap would not be retroactive, applying only to auto insurance policies issued or renewed after December 31, it would have several unintended consequences that would be devastating to Michigan.

A 2011 study by Public Sector Consultants found that more than 500 people every year will require long-term care as a result of suffering traumatic brain injuries in car accidents. If the PIP benefits are capped at $50,000, as proposed in SB 251, the total cost to the Michigan Medicaid budget could increase $30 million in the first year, roughly $61,000 per traumatic brain injury. And because an additional 500 people will suffer similar injuries each year, the costs to the state’s Medicaid budget could grow exponentially, as illustrated in the graph below.
“Early health care support and intensive rehabilitation is vital to helping brain-injured accident victims regain their skills and become productive citizens,” said Lynn Brouwers, president of the Michigan Brain Injury Provider Council, which paid for the study. “Any cuts to auto injury benefits will leave a huge population of accident victims without adequate care and reliant on the state’s welfare system.”

Cuts to PIP benefits and the elimination of the MCCCA also would severely threaten Michigan’s economy, especially the post-acute rehabilitation industry. An Anderson Economic Group study, also conducted in 2011, found that a $50,000 cap on PIP would result in the loss of up to 5,000 rehabilitation jobs and up to $150 million in lost earnings.

No-fault fee schedules supported by insurance companies would compound the negative impacts created by a cap on no-fault benefits. The Michigan Health and Hospital Association estimated that applying the workers’ compensation fee schedule to auto accident victims would cost the average health care system $10 million in reduced revenue. For large systems, such as Beaumont in Royal Oak, the cost would be upwards of $25 million.

Estimated Loss in Hospital Resources by Michigan Region (2011 data):

<table>
<thead>
<tr>
<th>Hospital Name</th>
<th>Annual Loss</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bay Regional Medical Center</td>
<td>$.88 million</td>
</tr>
<tr>
<td>Beaumont Health System, Royal Oak</td>
<td>$26 million</td>
</tr>
<tr>
<td>Borgess Health</td>
<td>$4.3 million</td>
</tr>
<tr>
<td>Bronson Methodist Hospital</td>
<td>$7.2 million</td>
</tr>
<tr>
<td>Bronson Battle Creek Hospital</td>
<td>$1.2 million</td>
</tr>
<tr>
<td>Central Michigan Community Hospital</td>
<td>$4.4 million</td>
</tr>
<tr>
<td>Detroit Medical Center</td>
<td>$24 million</td>
</tr>
<tr>
<td>Genesys Regional Medical Center</td>
<td>$.9 million</td>
</tr>
<tr>
<td>Henry Ford Health System, Detroit</td>
<td>$9.5 million</td>
</tr>
<tr>
<td>Hurly Medical Center</td>
<td>$14.4 million</td>
</tr>
<tr>
<td>Ingham Regional Medical Center</td>
<td>$.54 million</td>
</tr>
<tr>
<td>Lapeer Regional Medical Center</td>
<td>$1.3 million</td>
</tr>
<tr>
<td>Mid-Michigan Health</td>
<td>$2 million</td>
</tr>
<tr>
<td>Mount Clemens Regional Medical Center</td>
<td>$3.7 million</td>
</tr>
<tr>
<td>Munson Medical Center</td>
<td>$6.5 million</td>
</tr>
<tr>
<td>Oakwood Healthcare, Dearborn</td>
<td>$18.3 million</td>
</tr>
<tr>
<td>Saint Joseph Mercy Health System, Ann Arbor</td>
<td>$12.7 million</td>
</tr>
<tr>
<td>Sparrow Hospital</td>
<td>$15.3 million</td>
</tr>
<tr>
<td>Spectrum Health</td>
<td>$20 million</td>
</tr>
<tr>
<td>St. John Providence Health System, Warren</td>
<td>$9.3 million</td>
</tr>
<tr>
<td>St. Mary’s of Michigan</td>
<td>$3 million</td>
</tr>
</tbody>
</table>

Source: Michigan Hospital Association

If a no-fault fee schedule proposal becomes law, current hospital service levels would be cut and trauma units that care for those with catastrophic injuries would be in jeopardy. Ultimately, these changes would cost jobs and threaten health care access for every Michigan resident.

Above all, the no-fault reform proposals being advanced by the insurance industry simply do not provide the level of care needed by Michigan’s severely injured accident victims.

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Protecting Michigan’s Model No-Fault System

Through its partnership with organizations like the Michigan State Medical Society, the Coalition Protecting Auto No-Fault has been able to successfully oppose attempts to dismantle auto no-fault in Michigan. But with an insurance industry-friendly legislature, court system and governor, the 2013-14 legislative session threatens to be CPAN’s most challenging year.

As health care providers, you know the impacts that proposed reforms like SB 251 will have on the quality of life of seriously injured people. It’s also clear that any possible cost savings – none are guaranteed – will also be completely eroded by the impacts to hospitals, post-acute rehabilitation providers, and the Medicaid system.

Rather than dismantling the best auto insurance system in the country, CPAN will be working with lawmakers to promote alternative reforms that will improve auto no-fault. Proposals will be introduced this year that will aim to help.

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The author is President of the Coalition Protecting Auto No-Fault and of the Eisenhower Center.

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For More Information

MSMS members are encouraged to individually support CPAN’s efforts to protect auto no-fault by staying in close communication with their lawmakers in the House and Senate and by writing letters to their local newspapers. Information and advocacy will also be posted regularly on CPAN’s website ProtectNoFault.org and social media pages: Facebook.com/ProtectNoFault and Twitter.com/ProtectNoFault.
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Driving Force:
How Doctor Spanaki Scored a Win for Her Patients, Her Physician Colleagues & All Michigan Motorists

By Stacy Sellek

Getting a piece of legislation signed into law is no easy task. Few can tolerate the hoop jumping and political gamesmanship that are all too common in the process. Throw in elections and term limits, and sometimes it can take years of “hurrying up and waiting.” But Marianna V. Spanaki, MD, MBA, PhD, proves that possessing and applying passion, patience, persistence, and partnership can help make the journey worthwhile.

As a young girl in Greece, Doctor Spanaki had many dreams. In particular, she dreamed of becoming a physician since the age of eight. Specifically, she wanted to become a pediatric psychiatrist, which didn’t exist as a specialty there some 40 years ago.

“I was influenced by books that I was reading and my desire to offer help to people and kids, in particular,” she explains. “No one believed me, including my parents, who thought that I was reading too many books that resulted in dreams of unrealistic career paths.”

Although she describes her parents, who owned an office furniture business, as open-minded and supportive, Doctor Spanaki said that they considered becoming a doctor very challenging for a woman who would eventually want to start a family.

“But when I told my father that, for me, it was either medical school or nothing, he was convinced about my determination.”

That determination helped Doctor Spanaki earn her medical degree at the University of Patras, although instead of pursuing pediatric psychiatry, she was inspired to turn to neurology, thanks to a key influence. “I was fortunate to be mentored by a prominent female Greek neurologist and the first epileptologist in my country. It seemed to be my destiny to pursue neurology and epilepsy as a career path.”

Fulfilling another part of her destiny, as she puts it, “I met my husband-to-be in Greece, who had already planned further training in the US. We both knew that it was our dedication to medicine and dreams to come to the US that made our relationship strong and meaningful.”

Doctor Spanaki and her husband, Panos Varelas, MD, PhD, both completed neurology residencies at Yale University. About her husband, who works with her in the Henry Ford Medical Group, Doctor Spanaki says, “It is my husband’s unconditional support and understanding that helped me throughout this journey.”

She later completed a fellowship at the National Institutes of Health (National Institute of Neurological Disorders & Stroke). And if she wasn’t busy enough, Doctor Spanaki also carries two other degrees. She earned her PhD in the field of epilepsy from the University of Athens in Greece, and pursued an executive MBA at University of Tennessee in 2008.

