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FROM THE PRESIDENT

I recently attended the EDPMA Solutions summit. The message learned at both conferences is really important. We have a lot of challenges with our evolving specialty. We are dealing with reimbursement threats. Out of Network billing is at the top of legislative agendas around the country. Advanced Practice Professionals are gaining more clout. Our ED colleagues keep digging their heels in an attempt to resist any movement. The term “embrace change” has never been more important.

Our continued success is dependent upon how well we embrace change. Medicine in America is evolving. The driver is cost and even though we know where that cost is, we need to be at the table to drive the conversation and look for win-win solutions. APPs are part of this, payers are part of this, the American Hospital Association is part of this, and CMS is part of this. Would you pay 100% for a product if you could get it for 85%. That is the simplistic piece for APPs. We have an access-to-care problem and our approach has hurt us. The APP movement is out of the barn. It is time to realize that and massage the message for a win-win. The solution is about the greater good. That is the patient. If we stomp our feet and procrastinate on solutions, we will lose this fight. This is no different from our fight on out-of-network payments, violence in the ED, malpractice, etc. Politics are not clean. To change our perception and to improve and solidify our future as a specialty, we have to play the game. This is not an option. No one is going change the game to something that we like. If we are not at the table, we are on the menu.

Let’s talk about the current status quo. It is not a long-term solution. The costs are too high as a society and we are falling behind on outcomes compared to other westernized nations. That is the driver. Medicare was set up as a solution for a life expectancy of 2 years when people turned 67 years of age. Now it is being used, on average for 15 years, by our aging population as life expectancy is much higher. It was a successful endeavor, but it has to change. We as physicians are being out-funded by the hospitals, the payers, and big pharma in legislative endeavors. The average ED physician spends $27 a year on advocacy. It is not viewed as an investment to one’s future. Imagine what we could do if we all gave $100 or more. That is access and that is a better seat at the table. Let’s stop being our own worst enemy. Nobody is looking out for us. Nor are they looking out for our patients. Take a look in the mirror and ask yourself the following question, “What do I want emergency medicine to look like in 10 years?” Remember, if you don’t do anything to achieve it, it will not get there on its own. Then ask yourself, “What can I do to help?” Ask your chapter, ask your colleagues. Get involved. Learn the issues.

Lastly, I would like to touch on a subject that recently inspired me. We are leaders. Society looks to us. Get involved and do more. You have been given a privilege from society. Your degree imparts upon you certain privileges. This means that you “owe more.” We owe more. This is our opportunity to give back to society not just by going to work, saving lives, and going home, but taking that privilege to make the world a better place. Taking the time to do more outside of the walls of the hospital creates personal wellness, professional wellness, and societal wellness.
FROM THE ASSISTANT EDITOR

I write to you as your assistant editor of this newsletter for the last time. I reflect on the past six years serving alongside Dr. Gafni-Pappas and the transitions that occur in our specialty. We see transitions that occur with our patients. We also see the transitions that occur in leadership roles and responsibilities. This state chapter is such an asset to our patients and us as healthcare providers. Becoming a leader is a great honor and privilege. It is a wonderful opportunity for personal and professional growth. I highly encourage all of us to embrace leadership and growth opportunities in our daily lives, our professional lives, and in organized medicine.

Our jobs are stressful. We could come up with a mile-long list of the challenges we face on a daily basis. Over the years, these challenges and stressors can either get the better of you, or they can be used as fuel to make ourselves and others around us better. Innovation and growth occur best under necessity and stress. Please take the stressors and challenges in our lives and embrace them as opportunities for personal and professional growth.

I’ve recently realized how service excellence (patient satisfaction) can make my life better and my job easier. It has been an epiphany which fuels further learning and understanding. This has led to greater satisfaction with my career. This has translated into positive effects at home. As a husband and father of four, it has helped me facilitate the growth and learning of our young family. The ultimate goal is to make a great impact on as many people as possible. I thank MCEP, including my role as associate editor, for contributing to that.

Time changes everything and life goes on. As Dr. Gafni-Pappas and I transition the newsletter to the next two editors of our chapter, please consider increasing your level of engagement with the College. I promise you will find it welcoming and rewarding. If you are like me, it will become an opportunity to make yourself better on a personal and professional level. These moments of transition should be embraced. I’ve enjoyed working with Dr. Gafni-Pappas to institute the electronic infrastructure which created our E-Newsletter as well as working with Madey to create and grow MCEP studios. I’m excited to see the continued growth and evolution of our state chapter. The future is bright! Thanks for reading.

