Vanderburgh County Medical Society
Evansville Indiana

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MONITOR

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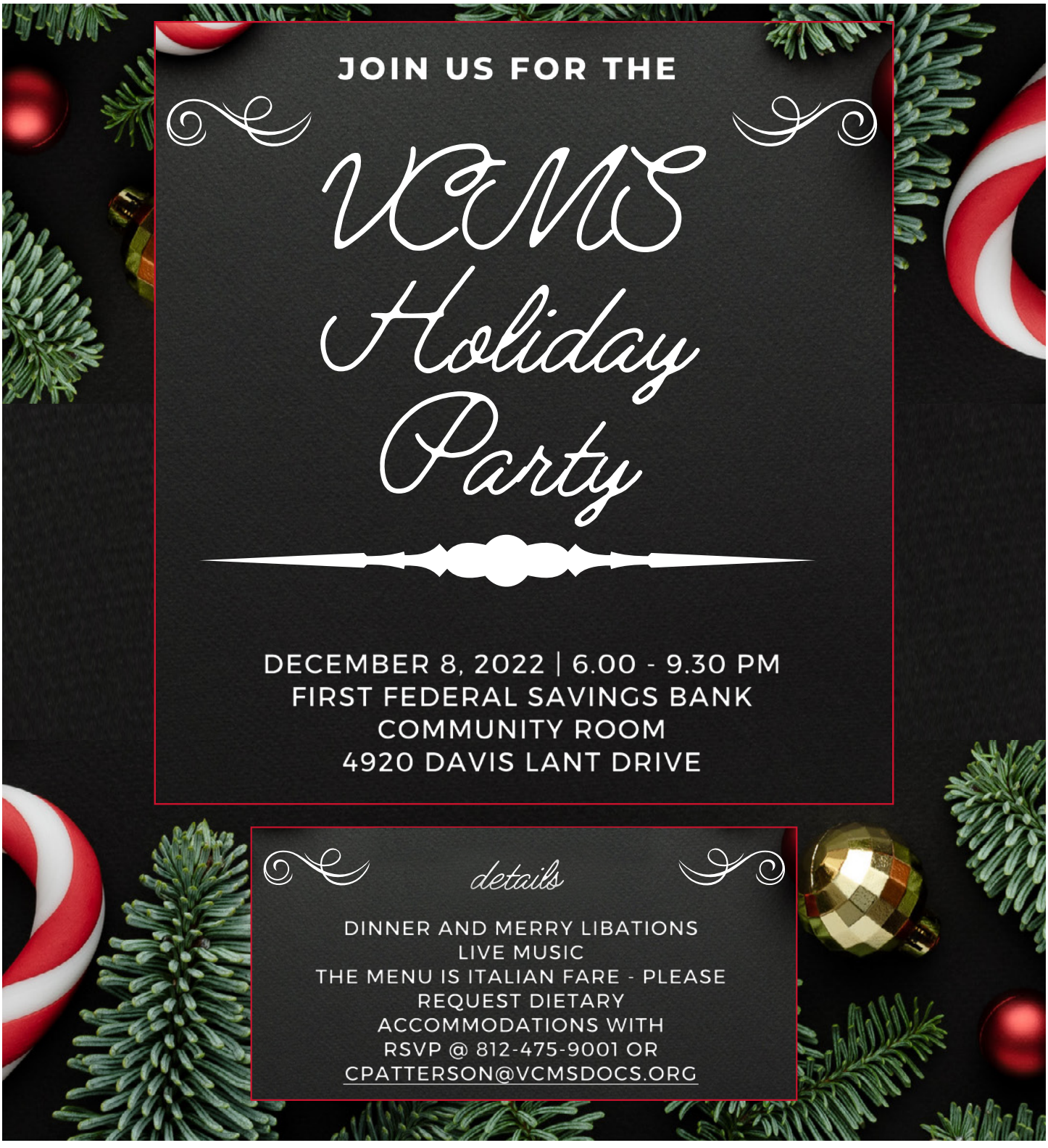

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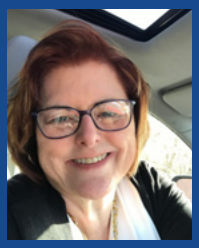
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The Vanderburgh County Medical Society is an Alliance of Physicians dedicated to the promotion of the Art and Science of medicine, to the continual Improvement of Community Health, and to the Advocacy and Protection of the Patient Physician Relationship. The purpose of this organization shall be to unite and strengthen the local medical community, to inform the public on matters of health and medical care, and to promote the best in medical care in our community.