“I was very interested in the business aspect of medicine in a rapidly changing health care environment,” she says.

Doctor Spanaki has held teaching positions at the University of Wisconsin and (currently) at Wayne State University School of Medicine.

Her drive, passion, and dedication to her patients and her profession are traits she hopes to impart on her 12-year-old daughter, Eleni-Nefeli, whom Doctor Spanaki plans to take on a medical mission in the future.

“Being a part of a strong Society was something that kept me going throughout this process. I think my own experience is a prime example that unless you team up with a strong voice, such as MSMS, you cannot be successful.”

— Doctor Spanaki
The Light Bulb

It was during her participation in the Palatucci Leadership Forum through the American Academy of Neurology (AAN) when Doctor Spanaki was inspired and compelled to make a difference in her field on a broad scale.

“I thought at the time this was the perfect opportunity for me. I wanted a project that would benefit the entire community – not only the physicians, but all the parties involved,” she explains.

“Since epilepsy is a big part of my life and my colleagues’ life, we had this big challenge about the driving privileges of our patients. And it’s not just epilepsy patients; it’s everyone who may have episodes of loss of consciousness. We didn’t really know how to address it in order to protect the safety of our patients and the public’s safety. And then there was also the physician liability. That was the starting point for me.”

After finishing her training at AAN, Doctor Spanaki returned to Michigan to get her project off the ground.

As a delegate, she eventually submitted a resolution to the MSMS House of Delegates (Res. 21-07A) that was adopted by the House. It resolved “that MSMS seek legislation that would provide immunity to physicians and institutions for injuries to or caused by individuals who are impaired due to any disease that reduces mental or physical

Why She Joined MSMS

“When I first came to Michigan, I heard a lot about MSMS [through Henry Ford] and I was impressed with the work being done. Our voice is not as strong as individual physicians as it is in an organized medical society. I feel part of a collective power by being a member of MSMS.”
skills and/or treatment of such condition provided that the physicians in good faith have properly warned the individual and documented such interactions/warnings in the patient’s medical record and otherwise complied with state law.”

Testing Her Drive
Maybe it should come as no surprise that an individual who hails from the birthplace of democracy would become involved – and successful – in legislative advocacy. But as a legislative neophyte, she admits, “I didn’t realize when I got started how difficult it would be.” Adding with a laugh, “Maybe that was good!”

“I really needed support from people who knew the legislative environment better than I do, and MSMS is the voice of all physicians in Michigan.”

One of the challenges Doctor Spanaki faced in making the case for legislation was that there was an existing law that few legislators wanted to touch. “I had to show that there was value in changing it and prove that it had many deficiencies and loopholes, and just wasn’t meeting its intended goal. To do this, I had to educate myself and sell the message. I had to find laws from other states to use as examples.”

Another major obstacle was the strong opposition to the legislation from trial lawyers, who felt it would give physicians a “free ride” from accountability. Then there was the stop-and-go nature of the legislature itself.

Despite the fact that the earlier impaired driver bills had died, what encouraged Doctor Spanaki to keep going was the fact that MSMS wouldn’t let the issue go away, and was instrumental in getting a new set of bills introduced.

“Whenever I needed MSMS – moments of too much resistance, negotiations – they were there for me. Being a part of a strong Society was something that kept me going throughout this process,” she enthuses. “I was really impressed by the knowledge of the people I worked with. Their communication skills and willingness to support me was outstanding! MSMS has a wonderful resource in its staff. They have been available, supportive, and I really applaud the Society for this.”

After years of advocacy efforts, Senate Bills 402 and 403 passed the Michigan Legislature in December 2012, and Doctor Spanaki was there when Gov. Rick Snyder signed them into law that month.

“This has been a very rewarding and fulfilling experience for me. How you present your idea, form partnerships, and overcome resistance are very important,” she shares. “It tests your limits and your drive.”

You Can Do It, Too!
Got an issue you want to advocate in the legislative arena? Doctor Spanaki offers some words of encouragement and helpful tips:

- Educate yourself about what the cause is and what it will bring to the community
- Be consistent and persistent in your message
- Be patient
- Have a lot of courage
- Don’t take everything personally – it’s rare to have everyone on your side
- Don’t feel guilty that you didn’t work hard if you don’t succeed; it’s part of the process
- Keep an open mind and listen to the opposition
- Be willing to compromise
- Work with MSMS – it’s worth devoting time to initiatives that will eventually help our profession

The author is Senior Manager, MSMS Communications & Public Relations.
BE BOLD WITH LEAN BEEF

Heard the good news about lean beef? The latest research presents a new way of thinking: lean beef can be part of a solution to one of America’s greatest health challenges—eating for a healthy heart. A study published in the American Journal of Clinical Nutrition found that participants in the BOLD (Beef in an Optimal Lean Diet) study experienced a 10% decrease in LDL cholesterol from baseline when they ate lean beef daily as part of a heart-healthy diet and lifestyle containing less than 7% of calories from saturated fat.

Setting the Record Straight
This groundbreaking clinical study substituted lean beef for white meat as part of an overall heart-healthy diet and found the improvements in LDL cholesterol seen on the beef-containing diets were just as effective as DASH (Dietary Approaches to Stop Hypertension).

MANY LEAN CUTS
Lean beef is easily served with vegetables, whole grains and low-fat dairy—improving taste, satisfaction and providing essential nutrients. And many of the most popular cuts of beef—like Top Sirloin steak, Tenderloin and 95% lean Ground Beef—meet the government guidelines for lean.

TEN ESSENTIAL NUTRIENTS
Packed with high-quality protein, lean beef provides a satisfying, nutrient-rich experience. A 3-ounce serving of lean beef contains 150 calories on average and is a good or excellent source of ten essential nutrients, including iron, zinc and B-vitamins.

PART OF A HEART-HEALTHY PLAN PATIENTS WILL LOVE
Lean beef can be a deliciously welcome and satisfying choice in a heart-healthy diet. Help your patients increase meal flexibility by including lean beef among other heart-healthy choices on their shopping lists.

Learn more about the many nutritional and heart health benefits of lean beef at: BEEF nutrition.org

The Michigan Beef Industry Commission
www.mibeef.org

* Subjects that consumed the BOLD diet experienced a 10% decrease in LDL cholesterol compared to baseline. In comparison, the Healthy American Diet subjects experienced a 4% decrease in LDL cholesterol on the BOLD diet.


Physician practices offering health insurance coverage to their employees need to be aware of the employer “shared responsibility” excise tax that will be implemented in 2014 under the Patient Protection and Affordable Care Act (PPACA). In January 2013, the US Treasury and the IRS published proposed regulations providing guidance on how these rules will be implemented. It is unclear when the regulations will be finalized.

Physician practices with at least 50 full-time employees can avoid the penalty if they offer minimum essential coverage to all full-time employees (and their dependents) and no employees receive a tax credit or cost-sharing reduction through the health care exchange. This would mean the coverage offered by the employee is affordable. These simple sentences need further clarification and has been the subject of the proposed regulations.

**Determination of “Full-Time” Employee**

There are two numbers a practice needs to consider. First, it needs to determine the number of full-time equivalent employees it has in order to determine if they qualify as a “larger employer.” In general, an employee who was employed on average of at least 30 hours per week or 130 hours per calendar month is considered a full-time employee. For part time employees, a practice should use the following calculation to determine full-time equivalency:

\[
\text{Total number of full-time equivalent employees} = \frac{\text{Total # of full time employees} \times (30 \text{ hours/week} \text{ or } 130 \text{ hours/month})}{120} + \text{Total hours worked by part time employees}
\]

If this number is at least 50, you are considered a “large employer” and must offer essential health coverage that is affordable to all full-time employees. Therefore, if a practice has 45 full-time employees but qualify as a large employer using the full-time equivalency calculation, the practice only has to offer the coverage to the 45 full-time employees.

