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AMA, TMA Involvement
the Key to Fixing Health System Reform, SGR

By B W. Ruffner, Jr., MD, FACP
President

The Annual Meeting of the AMA in early June is the topic I choose for my first report to you because I think the AMA is critical for a successful resolution to our struggle with the Patient Protection and Affordable Care Act. As expected, it was a lively meeting. We have great leadership in our Delegation Chairman, Chris Fleming. Our other delegates are Charlie White, Lee Morisy, David Gerkin and Don Franklin. To be a strong voice requires several years of involvement. All of the above have paid their dues and are respected by AMA leadership.

The opinions of the delegates on the HCR (Health Care Reform) Act are all over the board. It is important to note that the state delegates are proportional to membership in the AMA – if our membership drops as expected, we will lose votes. It is also important to remember that only about 50 percent of the delegates come from the state societies. Specialty societies, med students, residents, etc. make up the rest, with divergent perspectives.

The sentiments of the delegates on health reform cover a broad spectrum from enthusiastic support to strong dissent. Almost all agree there are good parts of the bill as well as parts that need to be changed. For many there are not enough good parts to justify the spectrum from enthusiastic support to strong dissent. Almost all disagree there are good parts of the bill as well as parts that need to be changed. For many there are not enough good parts to justify the spectrum from enthusiastic support to strong dissent. Almost all agree there are good parts of the bill as well as parts that need to be changed.

The Southern states delegations, including ours, feel the bad outweighs the good. A recent Rasmussen poll of Tennesseans finds that 63 percent favor repeal of the Act. The choice boils down to either working to repeal the bill or trying to modify it. The Southern sentiment has led to the formation of a Coalition of State Medical and National Specialty Societies (including Tennessee) that have voiced their displeasure with AMA leadership and have come up with a platform with three principles: the right to privately contract, that only physicians should determine what quality is, and that medical liability reform is essential. In addition the Coalition made it clear it felt the AMA Board had not expressed the will of the majority of practicing physicians by supporting the HCR bill. Nevertheless, they are committed to working for change within the AMA.

One of the Coalition’s principles is called the “right to privately contract.” Their intent is to allow physicians to balance-bill patients without withdrawing their participation in Medicare. Under current law a physicians may bill up to a little less than 115 percent of the Medicare-allowed amount as “non-participants.” Under this scenario the remittance goes to the patient and the physician bills the patient. In order to try to collect more than the 115-percent “limiting charge” from the patient, the patient must agree to collect nothing from Medicare and the physician must withdraw from Medicare for two years. With leadership from the Coalition, the House of Delegates passed a resolution requiring the AMA to draft legislation for a new Medicare option that would allow patients and physicians to freely contract for payments that differ from the Medicare schedule, while allowing patients to use their Medicare benefits and not require physicians to completely withdraw from the program. In my opinion this may be an approach to break the impasse over SGR. We have two senators in Tennessee who I respect but have resisted a “fix” that adds to the Federal deficit. Congress knows that if confronted with a 21-percent drop in reimbursement many physicians will stop seeing new Medicare patients. Some physicians may want to negotiate even higher fees, but if physicians were allowed to balance bill to make up for the 21-percent loss, patients might direct their ire to Congress and an important message would be delivered: if the recently enacted reform goes forward, either patients are going to pay more, taxes are going up, or the deficit is going up — but that’s a subject for a later column. There will be many emergency situations where patients will not be able to “privately contract.” A patient would find it difficult to negotiate before an emergency tracheotomy or coronary arteriogram.

Some last thoughts on the AMA meeting: I think the Board has gotten the message that it needs to listen to practicing physicians more. All three candidates for president-elect promised to do so. The winner was Peter Carmel, a pediatric neurosurgeon who was supported by the Southeast Delegation. Several resolutions, including one from the Tennessee Delegation, required that the Board be more accountable to the House of Delegates. All were well received.

I am convinced that if we want to maintain the autonomy I have enjoyed in my years as a physician, we must stick together and work through the TMA and AMA. If we do not work together, medicine will still be an honorable profession and our patients will look to us to help them to lead longer more productive lives and to relieve their suffering — but we will not be independent.

Share your thoughts with Dr. Ruffner at president@tnmed.org.
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Strong words in the title of this article, but the emerging healthcare environment may dictate it. Solo practitioners and small groups of physicians are now an endangered species. Overhead, federal rules and regulations, benefits, and their own health insurance costs are making it prohibitively expensive to practice alone.

**MERGER FEVER**

There is a new phenomena occurring in the state of Tennessee and elsewhere. Solo physicians are merging into large multi-specialty groups or with a practice plan with their hospital, rather than go it alone.

In Memphis, two orthopedic groups have merged, a large cardiology group has combined with a hospital, and several independent internists have consolidated into one group. In east Tennessee, Tennessee Valley Medical Group and Mossy Creek Family Physicians merged with Summit Medical Group of Knoxville; Summit is already a 270-physician primary care group with 55 consolidated practices in nine counties. Jefferson Family Physicians merged with Healthstar Physicians of Morristown; and East TN Heart Consultants has split—half are now employed by Mercy and half by Covenant. In Nashville, two large cardiology groups, Page-Campbell and Mid-State, have changed partners and hospital affiliations; multispecialty group Heritage has grown from more than 40 to more than 80 physicians over the past few years, while other specialty groups have combined to increase their market size and stature. And in Chattanooga, Memorial and Erlanger physician groups continue to grow.

It appears that within a few years, as a result of the necessary cuts to reimbursement the health care reform bill will produce, individual and small group practices may find it hard to compete in the marketplace and still provide benefits to their employees and maintain their own standard of living. Only larger groups will be able to successfully negotiate with the exchanges and larger private insurers that remain. Excellent examples are the large specialty groups in Memphis, Nashville and Chattanooga, which are known to have excelled in contracting.

More often the larger group can negotiate from a position of strength because it has a larger market share and can threaten not to participate. Insurers must have an adequate number of providers (panel) to meet their contractual obligation with the purchasing company. Hospitals that have combined with physicians can now offer one-stop contracting for the insurers with less uncertainty about cost.

Meanwhile, hospitals can negotiate contracts with insurers on a larger scale as well and more effectively than a solo physician or small group. In some areas they may even be in a monopolistic position (like a children’s hospital).

**THE TMA CAN HELP**

For physicians the devil is in the details or the contract. The TMA can help by referring those who are considering merger to legal professionals with experience with these matters and who the TMA trusts to look out for the physicians’ best interests. Remember it was the TMA that led the fight for medical legal reform, resulting in a 23-percent reduction in premiums for SVMIC.

The TMA has proven its value to the individual physician and will continue to do so in the future for these new larger groups and hospital partners.

Dr. Thompson is chairman of the TMA Insurance Issues Committee. He serves as chief of the Otolaryngology Division, Surgery Department at St. Jude Children’s Research Hospital, and chair of the Department of Otolaryngology-Head and Neck Surgery, associate dean of Graduate Medical Education and Continuing Medical Education, and professor of Otolaryngology - Head & Neck Surgery, University of Tennessee, Memphis.

The TMA welcomes but is not responsible for opinions expressed in this forum.

Solo physicians are merging into large multi-specialty groups or with a practice plan with their hospital, rather than go it alone.
Our distinguished Johns Hopkins Professor Dr. Redonda G. Miller has coordinated this Magnum Opus for all of us who serve in our specialty of internal medicine endeavoring to update our fund-of-knowledge and/or to achieve our certification and/or recertification by our American Board of Internal Medicine.

While it is daunting for me to cover just how much patient-focused information I learned and/or relearned in reading and re-reading the 720 pages of this exemplary text with hundreds of images in full color and vital text-in-bold, here might well be but a few:

• p. 344: “10-20% of cancer patients develop hypercalcemia at some point—associated with a poor prognosis, 50% mortality in one month” — caught my attention as I am a physician-cancer-survivor. 1

• p. 578: “The goals for diabetes-in-pregnancy include: a fasting blood glucose value of 60 to 80 mg/dL and a two-hour post prandial value less than 120 mg/dL” — as I am a physician-Type II diabetic, I applaud these goals; and I wonder if these need to be my own personal goals (fasting and two hours postprandial) for both my Type II diabetes as well as for all of my fellow Type II diabetics? 2

Supplemental must-reading includes our Images of Osler, published by our “Green Journal,” our official journal of our professors of medicine, just to cite but one illustrative case. 3

Our Mosby-Elsevier tech support was outstanding in facilitating my access to our Johns Hopkins Board Review patient-focused, online outstanding Q & A (vital to our day-to-day practice of our Art and Science of our specialty of Internal Medicine) tech support reasonably needed for those of us relatively senior internists who might well have submitted their initial contributions to our medical professional literature (as I myself did) on initially a manual and then an electric typewriter in the now-historic pre-computer, pre-World Wide Web era!