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The Slippery Slope of Utilization Management

An article from
Kevin Pho, M.D. Online

by
Sneha Tella, MD

Policy
September 28, 2022

"The patient has a severe infection of the hand and is not improving on the current antibiotics," I explained to the medical director at the insurance company.

"I understand. However, the patient has no elevated white count or fever, and I cannot get it to meet the criteria, so I will have to deny the necessity for the patient to stay in the hospital," she explained.

I felt my voice rising and my face turning red as I continued, "Well – where is this patient supposed to go then? As a fellow provider – what do you suggest I do?"

I knew this wouldn't end well, but I couldn't help but get outraged again. Eventually, the medical director even agreed the patient needed treatment; however, based on the guidelines, she could not approve the hospital stay. I let out a sigh of frustration and hung up the call.

Prior authorization (one part of the utilization management processes) is a widely known frustration among patients and health care providers. At the start of the pandemic, the Centers for Medicare & Medicaid Services (CMS) provided hospitals with several waivers to help them focus on direct patient care. Understanding that these processes were a hindrance to patient care. In the face of crisis, there was the recognition to remove administrative obstacles and allow hospitals to care for a community in need.

Inherently this puts into question the necessity of such processes. There has been a clear demonstration of the rise of administrative costs contributing to the overall cost of care in the U.S. When we increase regulations, the administrative burden increases. Is this increase justified? Has utilization management processes had the intended impact to justify the means?

The utilization management process largely came into play after the creation of CMS in the 1960s. During this time, health care costs were rising under the fee-for-service model. There was already a need to combat unnecessary testing and services. With the formation of CMS, there would be a massive undertaking by the federal government to provide health insurance to the elderly, poor and disabled. With this large expansion – cost containment was pushed to the forefront. The need was there and now the opportunity aligned with the ability of the federal government to mandate it.

Out of this bore the basis of utilization management (UM). The initial intent was to review the medical necessity of hospital stays, various procedures, and tests. Companies created "guidelines" to determine if medical decisions were made appropriately and if services were utilized correctly. If they were deemed "unnecessary," the people and places performing them would not be paid.

Before my frustrating conversation with the insurance company's medical director, these UM processes did occur. A utilization review nurse on both the hospital and insurance side reviewed the patient's current information against the criteria. The nurses were unable to justify the patient's medical status based on laboratory values, vital signs, or imaging results. What these guidelines often fail to factor in is scenario-specific information. This patient had a severe infection of his hand, which necessitated us to treat him differently. If he didn't improve, he could lose function in his hands, and his life would suffer greatly. While practicing medicine, there is always an element of judgment required that is hard for software to account for.

Under our current payor model, UM processes are a necessity. We need them for payors to understand the care being given by health care providers. Guidelines are a necessity as well. They aid in reducing unnecessary care and spending.

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There is good necessary work here. But what I fear is that, in allowing and adhering to these guidelines and processes, we have also opened ourselves to their abuse of them. Under the guise of utilization, payers can cut reimbursement for essential care. UM has become a wall for payors to hide behind without providing any room for clinical reasoning or flexibility.

Earlier this year, the DOJ filed a federal suit to stop the acquisition of UnitedHealth Group (one of the largest private insurers in the nation) of Change Healthcare. Change Healthcare maintains InterQual Criteria, one of the largest guidelines set for inpatient medical care. These guidelines are often cited as the reasoning behind the denial of payment or prior authorization. Now the largest private insurer would own these products and possibly be able to further impact outcomes to their benefit.

Commenting on the lawsuit, Principal Deputy Assistant Attorney General Doha Mekki of the Justice Department's Antitrust Division stated, "The proposed transaction threatens an inflection point in the health care industry by giving United control of a critical data highway through which about half of all Americans' health insurance claims pass each year." He says, "Unless the deal is blocked, United stands to see and potentially use its health insurance rivals' competitively sensitive information for its own business purposes and control these competitors' access to vital health care technology innovations. The department's lawsuit makes clear that we will not hesitate to challenge transactions that harm competition by placing so much control of data and innovation in the hands of a single firm."

I shudder to think what my earlier conversation with the medical director will look like now.

Sneha Tella is an internal medicine physician.

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If you have content you would like to contribute for the Monitor please contact Chris at 812-475-9001.

New CDC Guidance on Prescribing Opioids for Pain

BY
Megan Brooks
November 03, 2022

The US Centers for Disease Control and Prevention (CDC) has released updated and expanded recommendations for prescribing opioids for adults with acute and chronic pain not related to cancer, sickle cell disease, or palliative/end-of-life care.

The 2022 Clinical Practice Guideline provides guidance on determining whether to initiate opioids for pain; selecting opioids and determining opioid dosages; deciding duration of initial opioid prescription and conducting follow-up; and assessing risk and addressing potential harms of opioid use.