Note: When a practice calculates the hours, it must include not only the hours when the employee performs his/her duties, but also the hours for which the employee is paid – such as vacation, holiday, illness, layoff, jury duty, military duty, and leave of absence.

Because the number of full-time employees can fluctuate from month to month, the proposed regulations have included a safe harbor determination method. The safe harbor is complex. In general, a practice will need to choose a “measurement period,” which determines the employee’s average hours; a “stability period” for which the coverage is provided; and an “administrative period,” which allows time for enrollment and disenrollment.

**Penalty Amount**

A practice will have a penalty imposed if:

- It doesn’t offer minimum essential coverage to “substantially all” its employees. The proposed regulations state that a practice will meet the “substantially...
all” requirement if they offer health insurance coverage to at least 95 percent (or if greater coverage to all but five full-time employees) of its full-time employees (and their dependents). For practices that fail this test, the penalty will be:

Total Number of Full-Time Employees
(not full time equivalents) – 30 X $2,000

Note: The proposed regulations define “dependent” to narrowly include only an employee’s child (i.e., son, daughter, stepson, stepdaughter, adopted child, child placed for adoption and foster child) up to age 26. Dependents for the purpose of this rule DO NOT include an employee’s spouse.

• The coverage is unaffordable for the employee; does not provide minimum value; or the practice offers coverage to at least 95 percent but less than 100 percent of its full-time employees (and their dependents). For practices that fail this test, the penalty will be the lesser of:

Number of Full-Time Employees who receive minimum tax credit on an exchange X $3,000

or

Total Number of Full-Time Employees
(not full-time equivalents) – 30 X $2,000

Note: The practice will not be subject to the penalty unless at least one employee receives a premium tax credit to help them pay for coverage through the health care exchange.

Minimum Essential Coverage and Affordability
The proposed regulations define minimum essential coverage as a plan that covers 60 percent of the cost of health care.

The proposed regulations define affordable coverage to mean that the employee’s required contribution (premium share) towards the cost of self-only coverage does not exceed 9.5 percent of the employee’s household income for the taxable year. Because a practice will not know an employee’s household income, the proposed regulations has three safe harbor categories:

1. Form W-2 Safe Harbor: The practice may rely on the employee’s Form W-2 wages to determine if the employee’s required contribution does not exceed 9.5 percent of this figure. If the employee’s required contribution is equal to or less than 9.5 percent of this amount, the coverage is considered affordable.

2. Rate of Pay Safe Harbor: A practice may take the hourly rate of pay for each eligible hourly employee, multiply by 130 hours, and determine the affordability. If the employee’s required contribution is equal to or less than 9.5 percent of this calculated amount, the coverage is considered affordable.

3. Federal Poverty Level (FPL) Safe Harbor: The practice’s coverage would be considered affordable if the employee’s cost of self-only coverage does not exceed 9.5 percent of the most recently published federal poverty level for a single individual.

These are the basic steps that a practice needs to take to determine their eligibility regarding the employer shared responsibility penalty. Once a practice has made this determination, the practice will then need to decide what they need to do to avoid the penalty.

The author is Senior Director of MSMS Senior Director of MSMS Physicians Insurance Agency.
AFTER Gov. Rick Snyder’s first Director of the Michigan Department of Community Health, Olga Dazzo, returned to the private sector in 2012, he tapped Grand Rapids native Jim Haveman to return to his former post and drive his aggressive health and wellness agenda forward – something the Governor refers to as a critical piece for reinventing Michigan. Haveman sat down with MSMS’s Stacy Sellek to explain what he learned from his previous tenure at MDCH, how his experiences since then have shaped his approach to the job, and the importance of forging partnerships to move health care forward.

STACY SELLEK: After previously serving as MDCH Director for seven years, what lessons, accomplishments and goals have you carried with you – or left behind – from your last “tour of duty”?

JIM HAVEMAN: Last time I was here, it felt like we were moving so fast. Back then, we merged five state departments, closed several mental health institutions around the state, shifted from a fee-for-service to a managed care payment model, and experienced a shifting majority in the legislature, to name a few things. Now, things seem much more mature and settled. The budgets move faster, which helps everyone make plans and know what to expect in advance each year. There is much to be done regarding Medicaid expansion, the issue of dual [Medicaid and Medicare] eligibles, to name a few. But it’s a great time to be here.

SS: Health care has changed so much since you last worked for the state. What are the major changes you’ve noticed?

JH: One of the most noteworthy changes is the move away from a curative model to more of a preventive model with the advent of the medical home. We still have more than one million people in the state who are uninsured; they get care, but it’s uncompensated care.

Health departments are struggling with how they fit into all the changes in the health care arena. But what physicians, health directors, and community health board members are finding is that they’ve got to be friends with everyone right now. Everybody’s a potential funder and a potential participant. And if we move to accountable care organizations – which many of your members are already part of – it’s really going to change how we think about care. It’s going to be a shared experience, and there will be rewards and penalties. We never talked about that 10 years ago.

SS: You told the MSMS Board that you like the ACO model because it’s less “silo-focused” and that the medical home model is necessary to better coordinate care. What is the state doing to support new models such as these?

JH: One of the state programs is the MiPCT [Michigan Primary Care Transformation Project] program. We have about 1,700 doctors involved and 300 practices. It involves the Blues, the Medicaid program, and Priority’s joining us. These are practices all over the state that are really committed to best practices, best evidence, best structure, and how their offices can think smarter, manage patient care better, do more preventive care, and have better outcomes. It always works better when – and I’m no different than a doctor – you don’t have stuff jammed down your thinking process. You want to bring it into your practice and see how it works; and I think we’ve got to do a better job of deciding which procedures work best with patients.

SS: After working for two different governors – John Engler and Rick Snyder – how would you characterize their approaches to health care and how have they affected your role?

JH: They’re very similar. Both Engler and Snyder are very smart people who really want this to be a better state and a healthier state. I think Gov. Snyder has taken it to another level of health and wellness where he’s laid out a timeline that he expects everyone to follow. He’s also taken it to another level with regard to dashboards for such critical issues as infant mortality and obesity. We are charged with looking at whether something’s valued-added to
the state so we can see what’s working and what’s not working. [Engler and Snyder] both are willing to get rid of things that aren’t working. They’re both very supportive of their cabinets, too; they like to bring in smart people and have them do their jobs.

One big difference is that Snyder accepts no paper. You have to get used to that. I started working for the state in 1990 and we didn’t have many computers. The department now is much more technologically advanced. And doctors are going through the same thing with electronic medical records.

**SS:** You have said that in order to make an impact on people’s lives, we must take control of health care. Name one way you intend to do that. Also, what do you see as the biggest challenge in achieving that goal?

**JH:** By moving from fee-for-service to managed care in Medicaid, people are engaged in weight reduction programs, diabetes education programs; people at risk for heart disease are engaged in programs and obesity programs. As we look to expand Medicaid, we want to plug them into that same aggressive medical home that the current Medicaid population’s involved in. We’re going to be much more proactive, and that’s the part I have to educate the legislature on. This isn’t just the same old, same old.

**SS:** With nearly 1/3 of all Michiganders characterized as obese, the Governor has made reducing obesity levels a priority. How is the 4 x 4 Plan working toward this goal and how are you measuring the outcomes?

**JH:** The national metrics usually lag about two years behind, but we do enough surveying with county health departments that we will soon start to get some indication of what’s working. Incidentally, the 4 x 4 Plan was mentioned recently by Dr. Oz as something positive when he did a presentation to the National Governors Association, and I think we’ve got about 19,000 people signed up. We’ve got all kinds of partners on this: Quicken Loans, physician groups, health care provider groups, the Blues, Blue Care Network. McDonald’s is doing tray sheets for us under the MI Healthier Tomorrow program. We’ve also gotten cooperation from the Michigan Association of Broadcasters. We’d like to see even more partnerships.