As I credit my own certification by our American Board of Internal Medicine to our Topics in Internal Medicine, presented and coordinated by our own distinguished Hopkins Professor Emeritus Phillip A. Tumulty, MD, MACP (of greatly honored and deeply beloved memory), our new generations of internists will credit this must-read text. I plan to keep my copy on my desk for ready reference both in treating patients and teaching students.

Internal medicine chief residents and internal medicine residency program directors take heed! Family medicine chief residents and family medicine residency program directors take note; you, too, can and will learn from this text!

Bravo Distinguished Professor Redonda G. Miller, MD, MBA, FACP! Bravo Professor Bimal G. Ashar, MD, MBA, FACP! Bravo Professor Stephen D. Sisson, MD, FACP! +

References:
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HOW DO I RECOGNIZE AND REPORT A DOCTOR SHOPPER?

Q: I understand Tennessee law now requires me to report patients who are doctor shoppers. How do I know if a patient is doctor shopping and how do I report?

A: The requirement to report TennCare patients who are doctor shopping has been in effect since 2007. In 2009 the General Assembly passed a law to require the reporting of all other patients in Tennessee who are attempting to obtain controlled substances or prescriptions for controlled substances knowingly, willfully and with intent to deceive a prescriber. The law was updated and clarified in 2010 to require that a patient notify his or her prescriber that he or she has received a controlled substance or a prescription for a controlled substance in the 30 days prior to the current doctor’s visit.

The TMA Legal Department has developed a Doctor Shopping Guidance to assist member physicians in understanding the requirements for reporting “doctor shopping” patients. This document discusses the law, method for reporting TennCare patients and non-TennCare patients, and immunity available to those who make a report to law enforcement or a local judicial drug task force.

The Guidance also includes some Frequently Asked Questions for the non-TennCare patient reporting requirements.

Some FAQ examples:

Q: What criteria need to be met before one should reasonably report (i.e., report from family, report from other physician office(s), report from pharmacies, printed report from TN controlled substance database)?

A: The law says a physician should have actual knowledge that a patient has knowingly, willfully and with intent to deceive, obtained or tried to obtain controlled substance(s) or a prescription for controlled substance(s) from a prescriber. A physician may use his or her judgment and knowledge of the patient to determine if the patient didn’t realize that a previous prescription is a controlled substance, is within the 30-day time limit, or simply forgot about it. For instance, an Alzheimer’s patient may forget about a previous prescription. Because of that patient’s condition, a physician may determine the patient is not acting willfully or deceptively. Such a patient would not need to be reported. Also, if a family member reports that his or her spouse is addicted to drug X and getting multiple prescriptions and the physician believes the veracity of the statement, then a report may be made to local law enforcement or a judicial drug task force without independently verifying the information.

Q: Is a report from the Controlled Substance Database considered “actual knowledge” and therefore I must report, or is it still up to me to determine if I should report?

A: It will depend on the facts of the case. One can reasonably infer actual knowledge if you have a report from the last 30 days showing the patient got prescriptions from 10 different sources. On the other hand, if it is just one prescriber in the last 30 days and the physician knows the patient well and does not believe there is an intent to defraud, then he or she does not have to report.

(Cont.)
Q: Who do I call locally to report a patient? What phone number do I use? Who do I ask for?

A: The law requires that the prescriber report to local law enforcement or a judicial district or multi-district judicial drug task force but does not specify further. The law enforcement contact will vary from location to location and may be made to law enforcement in the city, town or county where the physician’s office is located. Callers in a city or town with its own police department should start there. Callers in rural areas not served by a police force should call the county sheriff’s department. When you call to make a report, ask to speak to the drug officer or drug investigator. If the prescriber chooses to report to a drug task force, choose the one appropriate for the location of the provider’s office. A list of the Tennessee Judicial Drug Task Forces may be found at [www.drugtaskforce.net/dtfdirectory.htm](http://www.drugtaskforce.net/dtfdirectory.htm). If the law enforcement agency is unfamiliar with the law, explain that the General Assembly enacted it as Public Chapter 67 in 2009 and amended it again in 2010. The effective date of the 2010 amendments (Public Chapter 663) was March 30, 2010.

Q: Do I have to verify (if possible) the information contained in the Controlled Substance Database report?

A: The language in the law states, “If the health care provider’s actual knowledge of conduct prohibited by §53-11-402(a)(6) is a result of the health care provider accessing the information available in the controlled substance database…” …

For the full response to this question and more, check out the Doctor Shopping Guidance at [www.tnmed.org/lawguide](http://www.tnmed.org/lawguide). Any questions may be directed to becky.morrissey@tnmed.org or the TMA Legal Department at 800-659-1862. +

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Tennessee Medicine + www.tnmed.org + AUGUST 2010
The U.S. Department of Health and Human Services and Centers for Medicare and Medicaid Services (CMS) on July 13 announced the long-awaited final rules addressing the “meaningful use” and certification of electronic health records.

Under the Health Information Technology for Economic and Clinical Health (HITECH) Act of 2009, eligible healthcare professionals (EPs) and hospitals must meet these criteria to qualify for Medicare and Medicaid incentive payments.

With “meaningful use” definitions in place, EHR system vendors can ensure that their systems deliver the required capabilities, providers can be assured that the system they acquire will support achievement of “meaningful use” objectives, and a concentrated five-year national initiative to adopt and use electronic records in healthcare can begin.

As much as $27 billion may be expended in incentive payments over 10 years. Eligible professionals may receive as much as $44,000 under Medicare and $63,750 under Medicaid, and hospitals may receive millions of dollars for implementation and meaningful use of certified EHRs under both Medicare and Medicaid.

The CMS rule makes final a proposed rule issued on Jan. 13, 2010. The final rule was modified based on concerns outlined in over 2,000 comments from healthcare stakeholders, including the TMA.

Key changes in the final CMS rule include:

- Greater flexibility in meeting and reporting certain objectives for demonstrating meaningful use. The final rule divides the obligation... (Continued on page 22)
Sign Up for 30th Annual TMA Insurance Workshops

Join the TMA and representatives from Medicare and commercial insurance plans for the 30th annual TMA Insurance Workshops, beginning August 31 and taking place in locations statewide through September 22.

FORMAT CHANGE
To avoid duplicate information and make the most of your time, the workshop will feature two panel discussions:
1. Bureau of TennCare – Heading up a panel discussion with representatives from AmeriChoice, AmeriGroup, and BlueCare/TennCare Select.
2. Medicare Advantage – A panel discussion including AmeriChoice, AmeriGroup, BlueAdvantage, HealthSpring, Humana and Windsor Health Plan. Cahaba will also participate on this panel to help clarify the differences between traditional Medicare and Medicare Advantage.

SPECIAL FEATURES
Cahaba GBA
We are pleased to announce that Cahaba GBA, the Js O A/B Medicare Administrative Contractor (MAC) for the state of Tennessee, will participate at every location.

Commercial Plans
You asked for it, so for the first time representatives from commercial carriers will address attendees. BlueCross BlueShield of TN, Cigna Healthplan and UnitedHealthcare are currently scheduled to participate. Others will be announced as added.

Submit Questions in Advance!
In addition to addressing the top reasons claims are denied, updated policies and procedures, who to contact and where to find information, representatives from the various insurance plans will address individual questions submitted prior to the meeting. All questions should be submitted in advance to phyllis.franklin@tnmed.org or faxed to 615-312-1895.

SCHEDULE
August 31 ..............Memphis .........Fogelman Center
September 1 ..........Jackson ..........Doubletree Hotel
September 14 .........Kingsport .........Meadowview Marriott
September 15 ........Knoxville .........Knoxville Convention Center
September 16 ........Chattanooga.......Doubletree Hotel
September 22 .........Nashville .........Nashville Airport Marriott

Registration (includes continental breakfast and lunch)
$179 ......TMA/TMGMA Member Employees
$129 ......Each Additional Attendee from TMA/TMGMA Members
$229 ......Non-Member Employees

To register, visit www.tnmed.org/workshop.

Clarification of PECOS Enrollment Deadline

In the wake of confusion over enrollment dates for the Provider Enrollment Chain and Ownership System (PECOS), Cahaba GBA has issued a clarification.

The July 6, 2010 date was when provisions of a new Final Rule took effect, but CMS contractors do not implement the provisions until CMS issues a directive in the form of a Change Request (CR).