"Patients with pain should receive compassionate, safe, and effective pain care. We want clinicians and patients to have the information they need to weigh the benefits of different approaches to pain care, with the goal of helping people reduce their pain and improve their quality of life," Christopher M. Jones, PharmD, DrPH, acting director for the CDC's National Center for Injury Prevention and Control, said in a news release.

How to Taper Safely

The last guideline on the topic was released by CDC in 2016. Since then, new evidence has emerged regarding the benefits and risks of prescription opioids for acute and chronic pain, comparisons with nonopioid pain treatments, dosing strategies, opioid dose-dependent effects, risk mitigation strategies, and opioid tapering and discontinuation, the CDC says.

A "critical" addition to the 2022 guideline is advice on tapering opioids, Jones said during a press briefing.

"Practical tips on how to taper in an individualized patient-centered manner have been added to help clinicians if the decision is made to taper opioids, and the guideline explicitly advises against abrupt discontinuation or rapid dose reductions of opioids," Jones said.

"That is based on lessons learned over the last several years as well as new science about how we approach tapering and the real harms that can result when patients are abruptly discontinued or rapidly tapered," he added.

The updated guideline was published online November 3 in the *Morbidity and Mortality Weekly Report*.

Key recommendations in the 100-page document include the following:

In determining whether or not to initiate opioids, nonopioid therapies are at least as effective as opioids for many common types of acute pain. Use of nondrug and nonopioid drug therapies should be maximized as appropriate, and opioid therapy should only be considered for acute pain if it is anticipated that benefits outweigh risks to the patient.

Before starting opioid therapy, providers should discuss with patients the realistic benefits and known risks of opioid therapy.

Before starting ongoing opioid therapy for patients with subacute pain lasting 1 to 3 months or chronic pain lasting more than 3 months, providers should work with patients to establish treatment goals for pain and function, and consideration should be given as to how opioid therapy will be discontinued if benefits do not outweigh risks.

Once opioids are started, the lowest effective dose of immediate-release opioids should be prescribed for no longer than needed for the expected duration of pain severe enough to require opioids.

Within 1 to 4 weeks of starting opioid therapy for subacute or chronic pain, providers should work with patients to evaluate and carefully weigh benefits and risks of continuing opioid therapy; care should be exercised when increasing, continuing, or reducing opioid dosage.

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Before starting and periodically during ongoing opioid therapy, providers should evaluate risk for opioid-related harms and should work with patients to incorporate relevant strategies to mitigate risk, including offering naloxone and reviewing potential interactions with any other prescribed medications or substances used.

Abrupt discontinuation of opioids should be avoided, especially for patients receiving high doses.

For treating patients with opioid use disorder, treatment with evidence-based medications should be provided, or arrangements for such treatment should be made.

Jones emphasized that the guideline is "voluntary and meant to guide shared decision-making between a clinician and patient. It's not meant to be implemented as absolute limits of policy or practice by clinicians, health systems, insurance companies, governmental entities."

He also noted that the "current state of the overdose crisis, which is very much driven by illicit synthetic opioids, are not the aim of this guideline.

"The release of this guideline is really about advancing pain care and improving the lives of patients living with pain," he said.

"We know that at least 1 in 5 people in the country have chronic pain. It's one of the most common reasons why people present to their health care provider, and the goal here is to advance pain care, function, and quality of life for that patient population, while also reducing misuse, diversion and consequences of prescription opioid misuse," Jones added.

Morb Mortal Wkly Rep MMWR. Published online November 3, 2022.

For more Medscape Neurology news, join us on Facebook and Twitter.

Dateline: Honolulu | Michael B. Hoover, M.D.

I'm here at the Hawaii Convention Center for the Interim meeting of the House of Delegates of the American Medical Association. Specifically, I'm at the meeting of Reference Committee C, where members discuss resolutions related to medical education, everything from pre-med education, through medical school and residency, to continuing medical education. Out of seventeen resolutions under consideration, no less than four are requesting that the AMA support and advocate for more leave for medical students and residents. Expanded paid medical leave, up to ninety days a year, bereavement leave, parental leave, miscarriage, and stillbirth leave are all under consideration. It makes me wonder when these young doctors and doctors-to-be will actually be taught anything or gain any experience. One answer could be extending medical school and residency for one or more years, but this doesn't seem to be a very popular alternative. I could also offer a more informal way of securing leave, the way my old friend John Moore was able to attend every running of the Kentucky Derby during his general surgery residency. John just told Dr. Warren, the department chairman, that his grandmother had died. This worked well until his fourth post-graduate year when Dr. Warren asked him just how many grandmothers he had.