**SS:** You have a professional background in mental health services and social work. As a mental health dialogue grows in the wake of national tragedies, how can Michiganders expect the administration to approach this critical issue here?

**JH:** The governor put $5 million more in our budget beginning in 2014 to work on some high impact programs for high risk kids. Physicians and juvenile courts know who they are – we have about 240 kids like that in the state. We’ve got to do a better job either in-home or out-of-home, and have a better approach with the Department of Human Services, schools and law enforcement. We’re also going to do Mental Health First Aid, which is a massive training of clergy, teachers, PTA groups, and other non-health care professionals who may interact with kids who are mentally ill. It gives them some mastery of mental illness so they understand it and know how to speak to somebody who is mentally ill or know how to get help when they see somebody who is decompensating. The program is from Australia, but there are some trainers in Michigan. And it’s evidence-based, so it’s a plug-in that we can just get trainers and do it.

The Governor also has just formed a commission on how to make the mental health system better. We’re also educating people (legislators, for example) on not stigmatizing mentally ill people. There’s the issue of unemployment, violence in the streets, and that is something you just can’t predict. This is one of the reasons why Medicaid expansion is important: to bring more people into the mental health system. There are people right now who aren’t getting services they need because they don’t qualify.

**SS:** In 2003, you were tapped by the White House to help build a sustainable health care system in Iraq. How did the challenges there

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**On Health Care as an Economic Driver:**

“The thing I keep emphasizing is that we are an economic engine that really makes a difference in this state. We don’t celebrate it enough; I think we are way too timid about that. We make a difference in every community in Michigan.”

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"I think one of the reasons I’ve come back here to this job in such a relaxed way – my own perception, I don’t know about others – is that I realized how blessed we are with what we’ve got.”

— Jim Haveman
compare to those you saw in Michigan?

**JH:** I left a state that was spending $10 billion on health care for 10 million people, and went to a country of 26 million people that was spending $16 million on health care. I had 240 hospitals and 1,200 clinics to run, and the hospitals received no maintenance for 30 years. I started out with two looted 10-story buildings. That’s what I walked into. There was no mental health department, and we started one. I was dealing with a country that was withholding health care from people so they would die and they could blame the sanctions. I was told there were no cat scans in Iraq, but then I would go to a warehouse in Baghdad and find 60 of them that weren’t made available to people.

However, many of the dynamics of health care are universal. Mothers in Iraq want their kids immunized and want their kids to be healthy and not to die at a young age. That’s no different than here. They want access to services. When I left, they were spending about $1 billion of Iraqi money, and today it’s about $4.5 billion, so it’s come a long way.

**SS:** What was the most important thing you learned from your experience in Iraq?

**JH:** To appreciate what we’ve got here, to make it better, and to make it more available. I think the fact that we have 40-50 million people who have no insurance in this country is something that we have to fix. We all know it; we just have to find a way to do it. There happens to be a model on the table right now that’s the law of the land. We’re going to seize it and make it work. If we find out the administration doesn’t meet its promises and says, ‘We didn’t mean 100 percent, we meant 90 percent,’ then the legislature can pull out of it. But for now, we are recommending that we bring in 46 percent of the people who are uninsured in this state.

**SS:** You have mentioned the importance of building teams and developing partnerships to improve health care. How does MDCH plan to keep engaging physicians and MSMS, in particular?

**JH:** Many of our health departments around the state have physicians who are part of their medical community and nothing’s going to change there. They want access to services. When I left, they were spending about $1 billion of Iraqi money, and today it’s about $4.5 billion, so it’s come a long way.

**SS:** What is one major goal that you still want to accomplish professionally?

**JH:** It’s very clear: the cost of multiple chronic conditions that people experience and our inability to get them engaged in behaviors that would start cutting down the chronic conditions and get them on a healthier pace is the number one goal. Eighty-plus percent of health claims are related to lifestyle choices, and we just have to get that across to people.

*The author is Senior Manager, MSMS Communications & Public Relations.*
OBITUARIES
The members of the Michigan State Medical Society remember with respect their colleagues who have died.

Gerald F. Barofsky, MD
Grand Rapids, died January 31, 2013, at the age of 90.

Robert G. Borchak, MD
Grosse Pointe Woods, died March 2, 2013, at the age of 86.

David C. Boyce, MD
Grand Rapids, died March 5, 2013, at the age of 94.

Robert D. Burton, MD
Grand Rapids, died February 15, 2013, at the age of 85.

William B. Comai, MD
Battle Creek, died January 23, 2013, at the age of 76.

Joseph Daniels, MD
Byron Center, died January 14, 2013, at the age of 81.

Luebert Docter, MD
Grand Rapids, died January 20, 2013, at the age of 96.

Vishnubhai U. Patel, MD
Pontiac, died January 9, 2013, at the age of 76.

Edward Y. Postma, MD
Grand Rapids, died January 9, 2013, at the age of 97.

L. Murray Thomas, MD
Grosse Pointe Park, died December 26, 2012, at the age of 90.

B. David Wilson, MD
Bonita Springs, FL, formerly of Kalamazoo, died February 10, 2013, at the age of 77.

IN MEMORY
If you would like to recognize a colleague by making a gift or bequest in their memory to the MSMS Foundation, the physicians’ own charity, please contact Rebecca Blake, Director, MSMS Foundation, 120 W. Saginaw, East Lansing, MI 48823, call 517-336-5729 or send e-mail to rblake@msms.org.

Be Wary of Being a “Dr. House”: Relying Too Much on Intuition Is Risky

Contributed by The Doctors Company

In the television show House, Doctor Gregory House bases his diagnoses on heuristics – the use of intuition and rule-of-thumb techniques or mental short cuts. While heuristics can improve efficiency and decision-making effectiveness, this subconscious process may lead a physician to make a judgment based on the facts that most readily come to mind, rather than making a conscious decision after formally analyzing all facts. It’s important to be wary of relying too heavily on heuristics, as this could lead to negative patient outcomes and increased liability risk.

The following is from a case study:
A patient presented progressive neurological symptoms and severe pain, but hospitalists based their diagnoses on heuristics and failed to consider a spinal epidural abscess (SEA). While infrequently encountered in clinical practice, SEA requires prompt diagnosis and treatment to prevent serious neurological complications. A delayed diagnosis can lead to irreversible neurological deficits.

In this particular case, various hospitalists who saw the patient failed to initially order an MRI of the spine or a neurology consultation, which would have led to an appropriate diagnosis. When an MRI was finally done, it showed an epidural abscess compressing the spinal cord. After surgery, the patient remained paraplegic.

Had the hospitalists been aware of the unconscious tendency toward using heuristics and had instead followed the standard of care to read nurses’ notes, review physical therapy assessments, and conduct thorough neurological examinations, it is more likely the patient would have had a timely SEA diagnosis and an increased chance to regain neurological function.

Because decision-making and problem-solving behavior in medical practice is guided by years of experience, heuristics inevitably plays a part, and that can be beneficial or harmful. Here are a few ways to avoid the risk:
• Be prepared to alter your course of treatment.
• Consider family history when making a diagnosis.
• Engage your extended team, including specialists, pharmacists, and physical therapists, to consult and treat the patient.
• Always review what other care providers have noted on the patient’s chart.
• Communicate with all providers involved in a patient’s care.
• Use a structured communication process to communicate critical or worrisome findings.
• Keep an open mind when there is conflicting information.
• Always have a back-up plan.

The Doctors Company is the exclusively endorsed medical liability carrier of the Michigan State Medical Society (MSMS). We share a joint mission of supporting doctors and advancing the practice of good medicine. For information about the company, visit www.thedoctors.com.
The Solution to Increasing Revenue?

Work Less

By Ren Carlton

How would you react if I told you that one of the best ways to increase revenue in your practice is to work fewer hours in it? Not only is it possible, but it is also simple and practical.

