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ReachMD
www.reachmd.com
info@reachmd.com
(866) 423-7849

Maximizing Insurance Reimbursement

ReachMD XM157 now presents this week's top stories from the pages of American Medical News, the nation's leading newspaper for physicians. American Medical News is published by the American Medical Association.

DR. MARK CHYNA:

Welcome to American Medical News on ReachMD XM157. I am Dr. Mark Chyna.

SUE BERG:

And I am Sue Berg. On this week's program:

Congress finally passes a Mental Health Parity Law.

The NIH redirect its AIDS vaccine research.

Researchers investigate the link between statins and muscle disorders. Now with a top story from American Medical News, here is Dr. Mark Chyna.

DR. MARK CHYNA:

After years of trying congress finally passed the Mental Health Parity Bill as an attachment to the government's huge financial bailout legislation. The loss of most group health plans that offered mental health and substance abuse benefits cannot put tighter restrictions on mental health benefits than on other benefits. Mental health benefits <_____> of higher cost sharing or treatment limits to take one example, the law also requires plans to cover out of network mental health benefits if they cover out of network medical and surgical benefits. The legislation takes effect in 2010 for most plans. Dr. Jeremy Lazarus is a psychiatrist and the speaker of the American Medical Association's House of Delegates. He says the law is important to advance.

DR. JEREMY LAZARUS:

I think this is an extremely significant event allowing patients, who have mental illness or substance use disorders basically get the same kind of coverage that other patients get in terms of medical or surgical benefits. So, this is a very significant bill. I think the hope will be that this will eliminate a number of the hurdles that patients has had in terms of getting treatment and hopefully mental health providers, psychiatrist, and other mental health professionals will be more receptive to taking these patients because the coverage will be better, it will be easy for patients again to see them.

DR. MARK CHYNA:

Patient advocates have been trying to broaden mental health coverage since the Mental Health Parity Act of 1996 was enacted. That law prohibits insurers only from imposing stricter lifetime or annual caps on mental health benefits than on other benefits, but allowed plan to charge higher deductibles for mental health care among other loopholes. Neil Trautwein is vice-president of the National Retail Federation. He says business leaders sought mental health parity in the late 1990s, but have changed their perspectives.

NEIL TRAUTWEIN:

What's Mark, questions of the laws and views, it have to do with our greater focus on wellness and identifying and managing chronic conditions. It also have to do with the process where we were allowed to negotiate the contents of the legislation with the skill and with providers and through that process we feel that a fair compromise merge and it was one that we could not only live with, but ethically support.

DR. MARK CHYNA:

The final version of the laws are compromise between the parity bills adopted by the house and senate. The senators agreed to drop a provision to preempt all state parity laws. The house agreed to drop a requirement that plans with mental health benefits cover all conditions in the Diagnostic And Statistical Manual of Mental Disorders version 4.

SUE BERG:

Researchers had been on the hunt for a vaccine for HIV, but so far clinical trials have been disappointing. Now, investigators are looking at other ways to prevent transmission of the virus. At least 7 trials are testing preexposure prophylaxis. The goal was to determine if the antiviral drug tenofovir with or without emtricitabine can prevent infection through sex or injection drug use. Investigators also think that providing greater access to care for those, who already have the virus can help with prevention because lower viral loads makes transmission less likely. Dr. Carl Dieffenbach is Director of the Division of AIDS at the National Institute of Allergy and Infectious Diseases.

DR. CARL DIEFFENBACH:

People who are already HIV positive and actually people who are at risk of being HIV positive over to themselves to get tested first and foremost and if they are HIV infected get into care and get on antiretroviral. The current batch of antiretrovirals we have are absolutely helpful drugs that can fully suppress the virus in the human body and with the appropriate adherence people can live relatively normal happy lives, but requires people being proactive, going out, getting tested, and then taking care of themselves and get into care.

SUE BERG:

The National Institute of Allergy and Infectious Diseases is encouraging more basic research on HIV biology in the hope that it will lead to an effective vaccine.

DR. MARK CHYNA:

From this week's Government & Medicine Section, Dr. Andy Harris, an obstetric anesthesiologist at John Hopkins is discovering that running for congress is more complicated than he might have expected. Harris running as a republican upset republican in common Wayne Gilchrist in Maryland's first congressional district earlier this year. Gilchrist followed by endorsing Harris' democratic opponent Frank Kratovil, an attorney. Two republican county commissioners also have endorsed the democrat. Dr. Harris has the support of Maryland State Medical Society and the American Medical Association political action committee. The two candidates differ sharply on healthcare reform. Kratovil wants to require universal health care coverage. Harris wants to replace Medicaid with vouchers or private insurance and he wants to cut back Medicare cost by requiring patients to pay more for their care. Dr. Harris wants to reduce government influence in health care and place the consumer in charge.

DR. ANDY HARRIS:

What we need to do is deal with the problem of the uninsured and we need to make health insurance more personal, more portable, more acceptable, more affordable, and we have got to, without expansion, large expansion of the government run healthcare. We have got to make sure that the average person has access to health insurance.

DR. MARK CHYNA:

Dr. Harris also wants to continue president Bush's ban on federal funding of human embryonic stem cell research.