Cahaba GBA continues to comply with the directives CMS issued in CR 6417, which established claims processing editing to verify the referring/ordering provider submitted on a claim is of the type to order/refer the service billed and is enrolled in Medicare as recorded in the national PECOS files or the contractor’s master provider files. The effective dates outlined in CR 6417 are provided below for further clarification.

IMPORTANT DATES
For all claims received claims processing editing will verify the ordering/referring provider submitted on the claim is of the specialty eligible to order/refer and is either enrolled in PECOS or on the contractor’s master provider file.

• From October 5, 2009, through January 2, 2011, if either of those requirements is not met, the billing provider receives an informational message explaining that the claim failed the ordering/referring provider edits. The claim will continue processing during this time period.

• Beginning January 3, 2011 – If either of those requirements is not met, the billing provider will not receive payment for the ordered/referred services/items billed.

RESOURCES
MLN Matters® Article for CR 6417:
MLN Matters® Article for CR 6310:
Full PECOS enrollment information:
www.cahabagba.com/part_b/whats_new/20100708_ProviderEnroll-mentInformation.pdf. ✪
Alert: New Law Changes Assignment of Benefits Requirements

If you deliver elective medical care as a non-participating facility based provider at a licensed facility in Tennessee, you need to know that a new law changes your payment process.

The new law:
- Requires insurance companies to accept assignment of benefits for out-of-network providers if the facility notifies patients being admitted on an elective basis:
  - that services may be provided by facility-based physicians who may not have a contract with the patient's insurer; and
  - that the patient may receive a bill for services unpaid by the carrier.
- Dictates that failure to notify the patient allows the carrier the option not to honor the assignment.
- Does not pertain to patients:
  - receiving services through a hospital emergency department
  - who are incapacitated or unconscious at the time of receiving services
  - receiving office-based services
- Prevents an out-of-network facility-based physician from reporting non-payment to a collection agency if the insured substantially complies with a payment plan developed within 45 days of receipt of the initial billing statement on any charges exceeding $200 over and above applicable co-payment, co-insurance and deductibles.

NOTIFICATION REQUIREMENTS

1. The facility (hospital, surgical center) must provide written notice to the insured at admission informing the insured that:
   - A non-participating facility-based physician may not have a current contract provider agreement with the patient's insurer; and
   - The insured may receive a bill for medical services from the non-participating facility-based physician for the amount unpaid by the patient's insurer.

2. The non-participating facility based physician must provide the patient with a billing statement that contains:
   - An itemized listing of services /supplies, including the dates of service;
   - A prominent, clear explanation that:
     - the physician is not currently contracted with the patient's insurer; and
     - the insurer has paid a rate, as determined by the insurer, that is below the physician's billed amount;
   - A telephone number to call to discuss the billing statement, provide an explanation of any acronyms, abbreviations, and numbers

OIG: No Sanctions for Waiving Additional Co-Pay Amounts Due to Medicare Pay Increase

In the wake of the protracted SGR battle in Congress and eventual passage of a bill delaying cuts and raising Medicare physician payment rates 2.2 percent through November 1, the U.S. Department of Health and Human Services Office of Inspector General (OIG) has posted a policy statement to its website concerning delayed and retroactive Medicare physician payments.

The policy statement assures providers, practitioners, and suppliers affected by retroactive increases in payment rates resulting from the operation of new Federal statutes or regulations that they will not be subject to OIG administrative sanctions if they waive retroactive beneficiary cost-sharing amounts attributable to those increased payment rates, subject to the conditions noted in the policy statement.

To get to the policy statement, visit: www.oig.hhs.gov/fraud/docs/alertsandbulletins/Retroactive_Beneficiary_Cost-Sharing_Liability.pdf

New Benefit Makes the Most of Ingenix Settlement

The TMA has contracted with Managed Care Advisory Group, LLC (MCAG), an outside firm, to offer TMA members discounted assistance in obtaining their share of a $350 million lawsuit settlement against United HealthCare and Ingenix.

ABOUT THE SETTLEMENT

Class action litigation is ongoing with a number of national health insurance companies who reimbursed physicians based on UCR (Usual, Customary and Reasonable) standard payment data maintained by Ingenix.

The first payer, United HealthCare (UHC), has settled for $350 million and parallel litigation is ongoing with Aetna, Cigna, and Wellpoint, which also used the Ingenix database to calculate UCR payments:
- The eligible claim period for the UHC Settlement ranges from 1994-2009.

(Continued on page 20)
The Memphis Medical Society set record numbers during recent medical student recruitment initiatives, registering more than 130 new intern/resident/fellow members during the University of Tennessee Health Science Center (UTHSC) orientation. MMS Executive Director Mike Cates talks to a potential student member during the orientation event in late June.

Dr. Marc Aiken (right) operates on a patient at St. Damiens Hospital in Port-au-Prince, Haiti. Dr. Aiken, Dr. Richard Duncan and Dr. Cal Johnson, of Watauga Orthopaedics in Johnson City, all spent time in Haiti this year aiding in medical missions related to earthquake relief.

Dr. Barrett Haik (left) presents Dr. Jere Freeman with a special award to honor his outstanding career as an ophthalmologist and humanitarian, one of several presented during the World Cataract Foundation’s 6th Annual Sight Night in Memphis in April. Dr. Freeman presented the Freeman Vision Award to Drs. Alfredo Amigo Rodriguez and Ariel Ramirez Aguayo, both of Mexico, for their contributions in the advancement of sight. Dr. Freeman also received the first Amistad Award, honoring unselfish service and uncommon dedication in helping the underprivileged to see. Photo: William Phillips.

Dr. Aiken, Dr. Richard Duncan and Dr. Cal Johnson
TMA Member Relations Specialist Jenny White and Communications Manager Angela Layton spent a day sorting donated goods for Hands On Nashville in the wake of the historic Nashville flood. The TMA gave employees a paid volunteer day to assist with flood relief efforts with the organization of their choice; 16 employees participated.
The Chattanooga-Hamilton County Medical Society hosted its annual Physicians Family Picnic at AT&T Field in Chattanooga in early June, with some 300 members and their families in attendance.

Nicholas Adkins, COO of Doctors Access, hosts a TMA Learn at Lunch session titled “All About EHRs” at TMA headquarters in April. The lunchtime educational event focused on federal stimulus payments for EHR adoption, IRS tax and other benefits of EHR adoption, as well as concepts for successful implementation.
TMA Members Elected to National AMA Posts

Three TMA members were elected to American Medical Association leadership positions during the AMA’s 2010 Annual Meeting in Chicago in June.

David G. Gerkin, MD, was re-elected as chairman of the AMA Council on Constitution and Bylaws. Dr. Gerkin, a Knoxville ophthalmologist, is Dr. Gerkin is a former TMA president and Board of Trustees chairman, current AMA delegation vice-chairman, and editor of Tennessee Medicine, the Journal of the TMA. He serves as medical director of the Tennessee Valley Eye Center.

Lee R. Morisy, MD, was re-elected to the AMA Council on Science and Public Health; Dr. Morisy is a general and trauma surgeon practicing with Drs. Morisy and Wood, PLC, of Memphis. He is a former Board of Trustees Executive Committee member, and currently serves on the TMA Insurance Issues Committee and Physician Leadership College Steering Committee.

Christopher M. Bell, a third-year medical student at the University of Tennessee Health Science Center in Memphis, was elected vice-chairman of Region 4 of the AMA-MSS (Medical Student Section). He is a UTHSC student representative on the TMA-MSS Governing Council.

AMA Policies Adopted at Annual Meeting

The American Medical Association (AMA), the nation’s largest physician group, voted during its Annual Meeting to adopt the following new policies:

**SCIENTIFIC POLICY**

*Assuring Patient Access to Physicians Under Medicare*

In the wake of the “Medicare Meltdown,” the AMA voted to immediately formulate legislation for a new Medicare payment option that would allow patients and physicians to freely contract for payments that differ from the Medicare schedule, while allowing patients to use their Medicare benefits.

*Shackling of Pregnant Women in Labor*

The AMA voted to develop model state legislation prohibiting the use of shackles on pregnant women unless flight or safety concerns exist.

*Medical-Legal Partnerships*

To help physicians identify and resolve diverse legal issues that affect patients’ health and well being, the AMA passed new policy that encourages physicians to develop partnerships with nurses, social workers and attorneys.

*Personalized Medicine*

The AMA adopted new policy supporting “personalized medicine” (PM) as a way to enhance patient care, including ongoing education for health (Continued on page 22)
TMA BOARD PONDERS HEALTH REFORM REALITIES, POSSIBLE CME INCREASE
(Continued from page 13)

with increasing hours up to 50.

“We still have questions about supporting evidence for the BME wanting to go up on the required hours; we believe it is quality, not quantity, that counts in continuing medical education,” said Dr. Eckstein.