The emphasis on the word “in” in the first sentence is not a typo. One of the most difficult challenges faced by physicians is maximizing the amount of revenue generated for the hours spent in the practice of medicine. The key to maximizing revenue is to make sure your hours are spent as a physician, not as an administrator, because your maximum earnings accrue from the practice of medicine. That’s your highest dollar value. Yet, when your name is on the door, several common business management dilemmas arise.

Dilemma 1: In order to earn more money, the physician/owner has to work more hours. Do you have the willingness and ability to work the number of hours you need to make the amount of money you want? Most business owners I know want to work fewer hours, especially as they get older. Are there opportunities in your practice now to dedicate more of your working hours exclusively to the practice of medicine?

Dilemma 2: You need a predictable volume of patients to fill the number of hours required to meet your financial goals. Most medical practices do not have a consistent, predictable, and recurring revenue stream from existing patients alone. This means you must constantly attract new patients. If you’re looking to grow your practice, acquiring new patients becomes even more important.

Dilemma 3: You maximize your income by working in your practice (e.g., treating patients) not on your practice (e.g., business planning, budgeting). Most physicians spend the majority of their working hours treating patients instead of running their business. This all too often leaves the business to “run itself,” which is a formula for disaster.

These three dilemmas add up to a very potent business and operational challenge. How can it be possible to earn more money practicing medicine yet work fewer hours? Here is a valid, real-world solution worth your consideration.

Through 13 years of experience working with high-level professional service providers, with physicians unquestionably occupying the topmost tier of that pyramid, I have learned an unsettling irony: the higher the level the professional (e.g., physicians), the less personal time and concentrated effort is available to apply to financial management. Yes, there are many successful medical practices, but I would argue that even successful practices leave a lot of money on the table because their financial management is not as diligent as it could be and should be.

Is the financial management of your practice as diligent and profitable as it should be? Here is a quick test that will indicate if the hours you spend at work are maximizing the income you earn:

Do you delegate effectively and appropriately? If you haven’t already done so, take a minute to calculate the closest approximation to your “hourly rate.” Calculate how many patients you see per day, how much you charge them, and what you receive in payment from individuals, insurance payments, and other resources such as teaching, lectures and/or publications. It’s quite possible that your “hourly rate” is $400-$600 per hour or more. If that’s your earning potential, does it make fiscal sense for you do anything remotely administrative? Delegating means relinquishing control. But all leaders must learn to do it. Build your practice around a “swat team” of support staff to whom you delegate all actions beneath your pay scale. Then commit all your work hours to practicing medicine and maximize your income. Limit your activities as a physician to just two things: treating patients and delegating all responsibilities beneath your pay scale.

Do you collect all the money that you’ve earned? Revenue cycle management is the formal term for collecting the money you are owed for the work you’ve already done. Revenue cycle management is the key to every profitable medical practice. It is also the vital financial management process where most medical practices fall short. Do you know – at this very moment – how much money your practice has earned but has not yet collected? Find that answer now. Put that on your “To Do” list today and start collecting what is owed you immediately.

Do you spend ahead? It takes money to make money. In order to maximize your earnings, invest prudently in your practice’s human infrastructure. Demand the best from your staff, your bookkeeper, your CPA, and your attorney. Invest in high quality help. It pays dividends in loyalty, time, money and peace of mind, and is essential to proficient business planning and professional business execution. So, how do you know which areas of your practice require spending ahead and which areas don’t? Talk to us. We can’t show you how to heal patients, but we can show you how to earn more.

Is there more to learn about increasing your earnings? Definitely. But even so, you can start implementing the above ideas immediately to begin improving the financial performance of your medical practice today – and work fewer hours in the bargain.
Spring Cleaning At Tax Time

By Nathan Mersereau, CFP, AAMS

Tax season yields a flurry of paperwork that needs to be sorted as you prepare to file your return, but have you noticed how quickly your paperwork accumulates? As you survey your unsightly mountain, do you wonder, “How much tax paper do I really need to keep and for how long?”

It’s a great question and one with a less-than-encouraging answer when it comes to spring cleaning. The IRS reserves the right to question your tax return information for three years. It has six years to audit your returns based on undeclared income. The right answer then is to keep your most important tax records for seven years. “Most important” is defined by the IRS as tax returns, W-2s, and 1099s, bank and brokerage statements, sales slips, invoices, receipts, canceled checks or other proof of payment and documentation of charitable gifting. You will also want to keep any paperwork relating to your expenses for which you claim a deduction or credit on your tax return. Among those are alimony, mortgage interest, real estate taxes and child care expenses. Documents relating to education savings accounts (529 plans) are also important to keep. The following link to the IRS can provide additional clarity on record keeping questions: www.irs.gov/publications/p552/ar02.html.

Exceptions to the Rules

The problem is that there are always exceptions to general rules. For instance, brokerage companies will typically send an all-encompassing year-end statement. This annual report should allow you to pitch the monthly reports – but be careful. It is vital that you keep track of when you bought and sold your investments. The IRS wants documentation on the “basis” or the original cost of each investment and how much above or below that investment was at the time of sale. So make sure to check your most recent annual report to see if it lists those transactions in full; if not, then it’s a better idea to keep the monthly statements listing the original transaction.

There is no such thing as “extraneous” when it comes to non-deductible retirement plan contributions for IRAs. You want to keep these records indefinitely, because you have already paid taxes on these contributions. The IRS puts the burden of proof on you, and you do not want to have to pay tax a second time when you start withdrawing your money. Also, don’t depend on your bank to have record of your check that was written to make your contribution. It’s a good idea to hang on to credit card statements that itemize large purchases like large appliances or jewelry; this is less for the IRS and more for your insurance company in the event of loss or damage. If you put charitable contributions on your credit card, remember to keep those statements for your tax records. If you find you have duplicate documents you want to toss, remember identity theft is real. Invest in a quality document shredder, and use it before discarding unnecessary statements.

Finally, since we live in the computer era, consider scanning and then backing up your documents – it will save paper and storage space. Still, keeping the documents on your computer may not be the safest place considering the short life spans of hard drives. Making DVD copies you can store in a safe-deposit box or using an external hard drive can give you the safety back-up you are looking for with such important documents.

Remember to consult with your tax preparer before you plug in your shredder. Look for ways to simplify your life and before you know it your mountain of paperwork will become more manageable.

The author is President of WealthCare Advisors, LLC, which is a partner in a joint venture with MSMS.

For More Information


Welcome to These New MSMS Members

Christina Louise Clark, MD, Detroit
Richard Manalo Hidalgo, MD, Troy
Michael John Langworthy, MD, Battle Creek
Wei C. Lau, MD, Troy
Kania Genavie McGhee, MD, Kentwood
Mary Frances Myrick, MD, Escanaba
Tracie Nicole Rulewicz, DO, Battle Creek
Charles Frank Schwartz, MD, Pontiac
Tom Gregory Shahwan, MD, Kalamazoo
Kirk J. Stubbs, MD, Britton
Andrew David Thompson, MD, Detroit
Troy Andres Thompson, MD, Stevensville
Prakash Varadarajan, MD, Saginaw
Daryl Eugene Warder, MD, Kalamazoo
2013 Immunization Schedule for Adults Includes Key Changes
An Update from the Michigan Department of Community Health

The 2013 Recommended Immunization Schedule for Adults (www.cdc.gov/vaccines) has been released. It includes updated recommendations for Pneumococcal Polysaccharide Vaccine (PPSV23), Pneumococcal Conjugate Vaccine (PCV13) and Tetanus, Diphtheria, and Pertussis Vaccine (Tdap) for Pregnant Women.