Nicholas Dyc, MD, FACEP
AUTO NO FAULT FINISHED

The tone to this issue this year was set early on during last year’s gubernatorial primary. Then candidate, now Governor, Gretchen Whitmer was criticized during the Democratic primary by her other competitors for not committing to lower auto insurance rates for Detroit residents. She eventually promised to help lower rates and end “redlining” in urban areas. Flash forward to the start of this year where Speaker Lee Chatfield (R-Levering) and Senate Majority Leader Mike Shirkey (R-Clarklake) kicked off the session with speeches about auto no fault being their number one agenda item. The Speaker created a committee specifically for auto no fault reform and the Senate introduced Senate Bill 1 as its first bill on no fault. Both chambers conducted months of hearings on the issue, but little ground was compromised by either side of the battle.

The House moved first with the passage of House Bill 4397 on a nearly partisan vote in early May. The Senate replied quickly with passage of Senate Bill 1. Conversations were ongoing between the House/Senate/Governor, but it wasn’t until Quicken Loans CEO Dan Gilbert threatened to go to the ballot that talks got serious. If Gilbert went to the ballot, an expensive undertaking, it would limit the ability of the Governor to negotiate on the final version because ballot questions are an up or down vote essentially. The Governor worked closely with the hospitals, health care advocates and trial attorneys to get a deal that was palatable for most involved. The bill was signed in late May on Mackinac Island at the Detroit Chamber Policy Conference. Below are the key provisions:

**Rate Rollbacks:** A key point of contention for all involved, rate rollbacks for personal injury protection (PIP) were agreed upon as follows: completely opting out of PIP coverage would mean a 100 percent rollback; choosing the $50,000 PIP coverage would mean a 45 percent rollback (this option is only available to those enrolled in Medicaid); choosing the $250,000 PIP coverage would mean a 35 percent rollback; choosing the $500,000 PIP coverage would mean a 20 percent rollback; and choosing the unlimited PIP coverage would mean a 10 percent rollback. The above rollbacks would begin July 1, 2020 and will last for eight years.

**Rating Factors:** Under the agreement, the following factors are prohibited from being used in setting insurance premiums: sex, marital status, home ownership, credit score (NOT insurance score or credit information), occupation and educational level attained (both allowed for group policies), and zip code (NOT “territory”). The rate factors were among the major issues Democratic members sought to change, ensuring those in more poverty-stricken areas are not unfairly overcharged.

**Fee Schedule:** Multiple levels would take effect two years after the bill takes effect (July 1, 2021) and once they are implemented, the rates will phase-in over two years, settling at the subsequent levels: 190 percent of Medicare for medical and rehabilitation treatment (not covered in any of the following categories); 220 percent for providers treating a high volume of patients enrolled in Medicaid (only care before initial discharge); 230 percent for Trauma 1 & 2 providers (again, only care before initial discharge); and 250 percent for providers treating a high volume of indigent patients. As noted in a summary of the agreement, the rates will be effective after 4 years and will be approximately 40 percent higher than the workers compensation fee schedule.

**Opt-out:** Drivers enrolled in Medicaid may opt out of PIP coverage, along with those who have private health insurance covering their entire household, any treatment for injuries caused by auto accidents, and that has a deductible lower than $6,000 per person.

**Managed/Attendant Care:** As agreed upon, attendant care fee schedules will remain at workers compensation limits, and managed care options for PIP may be offered by insurers. A managed care PIP plan will be available under each PIP choice level, but drivers are not required to choose one when considering coverage. Following an auto accident, a managed care company will “monitor and adjudicate” the claimant’s care.

**Bodily Injury Liability/Fraud:** Currently, bodily injury liability (BI) coverage equals $20,000 per bodily injury and $40,000 per accident. Under the agreement, those would be increased to $250,000 and $500,000, respectively. Another option drivers will have though is to increase the coverage only slightly, to $50,000 and $100,000 respectively. Originally written in Senate Bill 1, a fraud task force would be housed within the Michigan Department of State Police.

A more detailed analysis can be found at this [link](#).