The Board also heard an update from Mr. Beatty on TMA’s legal successes in its case against Health Research Insights, Inc. (HRI) (See related story in this section), and the ongoing case regarding the Ingenix UCR rate cases against Aetna and CIGNA.

OTHER BUSINESS
The BOT:
• Approved creation of a new TMA electronic health records resource. The new service will provide members with valuable contractual language, tools to evaluate systems and members-only discounts.
• Voted to support working with the Tennessee Center for Policy Research on a new tort reform research initiative.
• Continued its oversight of the future direction and strategic plan of the Association. The TMA is at the end of year one in its four-year plan to provide more accountability, focus and strategic management within the association and its subsidiaries.
• Renewed its endorsement of State Volunteer Mutual Insurance Company (SVMIC) as the preferred medical professional liability insurance company for its members.
• Received an Insurance Affairs update on Tennessee’s Medicare Plan Administrator, Cahaba GBA, and the PECOS enrollment process.

IMPACT is pleased to announce the launch of its new and improved website, www.tnimpact.com. Visit today to learn the latest news on the legislative front, electronically contribute to the PAC and in general, learn more about what IMPACT offers you as a TMA member. Join the fight and see how the “power of medicine” is working for you. For more information, call the IMPACT office at 615-460-1656.
TMA SUCCESSES MOUNT...
(Continued from page 13)

(Under State procedure rules, however, HRI could refile the cases within one year.)

“The TMA is pleased but not surprised by these victories,” added Dr. Ruffner. “These developments underscore the importance and effectiveness of TMA’s work on behalf of Tennessee’s physicians.”

He said this is just one example of the advocacy benefits members receive from the TMA and urged physicians to give additional support for this ongoing case and future legal advocacy for members and their patients by contributing to the TMA Legal Fund, www.tnmed.org/legalfund.

For details and background on the HRI lawsuit, log on to www.tnmed.org/HRI_successes.

ALERT: NEW LAW CHANGES...
(Continued from page 15)

used on the statement, or discuss any payment issues;
• Statement that the insured may call to discuss alternative payment arrangements;
• For billing statements that total an amount greater than two hundred dollars ($200), over any applicable copayments, coinsurance or deductibles, a statement in plain language that if the insured finalizes a payment plan agreement within forty-five (45) days of receiving the first billing statement and substantially complies with the agreement, the physician shall not furnish adverse information to a consumer reporting agency regarding an amount owed by the insured.

*Defined as a physician who has been granted clinical privileges, provides services pursuant to those privileges and does not have a current contract provider agreement with the patient’s insurer.

NEW BENEFIT MAKES THE MOST OF INGENIX SETTLEMENT
(Continued from page 15)

• To submit a claim for payment, you must identify any/all non-network claims from the eligible time period and submit the claim with the appropriate supporting documentation (billing and payment records including “patient pay” records).

Based on current information, the TMA believes the Ingenix UCR Settlement may benefit many TMA members.

Who is eligible and why?
All active and retired MDs and DOs are eligible for reimbursement of their “out-of-network” claims paid by UHC and its affiliates are eligible. This settlement will only be compensating physicians for non-network payments that were paid on a UCR pricing basis. Hospitals can recover non-network, physician/professional claims that they billed to UHC for the entire period of 1994-2009.

How do I file claims?
The Notice to Class Members for the UHC settlement was mailed out to all physicians last month; this initiated the start of the filing period. Additional information, such as claim forms and filing instructions, may be found online at www.ama-assn.org/go/ucrsettlement.

THE MCAG BENEFIT
In order to help our member practices maximize the opportunity available to them under the Settlement, the TMA has initiated an arrangement with MCAG, which specializes in helping physicians collect their proportionate share of refunds available from class action settlements. MCAG uses a claims data mining process to identify claims eligible for recovery under the Settlement. Member physicians may attempt to collect proceeds themselves but due to the complexity of the Settlement, members should consider this assistance. MCAG works purely on a contingent fee basis and the TMA has negotiated a special discount for our members.

For more information or to access this benefit, please contact MCAG at (800) 355-0466.

HOW DO CANDIDATES STACK UP ON THE ISSUES YOU CARE ABOUT?
Check out the results of the TMA 2010 Candidate Survey

www.tnmed.org/candidatessurvey
The Tennessee Society for Laser Medicine and Surgery – Annual Meeting Highlights

By Michael H. Gold, MD

The Tennessee Society for Laser Medicine and Surgery (TSLMS) began as an idea about seven years ago when a group of dermatologists and plastic surgeons in Nashville, TN began looking for an avenue to disseminate knowledge and have a voice in the legislative process regarding the treatment of the skin with lasers and light sources.

One of the tasks the group set out to do was hold a world-class laser and aesthetic meeting each year in Nashville. With the help of the TMA and through the assistance of companies that play an important role in the medical laser industry, TSLMS has achieved its goal, right here in our back yard.

In 2010 the group celebrated the 5th Annual Meeting of the TSLMS at the Hilton Downtown Nashville Hotel. Over 100 participants and 18 companies contributed to make this meeting our best one ever.

We are fortunate to have a “talent” pool of extensive laser and aesthetic experience, not only in our Nashville community and Middle Tennessee but also on the national and international fronts. Dr. Brian Biesman, an oculoplastic surgeon in Nashville, brings an incredible resume to the aesthetic and laser world, and is a past president of the American Society for Laser Medicine and Surgery (ASLMS). Dr. Darrel Ellis, professor of Dermatology at Vanderbilt University, has been one of the laser pioneers in the U.S., and Dr. Duco Jansen, PhD, also from Vanderbilt, is a leading laser researcher and the current president of the ASLMS.

Visiting the TSLMS this year was Mr. Patrick (Pat) Clark, laser educator, who teaches the fundamentals of the laser in such a concise way that he has set the bar high amongst laser teachers all over the country. Pat hails from Dallas, Texas, where he runs Medical Laser Dynamics and oversees laser instruction around the world. Also participating in the TSLMS meeting was Dr. Richard Fitzpatrick, of La Jolla, CA. Dr. Fitzpatrick has been one of the laser “gurus” for his entire career and it was a joy to welcome him to our faculty. Last but not least, we were honored for the third year by our local experts to participate once again. We have invited other world renowned speakers in both the plastic surgery and the dermatology worlds to share their expertise with us here in Nashville. We are going to expand the meeting to two days, have breakout sessions, and have additional speakers and surprises for the attendees of the meeting.

The TSLMS has scheduled its next meeting for March 4-5, 2011 in Nashville. We are excited to have invited several of our previous speakers back to Nashville, including Drs. Fitzpatrick and Anderson, and Pat Clark. We will also invite our local experts to participate once again. We have invited other world renowned speakers in both the plastic surgery and the dermatology worlds to share their expertise with us here in Nashville. We are going to expand the meeting to two days, have breakout sessions, and have additional speakers and surprises for the attendees of the meeting.

We encourage everyone interested in lasers and light sources to join the TSLMS and to come to our next meeting in 2011. It is a CME course and I assure you that you will learn and enjoy the camaraderie found among your fellow laser surgeons.

Further information can be found at our web site, www.tnlasersociety.com.

We look forward to seeing you in Nashville at our next meeting.

Dr. Gold is the principal with Gold Skin Care Center in Nashville, and is an associate clinical professor at Vanderbilt University Medical and Nursing Schools, as well as a visiting professor of dermatology for Hushan Hospital, Fudan University, Shanghai, and the First Hospital of China Medical University, Shenyang, China.
AMA POLICIES ADOPTED AT ANNUAL MEETING
(Continued from page 18)

Care workforce, adequate oversight and regulation, and insurance coverage of clinically useful PM.

New Treatments for Antibiotic Resistance
New AMA policy aims to increase public education about antibiotic resistance and raise awareness of the lack of new antibiotics in the drug development pipeline. The AMA will also endorse the “10 x ’20” initiative which aims to create 10 new antibiotics by 2020.

Skin Cancer Prevention in Communities of Color
New AMA policy supports and encourages efforts to increase awareness of skin cancer risks, skin cancer screening, and sun-protective behaviors in communities of color, which have lower melanoma survival rates and higher incidence rates.

PUBLIC HEALTH
Public Health Lessons from the Gulf Oil Spill
New policy will pair the AMA with the appropriate federal agencies to convene an expert panel to address the immediate and long-term human and environmental health impacts of the massive oil spill in the Gulf of Mexico. The AMA will also work to educate physicians, other health professionals and the public about the public health risks associated with exposure to crude oil and byproducts.