Pneumococcal Vaccines for Adults
Ensure all persons at high risk for invasive pneumococcal disease (IPD) are vaccinated. While not an invasive disease, pneumococcal pneumonia causes as many as 175,000 hospitalizations annually in the US and is a common bacterial complication of influenza. Pneumococcal meningitis and pneumococcal bacteremia (IPDs) have an annual estimated case rate of 3,000-6,000 and more than 50,000, respectively. About 25 percent of persons with pneumococcal meningitis also have pneumonia; meningitis has a case-fatality rate of 30 percent (up to 80 percent in elderly). Bacteremia occurs in about 25-30 percent of persons with pneumococcal pneumonia and has a case-fatality rate of about 20 percent (up to 60 percent among older persons).

The Advisory Committee for Immunization Practices (ACIP) recommendations published in October 2012 clarified the number of lifetime doses for PPSV23 and gave guidance for use of PCV13 for adults.

PPSV23
- Persons aged 2-64 years should be vaccinated with 1 or 2 doses based on their risk condition. Risk includes groups listed above for PCV13 vaccination, persons with chronic cardiovascular or lung conditions, diabetes mellitus, alcoholism, chronic liver disease or living in a long term care facility.
- Persons aged 19-64 years with asthma or who smoke cigarettes should receive 1 dose.
- All persons aged 65 years and older should receive 1 dose of PPSV23 regardless of the number of doses (1-2) given between the ages of 2 and 64 years. There is no recommendation for further doses.

For more information, refer to “Use of PCV13 and PPSV23 for Adults with Immunocompromising Conditions” October 12, 2012, at www.cdc.gov/mmwr/preview/mmwrhtml/mm6140a4.htm and “Use of Pneumococcal Vaccines in Adults aged 19 Years and Older” at www.michigan.gov/immunize.

PCV13
- Persons aged 19 years and older with highest risk for IPD should be vaccinated with 1 dose of PCV13 if no previous lifetime dose was administered.
- Risk groups include CSF leak or cochlear implant, functional or anatomic asplenia, immunocompromising conditions caused by disease (including HIV, lymphoma, generalized malignancy) or medication, or receipt of a solid organ transplant.

Tdap and Pregnancy
ACIP now recommends that pregnant women (adolescents and adults) receive 1 dose of Tdap during each pregnancy regardless of history of a prior dose of Tdap vaccine. To maximize the maternal antibody response and passive antibody transfer to the infant, optimal timing for Tdap is between 27 and 36 weeks gestation. However, if indicated (e.g., tetanus vaccine recommended for wound care), Tdap can be given at any time during pregnancy. If not previously vaccinated with Tdap, and a dose is not given during pregnancy, administer Tdap immediately postpartum.

Special situations for use of Tdap during pregnancy
- Pregnant women with an unknown or incomplete tetanus vaccination To ensure maternal and neonatal protection against tetanus, pregnant women never vaccinated against tetanus or who have an incomplete primary series should receive vaccine during pregnancy. Tdap should replace 1 dose of Td preferably between 27 and 36 weeks gestation.
- Pregnant women due for a tetanus booster If a Td booster is indicated during pregnancy (10 or more years since previous Td), then Tdap should be administered, using optimal timing of 27-36 weeks gestation.
- Cocooning infants less than age 12 months Adolescents and adults (e.g., parents, siblings, grandparents, child-care providers and health care personnel) who have or anticipate having close contact with infants less than 12 months of age should receive 1 dose of Tdap at least 2 weeks prior to contact (if no previous dose).

For More Information
“Updated Recommendations for use of Tdap in Pregnant Women” February 22, 2013, at www.cdc.gov/mmwr/preview/mmwrhtml/mm6207a4.htm?s_cid=mm6207a4_w.
The Advisory Committee for Immunization Practices (ACIP) recommendations are posted at www.cdc.gov/vaccines/pubs/ACIP-list.htm.
MsMs Foundation Educational Conferences

**Weight of the State: A Conference on the Causes, Prevention and Management of Obesity**
- **Date:** Wednesday, May 8, 2013
- **Time:** 8:45 a.m. to 4:15 p.m.
- **Location:** The Inn at St. Johns, Plymouth
- **Contact:** Caryl Markzon (517) 336-7575 or cmarkzon@msms.org
- **Note:** Continental breakfast and lunch will be provided.
- **Intended for:** Physicians, practice managers/administrators, executives, and all other health care professionals.

**Conference on Women’s Health**
- **Date:** Thursday, May 16, 2013
- **Time:** 1:00 p.m. to 4:15 p.m.
- **Location:** Somerset Inn, Troy
- **Contact:** Marianne Ben Hamza, (517) 336-7581 or mbenhamza@msms.org
- **Note:** Continental breakfast and lunch will be provided.
- **Intended for:** Physicians and office managers

**Doctor Joseph S. Moore Conference on Maternal and Perinatal Health**
- **Date:** Thursday, May 16, 2013
- **Time:** 9:00 a.m. to 4:15 p.m.
- **Location:** Somerset Inn, Troy
- **Contact:** Marianne Ben Hamza, (517) 336-7581 or mbenhamza@msms.org
- **Intended for:** Physicians, residents, physician assistants, nurses, and others who are engaged in health care with special emphasis on improving care for mothers and their infants.

**Business 101: A Crash Course for a Medical Practice**
- **Date:** Friday, May 17
- **Time:** 1:00 p.m. to 4:30 p.m.
- **Location:** Somerset Inn, Troy
- **Contact:** Kate McPherson, (517) 336-5755 or kmcp@msms.org
- **Note:** Continental breakfast and lunch will be provided.
- **Intended for:** Physicians and office managers

**Spring Scientific Meeting**
- **Date:** Thursday, May 16, & Friday, May 17, 2013
- **Time:** Concurrent courses run daily from 9:00 a.m. to 12:15 p.m., 1:00-4:15 p.m., and 5:00-8:15 p.m.
- **Topics:** Infectious Disease, Cardiovascular, Neurology, Endocrinology, Rheumatology, Dermatology, Pain Management, Asthma/Allergy and Epilepsy.
- **Location:** Somerset Inn, Troy
- **Contact:** Marianne Ben Hamza, (517) 336-7581 or mbenhamza@msms.org
- **Note:** Continental breakfast and lunch will be provided. Dinner will be provided in evening course.
- **Intended for:** Physicians and all other health care professionals.

**Audits and Payer Incentives: Show Me the Money**
- **Date:** Wednesday, June 5, 2013
- **Time:** 9:00 a.m. to 4:00 p.m.
- **Location:** Novi
- **Contact:** Marcie Barnum, (517) 336-5724 or mbarnum@msms.org
- **Note:** Continental breakfast and lunch will be provided.
- **Intended for:** Physicians, administrators, office managers, and all other health care professionals.

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Office: (248) 559-PAIN (7246) • Fax: (248) 849-3460
Also
Michigan Pain Management Consultants – West, P.C.
26750 Providence Parkway, Suite 120, Novi, MI 48374
Office: (248) 679-8000

**Jeffrey J. Kimpson, M.D., D.A.A.P.M.**
Medical Director, Providence Pain Management Center
Board Certified in Anesthesia and Pain Medicine

**John H. Traylor, M.D., D.A.A.P.M.**
Director of Clinical Services
Board Certified in Anesthesia and Pain Medicine

**Jeffrey J. Krouac, M.D.**
Member, American Pain Society
Member, American Academy of Pain Management

**Dominick Lago, M.D.**
Member, American Pain Society
Member, American Academy of Pain Management

**Alexander Ajlouni, M.D.**
Member, American Pain Society
Member, American Academy of Pain Management

Affiliated with Northland Anesthesia Associates, P.C.
The following actions of the Michigan Board of Medicine were taken following investigative and appropriate actions and are reproduced verbatim from summaries prepared by the Michigan Department of Community Health Bureau of Health Professions.

**Report Dated:** 12-3-2012 through 12-7-2012

**David Bruce Bosscher, DO**

Zeeland, MI

51-01-008747

12/06/2012

Probation

Failure to Meet Cont. Ed. Requirements

**Suzanne Marie Hanses, DO**

Lansing, MI

51-01-010432

12/06/2012

Reprimanded, Fine Imposed

Negligence – Incompetence

Chidzie Joshua Ononuju, DO, R.Ph.