**VIOLENCE IN THE EMERGENCY DEPARTMENT**

MCEP continues to work with legislators in both chambers to put in place tougher penalties for individuals assaulting health care workers in the hospital setting. We are pleased to support legislation introduced in the Senate by Senator Ken Horn (R-Frankenmuth), Senate Bill 80, and House Bills 4328 and 4329, introduced by Representative Hank Vaupel (R-Handy Township). MCEP Executive Director Belinda Chandler and Board Chairman Dr. Rami Khoury testified before House Judiciary in April. We continue to meet with legislators on the issue to try to have a bill ready for passage this fall.

**SURPRISE BILLING LEGISLATION**

Legislation has been introduced by Representatives Roger Huack (R-Mt. Pleasant) and Frank Liberati (D-Allen Park) to curb the practice of “surprise billing”. MCEP is opposed to the legislation as introduced but we are working with them as this issue unfolds nationally. ACEP has a lot of great issue papers on this topic and we are working with them to make some of them Michigan specific. Needless to say, most of the “surprises” happen when the patient figures out how little their health care coverage covers. MCEP will keep you posted on this issue throughout the summer. §
SUPERFICIAL OCULAR FOREIGN BODY REMOVAL—PROCEDURAL CODES

Proper documentation for the presence and removal of a superficial ocular foreign body is the key to determine what procedural code is to be used. Without the specifics needed in the initial documentation, the code set will be up to the interpretation of the coder or sent back to the provider for clarification. Specific information should include anatomical FB location, use of instrumentation for removal (or not), use of Slit Lamp in exam and removal (or not), and rust ring presence and removal (or not). Foreign body identification without removal is coded as an E&M level only.

FB LOCATION:
Removal of FB external eye, conjunctival superficial (625205)
Removal of FB external eye, conjunctival embedded (65210)
Removal of FB external eye, cornea, without Slit Lamp (65220)
Removal of FB external eye, cornea, with Slit Lamp (65222)

FB INSTRUMENTATION AND REMOVAL:
Document specific instrument used if applicable. Examples would include a rotary burr, needle, sterile Q-tip or flush. FB removal without instrumentation is coded as an E&M level only.

SLIT LAMP USAGE:
Documentation of usage adds complexity and additional RVU’s. Michigan Medicare procedural reimbursement for 65220 is $41.72 and 65222 is $51.65

RUST RING REMOVAL:
Presence and removal (or not) is important for documentation of expected outcome and follow up parameters. Recall the presence of a rust ring can delay healing, cause epithelial erosion, scaring and visual deficits.

Removal of FB, external eye, cornea, and simultaneous rust ring removal (65222)
Isolated rust ring removal in absence of FB (65435)

*As with any ocular injury or complaint, additional proper medico-legal documentation of a superficial ocular FB should always include visual acuity, absence of globe perforation/penetration, timely follow up and return with any worsening pain, sign of infection or visual changes. §

Don H. Powell, DO, FACEP
VP Revenue Cycle Management and Advocacy- Emergency Care Specialists
Michelle M Renis CPC, CEDC, ICD-10
Director of Coding and Reimbursement- Medical Management Specialists

REIMBURSEMENT CORNER

SAVE THE DATE

2019 Michigan Emergency Medicine Summer Assembly

July 28–31, 2019
Grand Hotel, Mackinac Island, MI

We hope you consider joining us on July 28–31, 2019 for our annual Michigan Emergency Medicine Assembly taking place at the beautiful Grand Hotel on Mackinac Island, MI. This year’s agenda will again include valuable updates and information you will find useful to you, your practice and your patients.
INTRODUCTION:
In this case report we describe an interesting presentation of a profoundly hyponatremic patient that presented to the hospital as a Level 2 trauma and was initially evaluated by the surgical team. Her initial confusion was thought to be secondary to trauma given the report, but was later discovered to be secondary to a metabolic derangement.

NARRATIVE:
A 50 year-old female presented to the ER as a Level 2 trauma after she was found falling in a parking lot at a nearby shopping center. The patient was initially unable to provide history and EMS had no other known history on the patient. She had contusions, and multiple abrasions to her head and body and her GCS was 12. She was moving all extremities, responsive to pain, opening her eyes and had inappropriate words. She was taken immediately to the CT scanner for a head and C-spine CT where she was found to have no acute intracranial process, and all other imaging was negative. The patient was taken back to a monitored bed in the ED and within minutes the patient began having a generalized tonic-clonic seizure. She was intubated. Her labs just after intubation were remarkable for a Na <100, and low urine osmolality. She was given hypertonic saline, started on normal saline infusion and admitted to the MICU. Her Na overcorrected to 117 in less than 12 hours and she was started on a D5 water infusion at 200 mL/hr. The goal was Na of 110 in 24 hours. It then decreased to 113 and she was given desmopressin. Afterwards she was fluid restricted for several days until her Na slowly normalized.