Accurate Reporting of Fats on Nutritional Labels
Current FDA nutrition labeling requirements allow trans or saturated fat content to be reported as zero if the food product contains less than 0.5 grams of trans or saturated fats per serving – this means an individual consuming just one serving of a product labeled “trans fat free” or “zero trans fat” could in reality be consuming as much as 25 percent of his or her recommended daily allowance of trans fats.

Decreasing Obesity by Reducing the Price Disparity Between Healthy and Unhealthy Foods
The AMA adopted policy supporting efforts to decrease the price gap between calorie-dense, nutrition-poor foods and naturally nutrition-dense foods to improve health in economically disadvantaged populations.

Physician Workforce
New AMA policies focus on improving access to care in underserved areas and increasing the physician workforce through graduate medical education expansion. To ensure that medical students can complete their training and become physicians, the AMA will strongly advocate for funding from all payers, both public and private, for residency training positions. In a continued effort to improve patient access to care, the AMA voted to encourage medical schools and residency programs to develop admissions policies and educational efforts aimed at attracting students likely to practice in underserved areas.

CMS/HHS ANNOUNCES FINAL RULES...
(Continued from page 13)

CMS’ and ONC’s final rules complement two other recently issued HHS rules. On June 24, 2010, ONC published a final rule establishing a temporary certification program for health information technology. And on July 8, 2010 the Office for Civil Rights announced a proposed rule that would strengthen and expand privacy, security, and enforcement protections under the Health Insurance Portability and Accountability Act of 1996.

As part of this process, HHS is establishing a nationwide network of Regional Extension Centers to assist providers in adopting and using in a meaningful way certified EHR technology. QSource has been established as a Regional Extension Center for Tennessee, known as tnREC (www.tnrec.org).

Links to Rules via Federal Register:
Meaningful Use:
EHR Certification:

Kenneth M. Allum, III, MD, has been named chief of staff at St. Mary’s Jefferson Memorial Hospital in Jefferson City. Board certified in both family and sports medicine, Dr. Allum practices with Tennessee Valley Pediatrics & Internal Medicine, a division of Summit Medical Group, PLLC.

Billy S. Arant, Jr., MD, has been named a Fellow of the American Society of Hypertension. Certified by the American Board of Pediatrics, Dr. Arant was among the first 500 physicians in the nation to become certified by the American Society of Hypertension as a specialist in Clinical Hypertension in 1999, and in 2005, one of the first 150 physicians certified by the American Board of Lipidology. Dr. Arant has written for some 200 medical publications and has presented his research in the United States and abroad, has served in an official capacity for national and international organizations, and has testified before the U.S. Congress on 11 occasions about research needs in nephrology and hypertension. In addition, Dr. Arant has been listed in every issue of Best Doctors in the United States since it was first published in 1992. In 2009, he was also recognized as one of America’s Leading Experts in Kidney Diseases. For his achievements, Dr. Arant was presented with the Founder’s Award in 2004 from the American Society of Pediatric Nephrology, which he had served previously as councilor, secretary/treasurer, and president. A former medical director of T.C. Thompson Children’s Hospital and chairman of the Department of Pediatrics for University of Tennessee College of Medicine-Chattanooga, he established the Hypertension Management Center at Erlanger Medical Center in 2001.

Frederick M. Azar, MD, of Germantown, has been named chief of staff of Campbell Clinic, Inc. Board certified in orthopaedic surgery, Dr. Azar is also a professor and sports medicine fellowship director at the University of Tennessee-Campbell Clinic Department of Orthopaedic Surgery. He serves on the editorial board for the American Journal of Sports Medicine and the advisory editorial board for AAOS Now. Dr. Azar is treasurer of the American Board of Orthopaedic Surgeons and a member of numerous organized medical groups including the American Academy of Orthopaedic Surgeons, American Orthopaedic Association, American Orthopaedic Society for Sports Medicine, Arthroscopy Association of North America, Society of NBA Team Physicians, Magellan Society, American Sports Medicine Fellowship Society, Southern Orthopaedic Association, Notre Dame Orthopaedic Society, and the Tennessee Orthopaedic Society. He serves as team physician for the Memphis Grizzlies, University of Memphis Athletics and Christian Brothers University Athletics.

Howard A. (Skip) Burris, III, MD, of Nashville, has received the Statesman Award from the American Society of Clinical Oncology (ASCO), for extraordinary volunteer service and leadership to the organization. ASCO is the world’s leading professional organization representing physicians who treat people with cancer. Dr. Burris is chief medical officer and director of drug development at the Sarah Cannon Research Institute (SCRI) in Nashville.

Cathy A. Deppen, MD, of Hermitage, was recently named Physician of the Quarter by the staff of Summitt Medical Center, recognizing her concern for patients and staff and commitment to improving obstetrical care in the community. At the end of the year, Summitt employees will name a Physician of the Year from among the hospital’s four Physicians of the Quarter. Dr. Deppen, board certified by the American College of Obstetricians and Gynecologists, practices with Tennessee Women’s Care, PC.

Mark A. Fox, MD, FACS, with Crossville Medical Group, PA, was recently voted “Best Surgeon in Cumberland County” in the Crossville Chronicle Readers’ Choice 2010 poll. A Diplomate of the American Board of Surgery and the National Board of Medical Examiners, Dr. Fox is also a Fellow of the American College of Surgeons and the Southeastern Surgical Congress. He is a licensed Advanced Cardiac Life Support and Advanced Trauma Life Support instructor, teaching CPR with the American Red Cross and the American Heart Association. He has also been active as an emergency medical technician since 1977 and as an expert in extrication, hazardous material and mountain rescue. A charter member of the American Hernia Society, Dr. Fox is also a member of the Harwell Wilson Surgical Society, the American Association of Physicians and Surgeons and the American Society for Lasers in Medicine and Surgery, where he is accredited in the use of the Nd:YAG Laser. He is a member of the Alpha Omega Alpha Medical Honor Society and received the University of Tennessee Alumni Award in Clinical Medicine in 1986. He is medical director and instructor for the Cumberland County Rescue Squad and EMS, Crossville Fire and Rescue and the Tennessee Highway Patrol/Special Operations.

Christopher E. Gafford, MD, of Fayetteville, has been voted “Best Doctor” in the Elk County Times’ 2010 Lincoln County’s Finest readers’ poll. Dr. Gafford practices with his wife Stephanie Gafford, MD, as Gafford Family Medicine, PLLC. For the past 13 years, Dr. Gafford has volunteered his time as drummer for the Fabulous 50s Show, a benefit for the Multi-County Cancer Network; he also works with the Carriage House Players and is a certified barbecue judge.
Fifteen TMA members are among physicians at UT Medical Group, Inc., of Memphis, listed in the 2009-2010 “Best Doctors in America.” They are: Michael S. Gelfand, MD, FACP, and Mack A. Land, MD, MACP, infectious disease; James E. Bailey, Jr., MD, internal medicine; Stephen J. Schwab, MD, nephrology; Daniel C. Martin, MD, OB/GYN; James C. Fleming, MD, FACS, and Barrett G. Haik, MD, FACS, ophthalmology; Claudette J. Shephard, MD, Jerome W. Thompson, MD, MBA, FACS, and John Zanella, Jr., MD, PhD, pediatric specialist; William L. Hickerson, MD, FACS, plastic surgery; Robert E. Gold, MD, and W. Chapman Smith, MD, radiology; Guy R. Voeller, MD, FACS, surgery; and Raza A. Dilawari, MD, FACS, surgical oncology.

John R. Maddox, Jr., MD, of Knoxville, was recently inducted into the Calhoun High School Hall of Fame in Calhoun, TN; the 1952 graduate was honored for his leadership in medicine. A pediatric surgeon, Dr. Maddox is a former chief of staff and board member at East Tennessee Children’s Hospital, and was chief manager of the East Tennessee Pediatric Surgery Group. He also served as an associate professor of Surgery at the University of Tennessee Medical Center.

John T. Matthews, MD, of Henderson, received the 2010 “Doctor of the Year” Award at Jackson-Madison County General Hospital. The award, given by hospital employees, honors physicians who exhibit the hospital’s Guest Excellence principles of integrity, professionalism, conflict management, leadership, respect for others and care and concern for patients and families. A board-certified cardiovascular and thoracic surgeon, Dr. Matthews practices with Cardiothoracic Surgery Center, PLC.

Jeffrey P. McCartney, MD, FCCP, of Jackson, has been appointed by Governor Phil Bredesen to serve a three-year term on the Tennessee Board of Respiratory Care. Founder of Jackson Pulmonary Care, PA, Dr. McCartney is a Fellow of the American College of Chest Physicians and a member of the American Academy of Sleep Medicine. In 2003, he was named Clinical Specialty Preceptor of the Year by UT Family Practice Center.