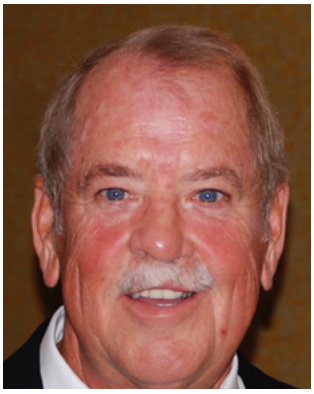
We are also discussing, as we do at every HOD meeting, CME as a requirement for board certification, board certification, and the abuses of recertification, state and federal political interference with state licensing boards. Demographic and socioeconomic inequities in the residency and fellowship selection process, and education and training in reproductive services (necessary in the current climate with Roe v. Wade having been struck down). This is the work of just one of six reference committees at this meeting. Other committees will be determining AMA policy on issues such as the corporatization of medicine, the pending Medicare across-the-board eight percent pay cut for physicians (Have you heard about that?), drug shortages, and rights of employed physicians. Also, price gouging for generic medications, expansion of telemedicine services and payment for these services, the Covid pandemic, the opioid pandemic, preserving physician leadership in patient care teams, scope-of-practice expansion, parity for mental health issues, as well as global climate change and limiting pornography viewing by minors.

You may think the AMA has no business dabbling in some of these issues, and I would wholly agree with you, but you have to agree that many of these topics directly impact your, my, and our practices and the care we give our patients. In a true democracy like the AMA, in which every member can submit resolutions for consideration, you are bound to get some wild and crazy suggestions. That's why we're here this weekend, to separate the wheat from the chaff and do everything we can to represent all of the physicians, and patients, in the United States.

And I promise you; I won't have a Mai Tai until the work is done.

Public Health is getting a new review from the Governor's Commission

Ken Spear, M.D.
Vanderburgh County
Health Officer



It is hoped good things will come from this review as we are entering a Budget Session in the Indiana Legislature when significant changes could occur due to increased opportunities for funding Public Health.

Currently, Indiana ranks near the bottom of all of the States for Public Health Care funding, and it is apparent in our smoking rates, Infant Mortality Rates, Drug Abuse rates, etc.

Money obviously doesn't solve all the issues, but you need well-trained, dedicated personnel to work on these issues and innovative programs for the most vulnerable in our society.

These are not inexpensive needs, and the State has fallen far behind in salaries and benefits, so we lose our best and brightest people to better-paying jobs in health care and other industries,

I am hopeful something meaningful will come out of this next Legislation; not confident, but at least hopeful.

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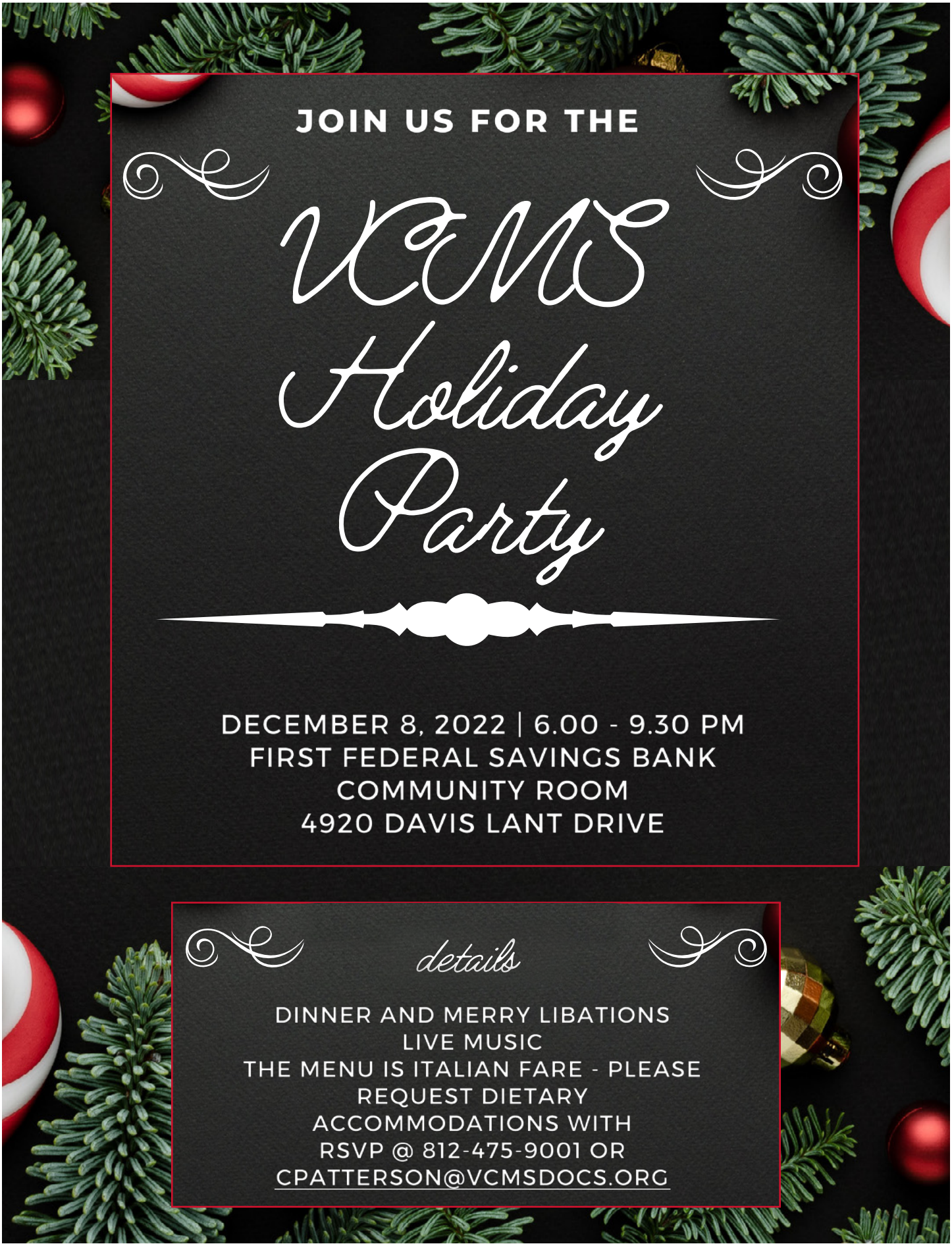
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What do the 2023 cost-of-living adjustment numbers mean for you?