DISCUSSION:
Hyponatremia is a common electrolyte derangement that is seen in the ER, but has many different presentations including extremes of presentation. Various studies have shown the prevalence of hyponatremia on admission to range from 5.5-37% with most patients commonly being mild (6). Hyponatremia is defined as a serum Na <135 with severe hyponatremia being Na <120-125. Plasma osmolality is mainly determined by Na. Thus, a low Na usually means a low plasma osmolality. Our bodies are typically able to excrete dilute urine as a protection against hyponatremia. When too much ADH is released, our kidneys are less able to maximally dilute our urine, leading to impaired excretion of water and thus subsequent hyponatremia. In disease states like CHF, there can even be an increase in ADH as there is a relative intravascular volume depletion, despite an overall fluid overload state (1).

It is helpful to address fluid status in in the initial work up of patients with hyponatremia, and to group patients as hypovolemic, euvoletic or hypervolemic. Potential causes of hypovolemic hyponatremia include GI losses, hypoalbuminemia, nephropathy, and mineralocorticoid deficiency. Causes of hypervolemic hyponatremia include congestive heart failure, cirrhosis, nephrotic syndrome. Causes of euvoletic hyponatremia include SIADH, medications including diuretics and antidepressants, high fluid intake, malignancies, and adrenal insufficiency (2).

Symptoms of hyponatremia include nausea, headache, and restlessness. Severe manifestations include seizure and coma. Mild hyponatremia may be asymptomatic, but especially in the geriatric population may show some cognitive or neurological symptoms (2). Hyponatremia can be categorized into acute, defined as less than 48 hours, and chronic being greater than 48 hours (3).

Psychogenic polydipsia is described as a hypo-osmolar hyponatremia. It is seen in psychiatric patients most commonly with schizophrenia and in anxiety disorders. Prevalence in the psychiatric population can be from 6-20% (7). It is thought to be multifactorial with a malfunctioning hypothalamic thirst center contributing. Those with co-existing SIADH can have profound hyponatremia. In our case our patient was found out later to be drinking an abundance of water and had history of psychiatric illness. She was also found to be on antidepressants, which can also contribute to hyponatremia.

MCEP Calendar of Events

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<td>December 4, 2019</td>
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Treatment for hyponatremia depends on the severity of symptoms, acute versus chronic hyponatremia, level of Na, and cause of hyponatremia. In our case, which was a severe case of hyponatremia including neurological manifestations and seizures the patient was given a bolus of hypertonic saline. The recommendation for using hypertonic saline includes severe hyponatremia with seizures. The initial rate of 3% hypertonic saline should be 1-2 mL/kg/hr and once serum sodium increases by 10% or neurological changes improve, a more conservative management approach should be used (4). In those with chronic hyponatremia, treatment will depend on the cause of hyponatremia. In hypovolemic states, treatment includes IV fluids and treatment of the underlying cause. In hypervolemic states, treatment includes fluid restriction, sometimes furosemide or spironolactone, or vasopressin antagonists like tolvaptan. This medication works by blocking vasopressin at the kidneys. This medication is metabolized by CYP3A4 and so has potential for drug interactions (5). For euvoletic states, it is recommended to start with fluid restriction and to search for potential causes of SIADH. If fluid restriction fails, a vaptan medication may be considered (6).

The known severe risks of correcting Na too quickly include osmotic demyelination syndrome. In those with chronic hyponatremia, the correction should not exceed 6-12 mEq in 24 hours. This syndrome occurs when Na is corrected too rapidly causing water to move from the inside of cells to the extracellular fluid. Symptoms include mental status changes, lethargy, seizures, dysphagia, coma and possibly death (4). When correcting sodium, it is important that a blood level is checked and neurological exams are performed frequently (6). §

REFERENCES:
SAVE THE DATE!