SUE BERG:

A federal court has ruled that San Francisco businesses with 20 to 99 workers must contribute to their own coverage plans or to the city's universal access program for uninsured residents. The Golden Gate Restaurant Association had challenged the requirement saying it violates the Federal Employee Retirement Income Security Act. The court said the ordinance was not in violation because the Gate's businesses options to comply with the spending requirement without establishing a benefit plan or changing the existing one. Sonya Schwartz is the program manager of the National Academy for State Health Policy. She says the ruling could impact other parts

of the country.

SONYA SCHWARTZ:

The San Francisco ruling certainly provides more of a roadmap for states that are looking to use financing from employers as a way to help form a health system and provide coverage for the uninsured. The decision generally, I think, is likely to spur those efforts. Although with state budgets the way they are and lot of competing priorities right now, I do not know that we are likely to see lots of enormous health reform efforts happening in the next couple of months.

DR. MARK CHYNA:

The Goldent Gate Restaurant Association is appealing to ruling. From the American Medical News Professional Issue section Dr. Sherwin Nuland, a Yale University surgeon and a noted medical writer, has published a new book summing up the lifetime of thoughts and experiences in medicine. In the book called Uncertain Art Thoughts on a Life in Medicine he says medical writing poses a quandary between telling stories and preserving patient's privacy.

DR. SHERWIN NULAND:

When one wants to have accurate medical facts that does not necessarily mean that there is anything about those facts that identify the patient, obviously, we change names. We may change formally the names including occupation, body build; anything that does not pertain to the pathology of the illness can be changed quite radically to the point where the patient is unrecognizable except the physicians, who dealt with that patient.

DR. MARK CHYNA:

Dr. Nuland encourages other doctors to write blog or otherwise tell their stories. He says medicine is still a mystery to many people and it would be good for them to know more about how doctors think, make diagnoses, and decide on therapy.

SUE BERG:

Voters in Washington are set to consider a ballot measure that would allow physician-assisted suicide for adults, who are judged by 2 physicians to be mentally competent and likely to die of a terminal illness within several months. The proposal states that doctors must help patients about options such as hospice and palliative care. The Coalition Against Assisted Suicide is campaigning against the bill. Dr. Shane Macaulay is a Seattle based radiologist, who volunteers with the Coalition.

DR. SHANE MACAULAY:

While Initiative 1000 is an ill conceived and poorly written initiative that will end up placing many patients in jeopardy. Before I get to that, of course, from the point of view of physicians it is fundamentally incompatible with the role of a physician as healer and that is statement from the American Medical Association position statement on assistance to decide. It takes the physician from our historical role of providing comfort and care to the patient and it asks physicians to help kill their patients. In addition, this particular initiative would then further require that the physician falsify the death certificate and note that the patient died of the underlying illness rather than from

the lethal drug overdose.

SUE BERG:

The Washington State Medical Association is also opposed to assisted suicide. More than half the state's residents favored it in a September poll. Physician assisted suicide is currently legal only in Oregon. The American Medical Association says it strongly opposes any bill to legalize physician assisted suicide because the practice in the AMA's own words is fundamentally inconsistent with the physician's role as healer.

In this weeks business section some nonprofit health plans were individually holding billions of dollars and surplus cash reserves. Critics want to see some of that money put back into the health system. In Michigan some health plans with healthy surpluses that asked for government help drawing fire from the critics. The issue has also arisen in Pennsylvania and New Jersey where plans are seeking to merge or convert to for-profit status. Opponents of those proposal say the plans multibillion dollar reserves show that they are not serving the public interest and do not need government help. Dr. William Custer is director of the Center for Health Services Research at Georgia State University.

DR. WILLIAM CUSTER:

Well, the surplus is the difference between the premiums they take in and the claims they pay out. Every plan needs to maintain a healthy surplus in order to ensure that they have the money to pay claims in the future and those surpluses are regulated by state governments.

DR. MARK CHYNA:

Some states have taken steps to limit nonprofit health plan reserve funds by blocking premium increases or mandating rebates. The most states plans must keep a minimum reserve level, but there is no maximum. Plans they may need to keep high reserves to keep premium cost down and be prepared for emergencies.

SUE BERG:

This week in Health and Science some patients who take statins can develop serious muscle problems and the National Institutes of Health wants to know why. It is awarded grants to determine the genes involved in the muscle problems and to develop tools physicians can use to identify patients most at risk. Dr. Georgirene Vladutiu is the head of a research group at the University of Buffalo in New York that receives funding for such research.

DR. GEORGIRENE VLADUTIU:

Well, we know that about 5 to 7% of patients that takes statins develop muscle pain and/or weakness from taking the drugs, and there is about 38 million people that take statins in the US right now so that is about 2 to 3 million people that develop aches and pains. They usually get better when the therapy is terminated and then sometimes they start up on a new therapy, lower dose, trying to adjust so that they do not get the pain any more. However, there is about a tenth to two-tenth percent of people taking statins, who develop severe life threatening symptoms. That is the standard definition and that would be about 38000 to 76000 people. But, our own research has found that it is more like half a percent, which is like 200,000 people that develop life threatening statin myopathy.

SUE BERG:

Muscle problems in patients taking statins can be tough to diagnose. These drugs are primarily used by older people and it is not always clear whether a new ache or pain is due to statins or to AH. Also, several studies have found that physicians may discount patient complaints of myalgia after starting these drugs.

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