Saginaw, MI

51-01-013295

53-02-032802

12/06/2012

Limited/Restricted

Probation, Fine Imposed

Drug Diversion, Unprofessional Conduct

Lack of Good Moral Character

Negligence – Incompetence

Jeffrey Scott Russell, DO

Coldwater, MI

51-01-011799

12/06/2012

Fine Imposed, Probation

Criminal Conviction

**Moses K. Shieh, DO**

St. Myers, FL

51-01-014406

12/06/2012

Fine Imposed

Sister State Disciplinary Action

Failure to Report/Comply

**Report Dated:** 12-10-2012 through 12-14-2012

**Harold Dieter Friedel, MD**

Kalamaazoo, MI

43-01-036711

01/11/2013

Suspended

Fine Imposed

Negligence – Incompetence

Dwight Eric Smith, MD

Detroit, MI

43-01-046520

01/11/2013

Fine Imposed, Suspended

Negligence – Incompetence

**Vincent J. Rizzo, DO**

Shelby Township, MI

CS License

51-01-005367

12/12/2012

Voluntarily Surrendered

CS & Drug Controlled Licenses

Technical Violation of the Michigan PHC

Notice of Intent to Deny – formal document that indicates the Department intends to deny the issuance of a license because of violations of the Public Health Code, past or current.

Probation – a disciplinary action in which the licensee’s practice is conditioned for a given period of time or until specific requirements are met. Probation can include conditions such as:

- participation in the Health Professional Recovery Program
- submission of regular reports from employer or other specified individual
- completion of specific continuing education requirement
- no violations of the Public Health Code
- other conditions deemed appropriate.

Reprimand – the written statement of rebuke from the Board because of violations of the Public Health Code, past or current.

Suspension – a disciplinary action in which the license was suspended or revoked.

Reinstatement – the granting of a license with or without restrictions or conditions to an individual whose license was suspended or revoked.

Notice of Intent to Deny

Michael Arthur Roth, MD

Novi, MI

43-01-028327

12/17/2012

Fine Imposed

Violation of General Duty/Negligence

**Report Dated:** 12-31-2012 through 1-4-2013

**Richard S. Neely, DO**

Durand, MI

CS License

51-01-004783

12/21/2012

Reinstatement Granted w/CSC License Limited/Restricted Probation

**Report Dated:** 1-7-2013 through 1-11-2013

**Mark Samuel Weis, MD**

Silver Spring, MD

43-01-0099738

01/07/2013

Summary Suspension

Failure to Report/Comply

Negligence – Incompetence

Incompetence

Lack of Good Moral Character

Unprofessional Conduct

Technical Violation of the Michigan PHC

Gregory C. Roche, DO

Bloomfield Hills, MI

51-01-007111

01/09/2013

Fine Imposed, Restitution

Violation of General Duty/Negligence

**Kevin Sterling Wott, DO**

Jackson, MI

51-01-012167

01/10/2013

Summary Suspension Dissolved

**Report Dated:** 1-14-2013 through 1-18-2013

**Charbal Butrous Bazo, MD**

Port Huron, MI

43-01-058648

01/16/2013

Reprimanded

Violation of General Duty/Negligence

Technical Violation of the Michigan PHC

George D. England, MD

Grand Rapids, MI

43-01-070691

02/15/2013

Limited/Restricted Probation

**Report Dated:** 2-4-2013 through 2-8-2013

**Thomas Michael Pinson, DO**

Southgate, MI

51-01-009701

02/07/2013

Fine Imposed

Violation of General Duty/Negligence

**Jonathan A. Agbebiyi, MD**

51-01-009504

02/15/2013

Summary Suspension

Notice of Intent to Deny – formal document that indicates the Department intends to deny the issuance of a license because of violations of the Public Health Code, past or current.

Probation – a disciplinary action in which the licensee’s practice is conditioned for a given period of time or until specific requirements are met. Probation can include conditions such as:

- participation in the Health Professional Recovery Program
- submission of regular reports from employer or other specified individual
- completion of specific continuing education requirement
- no violations of the Public Health Code
- other conditions deemed appropriate.

Reprimand – the written statement of rebuke from the Board because of violations of the Public Health Code, past or current.

Suspension – a disciplinary action in which the license was suspended or revoked.

Reinstatement – the granting of a license with or without restrictions or conditions to an individual whose license was suspended or revoked.

Suspension can include conditions such as:

- a licensee can not practice for a minimum period of three years; if the violation involved controlled substances, the licensee can not practice for a minimum of five years.

**Report Dated:** 2-16-2013 through 2-20-2013

**Gwendolyn Washington, MD**

Southfield, MI

43-01-036434

01/28/2013

Suspended

Summary Suspension

Failed to Report/Comply

Lack of Good Moral Character

Unethical Business Practice

Unprofessional Conduct

**Report Dated:** 2-28-2013 through 3-2-2013

**Cooperstown, NY**

51-01-009701

02/07/2013

Fine Imposed

Violation of General Duty/Negligence

**Frank Allen Zimba, MD**

Kalamazoo, MI

43-01-007545

01/16/2013

Fine Imposed, Reprimanded

Failure to Report/Comply

Sister State Disciplinary Action

**Basil Azmi Abdulmuti Qandil, MD**

Dearborn Heights, MI

43-01-087756

01/17/2013

Summary Suspension

Lack of Good Moral Character

Negligence – Incompetence

Drug Diversion

Amaning Kwarteng Sarkodie, MD

Saginaw, MI

43-01-064470

01/16/2013

Fine Imposed

Community Service Probation

Negligence – Incompetence

**Serge Paul Schilio, MD**

Saint Joseph, MI

43-01-055134

02/15/2013

Probation

Substance Abuse

Violation of General Duty/Negligence

**Linda Gail Sifven, MD**

Charlevoix, MI

43-01-041411

02/15/2013

Summary Suspension

Drug Diversion, Substance Abuse

Violation of General Duty/Negligence

**Mental/Physical Inability to Practice**

**Report Dated:** 3-6-2013 through 3-10-2013

**Thomas Michael Pinson, DO**

Southfield, MI

51-01-009504

03/09/2013

Probation, Reprimanded, Fine Imposed

Failure to Meet Cont. Ed. Requirements

Report Dated: 1-21-2013 through 1-25-2013

**Jonathan A. Agbebiyi, MD**

Southfield, MI

43-01-041053

01/25/2013

Summary Suspension

Criminal Conviction

Failure to Report/Comply

Lack of Good Moral Character

Unethical Business Practice

Unprofessional Conduct

**Report Dated:** 1-28-2013 through 2-1-2013

**Gwendolyn Washington, MD**

Southfield, MI

43-01-036434

01/28/2013

Suspended

Summary Suspension

Failed to Report/Comply

Lack of Good Moral Character

Unethical Business Practice

Unprofessional Conduct

**Report Dated:** 3-6-2013 through 3-10-2013

**Darrell Robert Cunningham, DO**

Stanton, MI

51-01-012407

01/31/2013

Summary Suspension

Mental/Physical Inability to Practice

**Report Dated:** 3-6-2013 through 3-10-2013

**Toms Michael Pinson, DO**

Southgate, MI

51-01-009701

02/07/2013

Fine Imposed

Violation of General Duty/Negligence

**Kathy L. Rosema, DO**

Muskegon, MI

51-01-009504

03/09/2013

Probation, Reprimanded, Fine Imposed

Failure to Meet Cont. Ed. Requirements

Explanation of Disciplinary Terms

**Board Order** – the legal document that is issued by the Department, on behalf of the Board, which describes the sections of the Public Health Code that have been violated and the discipline that has been imposed for the violation(s).