SHERATON ATLANTA HOTEL
SEPTEMBER 12 - 13, 2019

7TH ANNUAL
OBSERVATION
MEDICINE
- SCIENCE
AND SOLUTIONS
CONFERENCE

• Hear from and network with top Observation Medicine physician leaders and authors, Advanced Practice Providers and Nurses
• New this year! Option to tour state-of-the-art Observation units in a Community or University hospital setting
• Learn how to make the case that your hospital needs an Observation Unit
• Featuring 2 tracks - Beginners: Starting an Observation Unit and Advanced: Optimizing and Growing your Observation Unit
• Learn how to design, appropriately staff and successfully manage an Observation Unit using evidence-based best practice
• Discover how to document and maximize reimbursement for Observation Services
• Back this year! Innovations and research in Observation Medicine
A TIMELY TOPIC: SPECIALTY SPECIFIC DISABILITY INSURANCE

From the time you first step foot on a medical campus throughout your final rotation as a resident or fellow, specialty specific disability insurance tends to be a common theme. You have probably received a plethora of emails on the topic, maybe had the opportunity to attend a seminar or heard colleagues discussing it. But what is it? Why do so many physicians purchase policies and how do you decide what is right for you? The following are some of the most common questions regarding disability insurance. We hope you find them helpful.

WHAT IS SPECIALTY SPECIFIC DISABILITY INSURANCE?
Disability insurance will replace a portion of your income if you become too sick or injured to work in your specialty. This can include moonlighting, 1099 & self-employed income. Think of it as income insurance. If you can’t work your bills continue and your debt still needs to be repaid. Shouldn’t your income continue too? Even if you have disability insurance provided through your employer, you may choose to own a personal policy that provides additional coverage and travels with you from employer to employer.

WHAT IS THE LIKELIHOOD OF NEEDING DISABILITY INSURANCE?
Disability insurance helps replace income lost because of an accident or illness. One survey found that 43% of people aged 40 will suffer a disability of at least 90 days before they reach age 65. 2000 Field Guide, National Underwriter

According to the Kaiser Family Foundation, “Medical bills are a leading cause of personal bankruptcy in the U.S., contributing to 62 percent of personal bankruptcies in 2007. Most who filed for medical bankruptcy that year were well educated, owned homes, and had middle-class occupations. Three quarters had health insurance.” (Medical Debt Among People With Health Insurance Karen Pollitz, Cynthia Cox Follow @cynthiaccox on Twitter, Kevin Lucia, and Katie Keith Published: Jan 07, 2014)

According to the US Commerce Dept., nearly 1 in 5 people living in the U.S. will suffer a disability lasting for more than a year before the age of 65 - the opportunity cost of lost wages is tremendous.

HOW MUCH COVERAGE DO I NEED?
Know the financial needs of your family. How much are your essential needs? Consider your monthly spending on food, housing, insurances, car payments, car maintenance, home maintenance, childcare, schooling for children and debt repayment. A long term disability may lead to you losing your employer’s health insurance. Do you have another source of health coverage such as a working spouse? If not, factor in new health coverage which may cost upwards of $10,000 per year plus medical expenses. Now, add your own personal spending. What’s important to your family? Take time to differentiate between your “wants” and your “needs”. Knowing what is a priority to your family aids in your financial planning. Is giving to your charity essential? Perhaps birthday gifts and/or family vacations with your children are a “must have” even if you are disabled. Planning ahead and making an educated decision regarding the amount of disability insurance you need is a critical aspect of financial planning. Go Fund Me accounts are difficult to rely on when credit card bills come due.

YOUR PERSONAL POLICY AND EMPLOYER COVERAGE--DO I NEED BOTH?
In short, employer coverage alone rarely provides income replacement that a family would consider adequate. Consider the amount of coverage offered by your employer. If your employer pays for the coverage, the benefit you receive after filing a claim will likely be taxable income to you. Is this amount (after taxes) enough to meet your essential needs? Robust employer coverage typically covers up to 60% of your income. After taxes, you may be looking at income replacement of 50% of your income or less. How does this match up to your required household cash flow? If it falls short, you should consider purchasing a personal disability insurance policy.

Benefits are provided by your employer to better your financial situation. They are often a part of a package that is based on being an employee with that specific employer. When you leave your current employer what benefits are portable? Can you take any of the insurance coverages with you? Specialty Specific Disability Insurance is often only for current employees.