John J. McGraw, Sr., MD, of Jefferson City, was recently honored by Jefferson County High School with its 2010 Community Patriot Award. A full Colonel on the U.S. Army Reserves, Dr. McGraw was honored for his contribution to the county, school and American spirit. Dr. McGraw is a volunteer physician for Carson-Newman and Jefferson County sports teams. He is on the Board of Councilors (BOC) of the American Academy of Orthopaedic Surgeons, and is a partner with the Knoxville Orthopaedic Clinic and a former chief of staff of St. Mary’s Jefferson Memorial Hospital.
Phyllis E. Miller, MD, of Hixson, recently received the 2010 Women of Distinction Award from the American Heart and Lung Association Chattanooga chapter. She is the first female physician from Polk County, TN, the first woman to serve as president of the Chattanooga-Hamilton County Medical Society, the first female chief of staff at Erlanger Hospital, and the first woman elected president of the Tennessee Medical Association. She was awarded the TMA Outstanding Physician Award in April. Dr. Miller is president of the Medical Foundation of Chattanooga and has served on the boards of Hospice of Chattanooga and the March of Dimes, as well as on the advisory committee for the Rape Crisis Center. Dr. Miller currently has a private gynecology practice with The Women’s Institute for Specialized Health.

G. Fred Murphy, Jr., MD, of Murfreesboro, was recently recertified by the American Board of Family Medicine, and has been elected to membership in the American Academy of Family Physicians. Dr. Murphy practices at a new office location with Heritage Medical Clinic.

Bryan C. Myers, MD, of Winchester, has been voted “Franklin County’s Finest Obstetrician” by readers of the Tullahoma News. Certified by the American Board of Obstetrics and Gynecology, Dr. Myers practices with OB/GYN Associates in Winchester and Tullahoma. Active in medical missions, Dr. Myers previously served as an OB/GYN consultant at Tenwek Mission Hospital in Kenya, Africa, and continues to treat patients on regular trips to remote locations in Kenya, the Himalayas in India, the Amazon River in Brazil, in Mexico and Ecuador.

Merrill S. Wise, III, MD, of Memphis, has been elected to the board of directors for the American Academy of Sleep Medicine. Board certified in pediatrics, child neurology, sleep medicine and clinical neurophysiology, Dr. Wise has authored numerous articles, chapters, and abstracts, and co-authored numerous practice guidelines in sleep medicine; he was recently selected to head a national task force on the indications for polysomnography in children. He chaired a task force to evaluate the treatment of narcolepsy and other hypersomnias, served on the International Classification of Sleep Disorders revision committee’s pediatric subcommittee, and assisted in developing the American Academy of Sleep Medicine’s Sleep Scoring Manual. A former associate professor of Pediatrics and Neurology at Baylor College of Medicine in Houston, TX, Dr. Wise now practices with Mid-South Pulmonary Specialists, PC, in Memphis and is affiliated with the Methodist Healthcare Sleep Disorders Center with a practice devoted to pediatric sleep medicine and sleep neurology.

Are you a member of the TMA who has been recognized for an honor, award, election, appointment, or other noteworthy achievement? Send items for consideration to Member Notes, Tennessee Medicine, 2301 21st Ave. South, PO Box 120909, Nashville, TN, 37212; fax 615-312-1908; e-mail brenda.williams@tnmed.org. High resolution (300 dpi) digital (.jpg, .tif or .eps) or hard copy photos required.
Physicians have lots of different insurance needs. But knowing where to turn can be confusing. The TMA Association Insurance Agency can help. We provide comprehensive solutions — the full line of services and products you need.

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TMAinsurance.com — for details on all available plans.
With the books closed on the 2010 General Assembly, the TMA can congratulate itself on another productive session for members and their patients. The TMA came away with important wins in public health, insurance reform, practice management and health information technology.

Chief among its achievements was a necessary revamping of the 2009 Doctor Shopping Law, which requires prescribers to report all suspected “doctor shopping” patients – those who visit multiple doctors to obtain prescriptions for controlled substances for abuse or illegal sale. The 2009 law built on a previous doctor shopper reporting law that applied only to TennCare patients.
UNINTENDED RESULT CORRECTED

An unintended consequence of last year’s law – a Class D felony for those who fail to report doctor shoppers – was removed, immunity for all reporting providers was clarified, and the law was strengthened in two ways: allowing physicians to report certain limited but key information from the Controlled Substance Monitoring Database (CSMD) to law enforcement; and giving physicians the option of reporting doc shoppers to their judicial drug diversion task force, rather than to a local law enforcement agency.

“Drug shoppers are fairly smart; they don’t necessarily go to providers in the same community,” said TMA Government Affairs Director Gary Zelizer. “They may go to one in Nashville, one in Franklin, and one in Lebanon. If you have a task force that comprises multiple jurisdictions, the individual may show up on their radar a lot quicker than if the physician reports them to local law enforcement,” he explained.

The new version also gives certain mental health providers the option of reporting prescription misuse to law enforcement.

“I’m glad we recognized the problems with the original legislation and got them fixed promptly,” said Charles White, Jr., MD, of Lexington, who chairs the TMA Committee on Legislation. “The improvements clarify how physicians are able to use it in every day practice,” he added.

Tweaking the doctor shopping law was job #1, but close behind were achievements in a TMA priority area – insurance reform.

INSURANCE IMPROVEMENTS

Working with the insurance industry and the State Department of Commerce and Insurance, the TMA put in place a “fair and equitable” grievance and external review process. If an insurance plan refuses to approve or pay for a service the provider believes is appropriate and/or medically necessary, and is still denied after an internal review, the provider can request an external review by an objective third party entity. And no, the external review is not the final authority, although the TMA had to fight to keep it from becoming so.

“Quite honestly, the state wanted the external review process to be binding; we absolutely refused,” said Zelizer. “Final legislation allows that if the external review said no, the provider still has the option of going to court to protect their patients’ health care or their bottom line.”

“The important point is now the insurance industry knows there is an independent entity that could be asked to review some of these denials, so they may take the internal review process a bit more seriously,” said TMA Assistant Government Affairs Director Julie Griffin, adding the external review process is completely paid for by the insurance industry – another incentive for making sure the internal review is fair and legitimate.

The second big win in the insurance realm for the TMA deals with a patient’s assignment of benefits (AOB), a crucial element in giving patients access to doctors who are not in their provider network, and in protecting doctors from being forced to join provider networks. The AOB process had become routine in health care, but a 2009 Tennessee Attorney General’s opinion ruled that an insurance company could ignore the patient’s AOB request if the provider was out-of-network. In fact, one large insurance plan had already filed a request to limit its customers’ assignment of benefit rights based on the opinion,
and others were no doubt preparing to follow suit when the state, working with the TMA and select insurance plan representatives, stepped in to protect the AOB process.

In the end, all parties reached an agreement with the insurance industry to continue AOB for out-of-network providers with a caveat: patients checking into a hospital or surgical center must now be advised that they may be served by physicians not in their network, and might receive a higher bill as a result. The non-par provider would be required to send the patient a billing statement that includes certain information to ensure the insurance plan honors the AOB. The TMA government affairs staff credits the Tennessee Hospital Association with a vital role in this solution, working out the agreement for physicians who provide care in its facilities but do not normally see the patient at admission.

All told, the insurance industry successes were a big plus for doctors, according to TMA Legislative Committee Chairman Dr. White. “Any time we can level the field with insurance companies we are better off,” he said, adding, “We need to keep working on insurance reform until the field is flat.”

MEDICAL RECORD FEES

A third area of success was in higher fees for copies of medical records. Physician offices routinely make copies of medical records, yet the fees they can charge had not changed since 1997 and lagged far behind the rest of the country, coming in at about half of what other Southeastern states allow.

At the request of several specialty societies, the TMA acted to update the fees. Specifically, the new cap is $20 for the first five pages and $.50 for each additional page, and up to an additional $20 for a notarized copy.

“For the first time, we have put in the statute a charge of up to $20 for a certified copy of the medical record – which, generally, attorneys are going to want,” said Zelizer. The act prohibits charging a fee for copies requested by Department of Health officials pursuant to a complaint, inspection or survey, and does not change the amount the Department of Human Services will pay for a copy of a medical record pursuant to a disability determination.

HIT DOLLARS

The TMA was able to earn yet another feather in its cap: millions of dollars for health information technology (HIT) and health information exchange (HIE) in Tennessee.

“In a tight budget year, working with (Finance and Administration) Commissioner Dave Goetz, who is a strong proponent of electronic health records (EHR) and health information technology, we were able to assist with the infusion of new dollars for HIT,” said Zelizer. “After lengthy discussion and debate and in a very tight year – did we mention it was a tight budget year? – the General Assembly approved $13.25 million to support health information exchange in Tennessee, so healthcare providers are better connected in the future.”