KEMPER CPA GROUP LLP

October 27, 2022

The IRS recently issued its 2023 cost-of-living adjustments for more than 60 tax provisions. With inflation up significantly this year, many amounts increased considerably over 2022 amounts. As you implement 2022 year-end tax planning strategies, be sure to take these 2023 adjustments into account.

Also, keep in mind that, under the Tax Cuts and Jobs Act (TCJA), annual inflation adjustments are calculated using the chained consumer price index (also known as C-CPI-U). This increases tax-bracket thresholds, the standard deduction, certain exemptions and other figures at a slower rate than was the case with the consumer price index previously used, potentially pushing taxpayers into higher tax brackets and making various breaks worth less over time. The TCJA adopts the C-CPI-U on a permanent basis.

Individual income taxes

Tax-bracket thresholds increase for each filing status but, because they're based on percentages, they increase more significantly for the higher brackets. For example, the top of the 10% bracket increases by $725, to $1,450, depending on filing status, but the top of the 35% bracket increases by $22,950 to $45,900, again depending on filing status.

2023 ordinary-income tax brackets				
Tax rate	**Single**	**Head of household**	**Married filing jointly or surviving spouse**	**Married filing separately**
10%	$0 – $11,000	$0 – $15,700	$0 – $22,000	$0 – $11,000
12%	$11,001 – $44,725	$15,701 – $59,850	$22,001 – $89,450	$11,001 – $44,725
22%	$44,726 – $95,375	$59,851 – $95,350	$89,451 – $190,750	$44,726 – $95,375
24%	$95,376 – $182,100	$95,351 – $182,100	$190,751 – $364,200	$95,376 – $182,100
32%	$182,101 – $231,250	$182,101 – $231,250	$364,201 – $462,500	$182,101 – $231,250
35%	$231,251 – $578,125	$231,251 – $578,100	$462,501 – $693,750	$231,251 – $346,875
37%	Over $578,125	Over $578,100	Over $693,750	Over $346,875

The TCJA suspended personal exemptions through 2025. However, it nearly doubled the standard deduction, indexed annually for inflation through 2025. For 2023, the standard deduction will be $27,700 (married couples filing jointly), $20,800 (heads of households), and $13,850 (singles and married couples filing separately). After 2025, standard deduction amounts are scheduled to drop back to the amounts under pre-TCJA law unless Congress extends the current rules or revises them.

Changes to the standard deduction could help some taxpayers make up for the loss of personal exemptions. But it might not help taxpayers who typically used to itemize deductions.

AMT

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The alternative minimum tax (AMT) is a separate tax system that limits some deductions, doesn't permit others and treats certain income items differently. If your AMT liability is greater than your regular tax liability, you must pay the AMT.

Like the regular tax brackets, the AMT brackets are annually indexed for inflation. For 2023, the threshold for the 28% bracket will increase by $14,600 for all filing statuses except married filing separately, which increased by half that amount.