WHAT IF I AM SELF-EMPLOYED?
The privilege and responsibility of being self-employed is that you get to be both the employer and employee in your business. It is up to you to set up your benefits package. This includes specialty specific disability Insurance, your retirement plan, life and health insurance. You get to design each aspect, tailoring each option to your specific needs. If you are still in residency and plan on being self-employed, make a decision on

Continued on Page 10
the purchase of disability insurance prior to leaving residency. By doing this, you may be able to lock in discounts and take advantage of special programs only available during your resident years.

**HOW MUCH SHOULD PREMIUMS COST?**
Insurance companies that provide Specialty Specific Disability Insurance use your gender, specialty, health history, hobbies and any military status to determine your premium. It is the role of an independent agent to compare your options and help you understand them. Premiums may vary greatly from carrier to carrier based on your specialty alone. When comparing policies you have the option to add and remove optional riders such as inflation protection and choose the amount of coverage you want. The choices you make regarding these riders and the amount of coverage you want to put in place provide you with great flexibility in controlling premium. Premiums should fit comfortably in your budget, balancing today’s premium with potential future needs.

**HOW DO I CHOOSE AN AGENT?**
An Independent Agent has the ability to work with multiple insurance companies. Make sure your agent represents the “big six” disability insurance companies and makes you feel comfortable understanding the differences. These include Ameritas, Guardian, MassMutual, Ohio National, Principal, and The Standard. This ensures that you are receiving the most competitive pricing tailored for you as an individual. If you feel pressured – move on!

**I’VE HEARD THAT I SHOULD GET COVERAGE DURING RESIDENCY OR FELLOWSHIP. WHY IS THIS?**
Resident and fellow programs often have unique discounts that are permanent and reduce your policy premiums throughout your career. Guaranteed renewable, non-cancelable polices stay in force when you change jobs, move from one state to another and the premiums are locked in.

In addition to locking in low discounted premiums, you can also lock in your health with a “future increase option”. Using the “future increase option” you can purchase more coverage without regard to changes in your health. As long as you are working full time, and you have enough income to justify more coverage, you can buy more coverage.

**WHAT IF I HAVE SERIOUS HEALTH HISTORY?**
If you have an existing health history, a guaranteed issue program may be available to you during residency. Guaranteed issue programs enable you to purchase a policy without regard to most pre-existing health conditions. Where a pre-existing condition would lead to a decline for coverage, a guaranteed issue policy may be placed without any exclusions or limitations. This would be an excellent opportunity to put a personal policy in place that can travel with you after graduation. §

This article written by The BattDouglas Financial Group: serving the Emergency Medicine physician community throughout the United States. Allison Batt, M.S. & Michael Douglas, CLU®, ChFC®, CFP®

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**MCEP members turn out strong with the largest number of state chapter attendees for the ACEP Legislative and Advocacy Conference in Washington, DC. Attendees got to meet with their legislators, including Senator Debbie Stabenow.**
ENJOY GOLFING TWO BEAUTIFUL COURSES IN THIS INAUGURAL FUNDRAISER FOR THE MICHIGAN EMERGENCY PHYSICIAN FOUNDATION. DONATIONS FOR THIS EVENT ASSIST UNDER-REPRESENTED MEDICAL STUDENTS ACCESS TO EDUCATION AND RESEARCH IN THE FIELD OF EMERGENCY MEDICINE.

WHAT & WHERE: Carriage Pickup is at 9:30am at the Pro Golf Shop. Golfing starts at 10:00am on the Woods Course. Boxed Lunch and Drink Cart Will be Available. All Golfers receive 2 drink tickets with registration

RAFFLE & GIVEAWAYS: Longest Drive Mulligan’s 4 for $20 Closest to the Pin Raffle Tickets: 6 for $5 or 30 for $20

Banquet and Award Ceremony at 4:00 p.m. at the Jockey Club

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Executive Committee
Rami Khoury, MD, FACEP — President
president@mcep.org
Warren Lanphear, MD, FACEP — President-Elect
Nicholas Dyc, MD, FACEP — Treasurer
Gregory Gafni-Pappas, DO, FACEP — Secretary
Jacob Manteuffel, MD, FACEP — Immediate Past President

Editor
Gregory Gafni-Pappas, DO, FACEP
mcep@mcep.org

Assistant Editor
Nicholas Dyc, MD, FACEP
mcep@mcep.org

Executive Director
Belinda Chandler, CAE
bchandler@mcep.org

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ProAssurance has been monitoring risk and protecting healthcare industry professionals for more than 40 years, with key specialists on duty to diagnose complex risk exposures.

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