Some of that amount could generate up to a nine-to-one match in federal dollars, giving state eHealth officials the backing they need as they continue to develop the statewide health information exchange (HIE). The HIE will be the means of information transfer between EHR systems at physician practices, hospitals, pharmacies, healthcare agencies and other entities. It also enables health information exchange that allows improvement in management of chronic diseases like diabetes and asthma that affect thousands of Tennesseans.

ONE DISAPPOINTMENT

Political will stood in the way of a TMA push to require direct physician oversight of mid-level practitioners providing chronic pain management in unlicensed settings.

“Despite data reflecting significantly higher spinal blocks and facet injections by mid-level practitioners in Tennessee compared to their peers in other states, our opponents were able to convince legislators that this isn’t a problem,” said Zelizer.
The symbiotic relationship between Tennessee physicians and the Independent Medicine’s Political Action Committee-Tennessee (IMPACT) is obvious to those who already support the PAC’s mission: to elect medicine-friendly candidates who will land on the side of good medicine when the chips are down.

To IMPACT Chairman Ken Moore, MD, the relationship is simple: IMPACT needs physician support so it can continue to look out for physicians and their patients. And in a crucial election year, with the political makeup of the General Assembly at stake, that symbiosis is even more vital.

“Physicians in this state must become unified and participate in the legislative process,” Dr. Moore recently told the TMA House of Delegates. “We as physicians cannot sit by and expect things to go ‘our way.’ We have to be engaged and active. In fact, we have to participate even more because we are the ‘target’ of so many groups,” he said.

UNFINISHED BUSINESS

Depending on the elections and their impact on the makeup of the Tennessee legislature, the TMA may also revisit this issue next year, along with some other unfinished business. Next year’s TMA legislative agenda will be vetted and determined over the summer and fall. “The Legislative Committee will work with members and specialty societies to decide what issues we need to tackle in 2011. The elections could have significant influence over how those decisions are made,” said Zelizer.

“Our members need to be aware of what’s at stake in this election cycle,” emphasized Griffin. “District lines will be redrawn, and who’s in charge after the election will be over those decisions and will determine how successful we are in advancing medicine’s agenda in the coming years.”

Read more about the TMA’s legislative victories this session: www.tnmed.org/2010legiswrap.

Symbiosis: IMPACT Needs You More Than Ever ... and You Need IMPACT!

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STRONGER VOICE NEEDED

He brought up this year’s scope of practice battle to require direct supervision of mid-level practitioners treating chronic pain – the TMA’s one disappointing loss in an otherwise successful legislative session. Nurses, CRNAs, PAs and chiropractors were able to defeat the TMA’s legislation, simply because they were able to mobilize their forces more effectively.
Gary Zelizer, our government affairs director, was thanked by the chief fundraiser of the CRNAs, saying that TMA’s efforts to stop these practices were the best thing that could have happened to the CRNA PAC,” said Dr. Moore.

IMPACT fundraising is down – partly because of an admittedly-tough economic climate. But other groups are managing to find the money, he added.

“Our PAC is dwindling as our opponents’ PACs are expanding. When are we going to learn?” Dr. Moore said. “Our strength is in our numbers and right now our strength is subsiding because we are letting our numbers decrease. We are letting our influence dwindle. This is unacceptable. This is our profession and this is our chance to take it back.”

NOVEMBER ELECTIONS CRUCIAL

In November, Tennessee will elect a new governor, half of the Senate seats and all of the House seats. IMPACT’s new website, www.tnimpact.com, states the case for more physician involvement: “The 2010 state elections could well be a watershed event for organized medicine in Tennessee but only if Tennessee physicians become more engaged in the process.” IMPACT officials say physicians are poised to accomplish some big goals in the wake of November elections if they can muster enough support.

A new member of the IMPACT board agrees. Mark Harriman, MD, of Germantown, (Cong. Dist. 7) has been actively recruiting his fellow physicians to the cause.

“I can’t sit around and let others foot the bill to fight the challenges that organized medicine faces,” he said. “Challenges like scope of practice, insurance plans’ silent PPOs and, of course, medical malpractice reform. It takes a lot of money to fight these challenges – our money.”

Dr. Harriman said he tells his colleagues to think of supporting IMPACT as an investment.

“It’s very simple, really: Join IMPACT and your money is used immediately to protect and improve the practice of medicine in Tennessee,” he said. “In this election year, how could joining IMPACT be anything other than a ‘no-brainer’?”

**IMPACT Contributions**
**As of July 2010**

| Goal: $303,000 | $178,800 |

**Find out more about IMPACT: www.tnimpact.com.**
Victories for Medicine 2010

The Tennessee Medical Association advanced an aggressive agenda for medicine in 2010. As a result, doctors and patients came out winners in the delivery, reimbursement and regulation of health care. We restored protections in the Doctor Shopping law, had real successes in insurance reform and in a tight budget year, helped secure millions of dollars for e-health technology adoption!

LEGISLATION WE WON

INSURANCE REFORM

Insurance External Review
Established an objective external review process for patients and providers when appeals to insurance carriers on medical necessity or claims payment issues cannot be resolved through internal grievance procedures.

Third Party Reimbursement
Worked with stakeholders to overturn a 2009 Attorney General’s opinion that would have allowed insurance plans to ignore a patient’s assignment-of-benefits request to pay out-of-network providers directly. The opinion jeopardized insurance reimbursement and patient access to out-of-network providers.

PRACTICE

Medical Records
Doubled the amount physician practices can charge for copies of medical records and established a new fee of up to $20 for a certified copy.

PUBLIC HEALTH/REGULATORY

Doctor Shopping
Removed an unacceptable provision in the doctor shopping law penalizing prescribers who failed to report doctor shoppers to law enforcement; strengthened the law by allowing physicians to submit limited documentation from the controlled substance database to law enforcement.

TennCare Hospital Fee
Stopped a seven-percent cut in TennCare reimbursements to participating physicians and avoided the elimination of $50 million for graduate medical education programs through our active public support of the Tennessee Hospital Association’s proposed hospital enhancement fee.

eHealth Technology
Successfully helped secure $13.25 million for electronic medical records and health information technology as part of the Administration’s 2011 appropriations request.

Level III Office-Based Surgery
Reinstated unusual incident reporting for Level III office-based surgery. This assures that unanticipated events are reported and investigated if necessary.

DUI Ignition Interlock
Supported passage of the mandatory use of ignition interlock devices for individuals convicted of certain DUI offenses.
Malpractice Limit Discovery
Would have allowed discovery by a plaintiff’s attorney of a physician’s medical malpractice limits. Maintaining confidentiality of these limits helps to ensure that malpractice awards are based on actual damages, rather than pegged to the amount of malpractice insurance a physician carries.

Expanded Law Enforcement Access to the Controlled Substance Monitoring Database
Law enforcement personnel would have had greatly expanded access to the CSMD, exposing patients’ health information and physicians’ prescribing patterns to individuals outside the health care arena. In addition, this continues to protect patient data from the possibility of unwarranted “fishing expeditions” by law enforcement.

Insurance Sales Across State Lines
Would have permitted insurance companies licensed in other states to sell health insurance in Tennessee, allowing them to disregard our hard-won state laws and regulations, such as prompt pay and credentialing, that protect patients and healthcare providers.

Motorcycle Helmet Law Exception
An exception to the universal mandatory helmet law for adult out-of-state residents driving or riding a motorcycle in this state would have saddled our state with higher costs resulting from crashes involving non-helmeted motorcyclists.

Medical Marijuana
Would have allowed physicians (and APNs and PAs) to prescribe medical marijuana for patients with certain medical conditions despite a lack of broad scientific evidence on the drug’s effectiveness.

Cosmetic Surgery Disclosure
Would have codified in law an expanded, detailed list of potential adverse outcomes a physician would have to disclose to a patient before performing elective cosmetic surgery.

Tobacco Sales Liability
A business owner’s legal culpability for selling a tobacco product to an underage purchaser would have been eliminated.

Coerced Abortion Notices
We mitigated some of the most troublesome aspects of a mandate requiring physicians performing in-office abortions to post notices on coerced abortions in conspicuous areas.

Medical Staff Background Checks
Changed a requirement to perform universal criminal background checks on all new hires to instead require a check of national and state sex offender and elder abuse registries if a criminal background check is not completed. A prospective employee appearing on a registry would be prohibited from being employed if providing direct patient care.
Innovation is the best medicine

Breakthrough medicines are our highest priority—they open up healthcare’s frontier and answer unmet needs. But no two patients are exactly alike. That’s why at Novartis we go beyond breakthrough medicines to offer disease prevention, generic alternatives and access to medicines. Think What’s Possible
Public Reporting of Quality Information: What Grade Do the Report Cards Get?