2023 AMT brackets				
Tax rate	**Single**	**Head of household**	**Married filing jointly or surviving spouse**	**Married filing separately**
26%	$0 – $220,700	$0 – $220,700	$0 – $220,700	$0 – $110,350
28%	Over $220,700	Over $220,700	Over $220,700	Over $110,350

The AMT exemptions and exemption phaseouts are also indexed. The exemption amounts for 2023 will be $81,300 for singles and $126,500 for joint filers, increasing by $5,400 and $8,400, respectively, over 2022 amounts. The inflation-adjusted phaseout ranges for 2023 will be $578,150–$903,350 (singles) and $1,156,300–$1,662,300 (joint filers). Amounts for married couples filing separately are half of those for joint filers.

Education and child-related breaks

The maximum benefits of certain education and child-related breaks generally remain the same for 2023. But most of these breaks are limited based on a taxpayer's modified adjusted gross income (MAGI). Taxpayers whose MAGIs are within an applicable phaseout range are eligible for a partial break — and breaks are eliminated for those whose MAGIs exceed the top of the range.

The MAGI phaseout ranges will generally remain the same or increase modestly for 2023, depending on the break. For example:

The American Opportunity credit. For tax years beginning after December 31, 2020, the MAGI amount used by joint filers to determine the reduction in the American Opportunity credit isn't adjusted for inflation. The credit is phased out for taxpayers with MAGI in excess of $80,000 ($160,000 for joint returns). The maximum credit per eligible student is $2,500.

The Lifetime Learning credit. For tax years beginning after December 31, 2020, the MAGI amount used by joint filers to determine the reduction in the Lifetime Learning credit isn't adjusted for inflation. The credit is phased out for taxpayers with MAGI in excess of $80,000 ($160,000 for joint returns). The maximum credit is $2,000 per tax return.

The adoption credit. The phaseout ranges for eligible taxpayers adopting a child will also increase for 2023 — by $15,820, to $239,230–$279,230 for joint, head-of-household and single filers. The maximum credit will increase by $1,060, to $15,950 for 2023.

(Note: Married couples filing separately generally aren't eligible for these credits.)

These are only some of the education and child-related breaks that may benefit you. Keep in mind that, if your MAGI is too high for you to qualify for a break for your child's education, your child might be eligible to claim one on his or her tax return.

Gift and estate taxes

The unified gift and estate tax exemption and the generation-skipping transfer (GST) tax exemption are both adjusted

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annually for inflation. For 2023, the amounts will be $12.92 million (up from $12.06 million for 2022).

The annual gift tax exclusion will increase by $1,000 to $17,000 for 2023.

Retirement plans

Nearly all retirement-plan-related limits will increase for 2023. Thus, depending on the type of plan you have, you may have limited opportunities to increase your retirement savings if you've already been contributing the maximum amount allowed:

Your MAGI may reduce or even eliminate your ability to take advantage of IRAs. Fortunately, IRA-related MAGI phaseout range limits all will increase for 2023:

Type of limitation	2022	2023
Elective deferrals to 401(k), 403(b), 457(b)(2) and 457(c)(1) plans	$20,500	$22,500
Annual benefit limit for defined benefit plans	$245,000	$265,000
Contributions to defined contribution plans	$61,000	$66,000
Contributions to SIMPLEs	$14,000	$15,500
Contributions to IRAs	$6,000	$6,500
"Catch-up" contributions to 401(k), 403(b), 457(b)(2) and 457(c)(1) plans for those age 50 and older	$6,500	$7,500
Catch-up contributions to SIMPLEs	$3,000	$3,500
Catch-up contributions to IRAs	$1,000	$1,000
Compensation for benefit purposes for qualified plans and SEPs	$305,000	$330,000
Minimum compensation for SEP coverage	$650	$750
Highly compensated employee threshold	$135,000	$150,000

Traditional IRAs. MAGI phaseout ranges apply to the deductibility of contributions if a taxpayer (or his or her spouse) participates in an employer-sponsored retirement plan:

For married taxpayers filing jointly, the phaseout range is specific to each spouse based on whether he or she is a participant in an employer-sponsored plan:

For a spouse who participates, the 2023 phaseout range limits will increase by $7,000, to $116,000–$136,000.

For a spouse who doesn't participate, the 2023 phaseout range limits will increase by $14,000, to $218,000–$228,000.

For single and head-of-household taxpayers participating in an employer-sponsored plan, the 2023 phaseout range limits will increase by $5,000, to $73,000–$83,000.

Taxpayers with MAGIs in the applicable range can deduct a partial contribution; those with MAGIs exceeding the applicable range can't deduct any IRA contribution.