**Limitation** – a restriction or condition imposed on a licensee by the Board for a specified period of time such as:

- confinement of practice to a location
- supervision of practice – either on-site or periodic review by Board or other Board approved licensee
- restriction of practice to specific activities
- no access to controlled substances
- no ownership or financial interest other restrictions or conditions deemed appropriate.
Employment Opportunities

WANTED: INTERNIST OR FAMILY PRACTICE PHYSICIAN for part-time work in a medical office in Farmington Hills. Call 248-626-1366 or email farmingtonmed1@yahoo.com.

DOCTOR WANTED for pain management clinic. Ownership with excellent incentives. Call Dr. Chapman at 630-240-3396 or email resume to: drbkchapman@aol.com.

MOBILE DOCTORS, a premier company specializing in home visits, seeks a full and a part-time physician to do House Calls. No evening work or on call. MedMal insurance, MA and company car are provided. E-mail CV to Nick at nick@mobiledoctors.com or fax to 312-284-4755. Call Nick at 312-848-5319 for more information.

WANTED: FULL TIME INTERNIST, Downriver area. Offering $150k plus, partnership and ownership options for the right candidate. Must be board certified or eligible. For more details, contact our practice specialist Joseph at Union Realty, 248-919-0037 or 248-240-2141 (cell) joezrenchik@yahoo.com, www.unionrealtypc.com. All inquiries strictly confidential.

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BUSY, LONG TIME ESTABLISHED, HIGHLY GROSSING FAMILY PRACTICE near DMC, Harper hospitals. Modern facility, 3200 sq.ft., multiple exam rooms, plenty of fenced parking. The two rental incomes should offset cost of real estate and practice. Asking $590,000 for everything. Physician and PA available to assure a smooth transition period for 6 months, 1 year or longer. Flexible terms. Call for details on income and terms. For more details, contact our practice specialist Joseph at Union Realty, 248-919-0037 or 248-240-2141 (cell) joezrenchik@yahoo.com, www.unionrealtypc.com.
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LONG ESTABLISHED PRIMARY/URGENT CARE CLINIC, St. Joseph/Benton Harbor area, has triage room and equipment for most procedures, including surgery. High visibility and central location. Asking $100,000 for practice, real estate available. For more details, contact our practice specialist Joseph at Union Realty, 248-919-0037 or 248-240-2141 (cell) joezrenchik@yahoo.com, www.unionrealtypc.com. All inquiries strictly confidential.

Real Estate For Sale

1) WESTLAND – 3822 SQFT medical office $320,000
2) LIVONIA – 2000 SQFT $149,000. FOR LEASE:
3) PLYMOUTH – 700 TO 5000 SQFT. For professional site selection agency on existing buildings, and land to build, call Van Esley Real Estate 734-459-7570.
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- Appeals of RAC, Medicare, Medicaid & Other Third Party Payor Claim Denials & Overpayment Demands
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- Healthcare Billing & Reimbursement
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COURSE DIRECTOR
Hadi Sawaf, MD
Director of Hematology/Oncology, St. John Hospital and Medical Center, Detroit, MI

SYMPOSIUM

Polycystic Ovarian Syndrome
Anne Schneider, MD
Assistant Clinical Professor, Wayne State University School of Medicine, Department of Obstetrics and Gynecology, St. John Hospital and Medical Center, Detroit, MI

Type II Diabetes
Julie Surhigh, MD
Pediatric Endocrinologist, St. John Hospital and Medical Center, Detroit, MI

Eating Disorders
Joy Friedman, MD
Assistant Professor, Oakland University – Beaumont School of Medicine, Beaumont Adolescent Health Center, Beverly Hills, MI

Late Effects of Pediatric Cancer Treatment
Jim Connelly, MD
Assistant Professor of Pediatric Bone Marrow Transplant, University of Michigan, Ann Arbor, MI

Pilonidal Cysts and Hidradenitis Suppuritiva
Marc Cullen, MD, MPH, FACS
Division Chief – Pediatric Surgery, St. John Hospital and Medical Center, Detroit, MI

Adolescent Depression
Lisa Beauvais, MA, LLPC, NCC
Licensed and Board Certified Counselor, Wellness Counseling and Consulting, Troy, MI

Risk-Taking Behaviors in Adolescence
Mark Erwin
Community Collaboration Coordinator, Ruth Ellis Center, Highland Park, MI

Headaches in Adolescents
Steven Leber, MD, Ph.D.
Division of Pediatric Neurology, Professor, Pediatrics and Neurology, Medical Director, Pediatric Specialty Clinics, University of Michigan, Ann Arbor, MI

ACCREDITATION
St. John Hospital & Medical Center is accredited by the Michigan State Medical Society to provide continuing medical education for physicians. St. John Hospital designates this live activity for a maximum of 5.5 AMA PRA Category 1 Credit(s)™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This symposium will be held at the Grosse Pointe War Memorial, 32 Lakeshore Dr., Grosse Pointe Farms, MI 48236

For more information contact:
313-343-3877 as these may be subject to change.
In Lansing and Washington, the Doors Are Open to Physicians
by John G. Bizon, MD

Who are the voices in your community who can have a real impact on state, and even national, politics? The physicians reading this will probably be able to name half a dozen local leaders whose letters, calls, and emails get a response from Lansing or Washington – but few of you include your own name on that list; yet, you should.

In February, I attended an American Medical Association conference in Washington, DC, on the topic of legislative advocacy. One of the speakers was Congressman Fred Upton, of Michigan’s Sixth Congressional District. I’ve met Congressman Upton previously in my work with our Michigan Doctors’ Political Action Committee (MDPAC), and he invited me to attend a hearing at the House Committee on Energy and Commerce, which he chairs. The hearing addressed the Medicare Sustainable Growth Rate (SGR) formula, and the growing need to find a “fix” for SGR as part of the federal budget negotiations.

As you’re aware, the need to deal with the current flawed SGR formula is crucial for making Medicare sustainable, and the hearing offered a good roundtable of expertise on the topic, with intense questioning from committee members. Indeed, the hearing was supposed to last for an hour or so, but instead ran from 10:15 a.m. to almost 2:00 p.m., largely due to the many questions from congressmen on the committee.

While at the Capitol, I arranged to visit three other members of the Michigan congressional delegation. I contacted their offices, and was quickly scheduled for face-to-face meetings with the congressmen on health care issues facing Michigan physicians.

Now, I’m not telling you this to show off that I get to hobnob with politicos in Washington. Yes, serving as current president of the MSMS can help open some doors, but I’ve found that titles matter far less than interest. The legislators I spoke with weren’t even in my district, but they were willing to clear their calendars to hear from home. Despite all the current cynicism about the job done by congress, our representatives truly do want to hear from those they represent.

And any of us can do this, and make our opinions heard. Elsewhere in this issue, you’ll read the story of Doctor Marianna Spanaki-Varelas. She’s a Detroit neurologist who saw first-hand the damage impaired drivers can do, but was concerned about the potential liability physicians could face for reporting such drivers. She raised the idea of legislation to give physicians a safe harbor for reporting impairment, became an advocate in Lansing for the idea, and worked to help the MSMS craft language for such a law. This physician liability shield recently became Michigan law.

One physician, much like you, stood up – and that made all the difference. Our legislators, whether in Lansing or Washington, value your input because they recognize physicians are the real local experts on the issues that impact our communities. Further, if you aren’t making your voice heard on these issues, who will be shaping the views of our leaders? Those who want to limit health care funding, take risks with our medical care models, or assume “they know what’s best” for your patients? Those voices are the ones our representatives will hear – unless you speak out. Sitting back and assuming that nothing can be done, or that this is what the MDPAC is for, are not the answers. Have you been in contact with your district legislators? Do you know when and where your federal representatives hold “in district” visiting days? You should. Because their doors are open – and they’re waiting to hear from you.

Doctor Bizon, a Calhoun County otolaryngologist, is President of the Michigan State Medical Society.
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