But a taxpayer whose deduction is reduced or eliminated can make nondeductible traditional IRA contributions. The $6,500 contribution limit for 2023 (plus $1,000 catch-up, if applicable, and reduced by any Roth IRA contributions) still applies. Nondeductible traditional IRA contributions may be beneficial if your MAGI is also too high for you to contribute (or fully contribute) to a Roth IRA.

Roth IRAs. Whether you participate in an employer-sponsored plan doesn't affect your ability to contribute to a

Continued on Next Page

Roth IRA, but MAGI limits may reduce or eliminate your ability to contribute:

For married taxpayers filing jointly, the 2023 phaseout range limits will increase by $14,000, to $218,000–$228,000.

For single and head-of-household taxpayers, the 2023 phaseout range limits will increase by $9,000, to $138,000–$153,000.

You can make a partial contribution if your MAGI falls within the applicable range, but no contribution if it exceeds the top of the range.

(Note: Married taxpayers filing separately are subject to much lower phaseout ranges for both traditional and Roth IRAs.)

Crunching the numbers

With the 2023 cost-of-living adjustment amounts soaring higher than 2022 amounts, it's important to understand how they might affect your tax and financial situation. We'd be happy to help crunch the numbers and explain the best tax-saving strategies to implement based on the 2023 numbers.

A Resource for Physicians

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for Members of the Vanderburgh County Medical Society

From start to finish, Team McClintock will manage the purchase of your home by assisting with all your real estate and related needs. We are your advocate in this entire process. All from the comfort of home or your busy office...

FINDING THE PERFECT HOME

- Send electronic "wish" and "needs" list to team member
- New listings will be emailed to you when listed
- Agent will Facebook or Skype from any of the homes of interest
- Agent will set up instant showings to meet your busy schedule
- Provide comps within hours of viewing any homes
- Gather community and school information
- Write offer, negotiate, provide counters all via phone and electronically

MAKING SURE IT'S THE RIGHT ONE

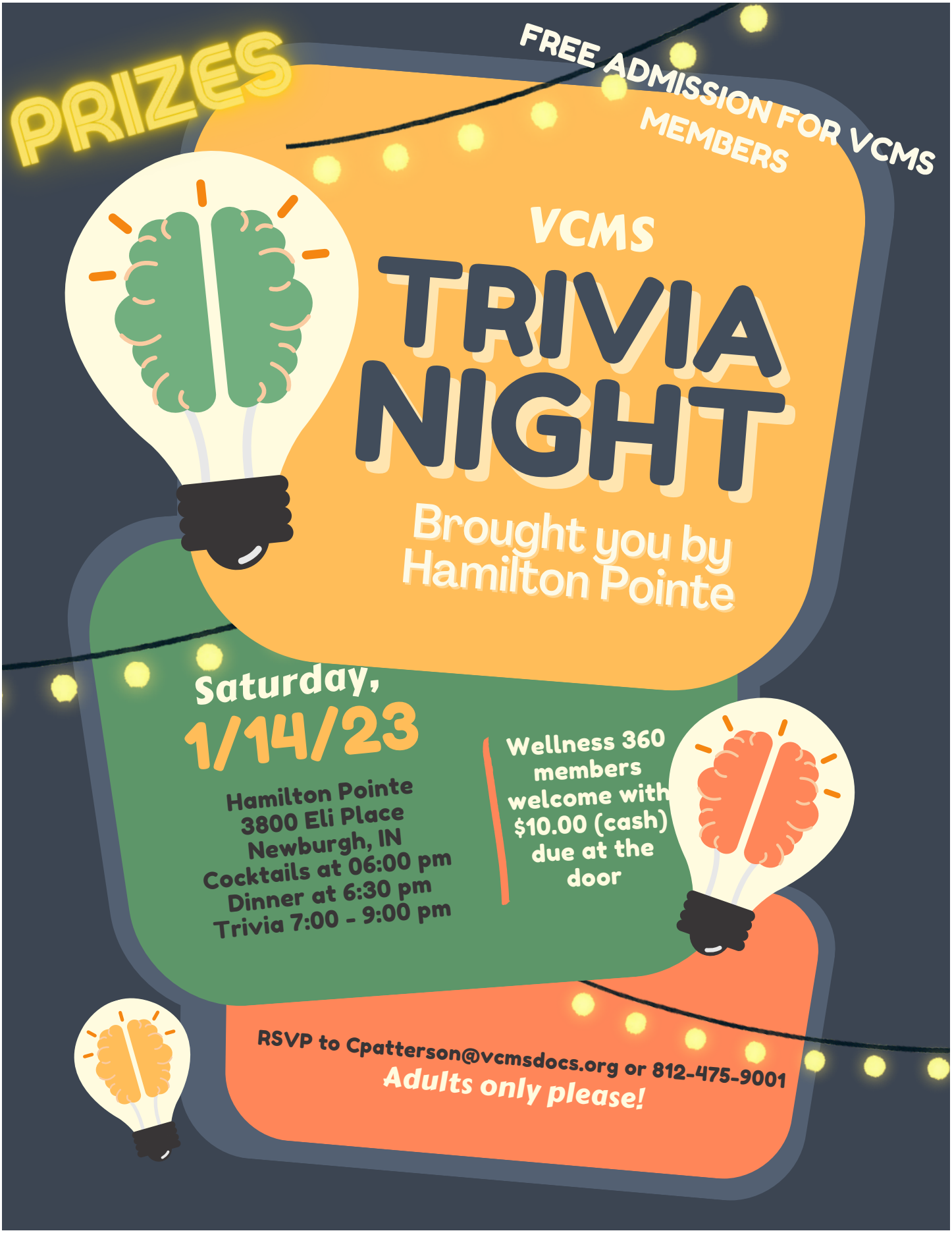
- Agent will set up all inspections at home and arrange for payments to be made at closing
- Agent will review all inspections, order any necessary additional inspections/estimates
- Work with you to respond to the inspections electronically
- Provide a Supreme Homes Buyers Warranty for one full year at closing

FINISHING THE JOB

- Help to identify lender, work with lender to provide information needed
- Pick up your earnest money check at home or office, deliver to Listing Agent
- Get Home Owner Insurance quotes
- Arrange for moving company
- Change utilities
- Facebook or Skype walk through prior to closing
- Attend closing at your home or office
- Provide a closing gift!
- Deliver the keys!!

It's that simple to move to the home of your dreams!

Team-McClintock.com • 812.777.5220 • F.C. Tucker Emge REALTORS®


PRIZES
FREE ADMISSION FOR VCMS MEMBERS
VCMS
TRIVIA NIGHT
Brought you by Hamilton Pointe
Saturday,
1/14/23
Hamilton Pointe
3800 Eli Place
Newburgh, IN
Cocktails at 06:00 pm
Dinner at 6:30 pm
Trivia 7:00 - 9:00 pm
Wellness 360 members welcome with $10.00 (cash) due at the door
RSVP to Cpatterson@vcmsdocs.org or 812-475-9001
Adults only please!

Member Birthdays

December

Susan M. Martin, MD 1
Thomas J. Rusche, MD 1
Gary L. Beck, MD. 2
Thomas B. Anderson, MD . . . 3
Nicholas C. Kuchle, MD 3
Andrew S. Pfaff, MD 3
Taylor S. Gardner, DO. 4
John D. Guletz, MD 4
Jerry D. Becker, MD 6
Jon D. Frazier, MD 6
William J. Millikan, Jr., MD . . 6
Andrew T. Saltzman, MD . . . 7
Mark E. Meyers, MD. 9
Sally G. Primus, MD. 9
R. Buckland Thomas, MD . . . 11
Todd M. Dunaway, DO 15
Carl H. Linge, MD 15
Richard A. Tibbals, MD 17
Bruce W. Romick, MD. 18
Thomas M. Harmon, MD. . . 20
Peter A. Rosario, MD 20
Steven G. Becker, MD. 21
Hunter J. Hicks, DO. 21
Robert L. Rusche, MD 22
Gene R. Flick, MD 25
V. Paul Banning, MD. 26
Jean S. Haseman, MD. 27
Edward L. Brundick, MD . . . 28
James R. Porter, MD 28
Craig T. Carter, MD. 29
Bryn N. Thatcher, MD. 29
Juan C. Cabrera, Jr., MD . . 30

Calendar of Events

Save the Date

DECEMBER 2022	December 8	**VCMS Holiday Party** First Federal Community Room 6:00 - 9:30 pm
JANUARY 2023	January 14	**VCMS Trivia Night** Hamilton Pointe Recreation Room 6:00 - 9:30 pm

More exciting events to come!

Stay updated on future events and visit the VCMS website at http://vcmsdocs.org/events/

Welcome New Members!

Alexander Clayton, MD

Maunil Sheth, MD

Vanderburgh County Medical Society

ADVOCACY • COMMUNITY • EDUCATION

What can we help you with?

Call 812-475-9001 for assistance today!

Vanderburgh County Medical Society
Evansville Indiana

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MONITOR

PHYSICIANS DEDICATED TO THE HEALTH OF THE COMMUNITY

3116 E. Morgan Ave., Suite F • Evansville, IN 47711