By David M. Mirvis, MD

Public reporting of the performance of physicians and hospitals has gained new momentum. The initial reporting of surgeon- and hospital-specific cardiac surgery mortality rates in New York State in the early 1990s has progressively evolved into internet-based grading of physicians, hospitals and health plans on a wide range of quality and cost metrics by community and government organizations.

Why has this trend progressed? What are the goals of public reporting? Has public reporting achieved its goals? And, if not, what are the barriers to success? These are the questions we will approach in this installment of the Health Policy Series.

WHAT IS THE HISTORY OF PUBLIC REPORTING?

Public reporting of health care information is not new. Florence Nightingale disclosed differences in outcomes of London hospitals in the 1860s and Earnest Codman, a Boston surgeon, argued for release of hospital-specific outcome data in 1916. But little happened until the late 20th century when the major drive for public disclosure began.

A major step toward public disclosure occurred in 1990 with the release of surgeon- and hospital-specific mortality rates after coronary artery bypass graft (CABG) surgery by New York State in response to a lawsuit filed by Newsday. New York later expanded the release to include all percutaneous coronary intervention (PCI) procedures. Other states, including Pennsylvania, Massachusetts and California, also began release of similar data.

On a national level, the Centers for Medicare and Medicaid Services (CMS) began to publically report hospital-specific quality of care data for acute myocardial infarction in 2004. This reporting expanded to include data on congestive heart failure, pneumonia, and other conditions on a dedicated web site (www.hospitalcompare.hhs.gov).

Communities have more recently begun to report performance measures on local physicians. For example, as part of the Robert Wood Johnson Foundation’s Aligning Forces for Quality program, the Healthy Memphis Common Table has recently posted physician-specific patient satisfaction information, including ratings on doctor-patient communication, appointment availability and office staff courtesy on its website (www.checkbook.org).

WHAT DOES PUBLIC REPORTING SEEK TO ACHIEVE?

An overarching goal of publically releasing quality data is to fulfill the perceived right of patients, as consumers, to know more about the quality of the services they are purchasing and receiving. A primary goal is to enhance the quality of care provided to patients. This may occur though two paths. First, the data may stimulate patients, as informed consumers, to choose providers with better outcomes, thereby using market forces to reward those who provide quality care and punish those who do not. This pathway may also apply to payers who can use the results to contract with high quality providers. Second, the data gives providers insights into the quality of medical information allowed the collection and release of comparative data that showed wide variation in outcomes, including a high prevalence of suboptimal or substandard quality of care. And the availability of these data and medical information on the internet demystified aspects of medicine that were previously accessible only to physicians. These forces were fueled by the rapidly rising costs of health care. The net result was a demand for greater transparency and accountability for the quality and the cost of care.

Society cannot solve its social problems until it knows that it has them, and often cannot know it has them until it can measure them. —U.S. Senator Daniel Patrick Moynihan (1927–2003)
their own practices, identifies areas for improvement and provides a stimulus to intervene to improve quality. This second path is illustrated by the statement by the late Daniel Patrick Moynihan, the former senator from New York, shown above.

Other goals have also been proposed. These include the use of quality data as marketing tools for those with best grades, an approach to reduce healthcare costs by demonstrating that some providers provide equivalent care at lower cost, as a counterbalance to using only cost as a basis for contract negotiations, as a basis for developing quality-linked reimbursement systems, and as a means to increase the regulation of the healthcare industry. Public release also makes the problems of quality harder to ignore by stakeholders and interest groups. Thus, the goals of release are broad and, in general, reflect the desire to improve the quality and efficiency of the healthcare system.

HAS PUBLIC REPORTING ACHIEVED THESE GOALS?

Despite the widespread interest and solid intent of these programs, actual use of public release has been limited. Numerous studies as well as recent reviews have suggested the major benefit of public release has been at the hospital level to improve outcomes, with less impact at the patient, health plan, and healthcare purchaser levels to promote competition based on quality.

The greatest use of data appears to be at the hospital level. Although some react defensively, others use the data as a catalyst for quality improvement. The most intensely studied intervention has been the release of cardiovascular surgery outcome data in New York State.1 CABG mortality rates in New York fell by 41 percent in the three years after data release, and mortality after percutaneous coronary interventions (PCI) fell by 36 percent between 1997 and 2003—rates of decline that significantly exceeded the national averages. In Massachusetts, PCI mortality fell by 43 percent in the two years after rates were made public.

These studies and many others are observational studies rather than controlled clinical trials. One controlled clinical trial of 86 hospitals in Ontario, Canada, compared the overall mortality rate after acute myocardial infarction in hospitals whose outcome data were publically released earlier rather than later. Thirty-day mortality rates were lower in the group with early public release.3

Consumer use of public data to select high-performing physicians and hospitals has been disappointing. In a review of 14 studies, Faber et al reported that although 50 percent of consumers stated that having high quality care was the most important concern when selecting a provider, fewer than five percent acknowledged that quality information influenced their choice.6 In one study of patients undergoing CABG at four hospitals in Pennsylvania, only seven of 474 patients knew the ratings of their surgeon and only four used the data in selecting a surgeon.7

A recent consumer survey conducted by the Kaiser Family Foundation reported low and, more disturbing, declining rates of consumer use of quality data.8 In 2008, fewer than half of patients believed that “big” differences among providers in quality existed. Only 30 percent of those surveyed had seen comparative quality information on doctors, hospitals, or health plans, and only 14 percent said they had seen and used such data in the past year. Results from a similar survey in 2006 were 36 percent and 20 percent, respectively. More people stated they would rely on recommendations from family and friends (70 percent) than from health professionals or standardized quality indicators, and more would choose a surgeon they had previously seen who had low quality ratings (58 percent) than one with higher ratings they had not seen before (38 percent). A survey of Medicare Part C enrollees reported that 42.2 percent were enrolled in plans with low quality ratings (three or lower out of five) and only 0.4 percent were enrolled in those with highest ratings (five out of five).

There is also little evidence that physicians rely on comparative data when referring patients for procedures. One survey in New York reported that only 10 percent of cardiologists and cardiac surgeons considered the data to be “very important” in assessing the performance of a surgeon, and only eight percent said the data impacted their surgical referral patterns.7

Quality data is also generally not utilized in the market. A positive impact was observed in New York State. Surgeons with high reported mortality rates were more likely than others to leave the state; 20 percent of those in the lowest quartile stopped practicing in New York, compared to only five percent of the others. However, market share of high and low quality hospitals was not affected by release.1

Use of quality data in contracting practices by managed care and other health plan organizations appears to be limited.9 In a survey of large employers, only 11 percent consider NCQA accreditation of plans to be an important selection criterion and only five percent consider HEDIS quality information to be important in contracting.2

WHAT ARE THE CONCERNS?

Numerous concerns about public release have limited its application in the “real world.” To be effective, the reporting system must have valid (that is, measurements that focus on the outcome of interest) and reliable (that is, that identify true differences in performance rather than random variation or “noise”) methods for measuring the outcome of interest and for assigning providers to high and low outlier subgroups. This requires the development of optimal data-collecting tools, cooperation of participating groups to uniformly collect and report accurate data, and the development of valid and reliable statistical methods. A major concern is that when the available data are not sufficiently valid or reliable, they will lead to bad patient choices, harm reputations, and unfairly reward or punish providers.

Data have both minimized and supported these concerns. Some reports have demonstrated, for example, that hospitals with low quality ratings in one year remain
in low quality categories in subsequent years, and that patients in hospitals or operated on by surgeons that were rated as high quality in past years have lower mortality rates than those in lower quality facilities.10

On the other hand, error rates as high as 43 percent in classifying physicians as high or low cost providers have been reported.11 Other studies have reported significant differences in the classification of physicians and hospitals based on differences in the statistical method used to measure and assign providers to high and low performing subgroups.

A related issue is that of “attributed variability,” that is, the proportion of the differences in an outcome directly attributable to a specific group of persons or organizations. For example, one study showed that differences in physician practices accounted for less than one-fifth of the differences between reported physician-specific costs of care; most of the variation was attributable to differences among patient groups.12

Other concerns include the longtime delay in reporting (12-24 months), use of differing end-points (e.g., in-hospital vs. 30-day mortality rates), the accuracy of data reported by hospitals (with one study reported a 27 percent difference in CABG volume from administrative data sets and from chart audits), inclusion of outcomes from patients transferred from one hospital to another (with outcomes often attributed to the original hospital), lack of inclusion of clinically relevant co-morbidities that impact risk, and failure to differentiate between co-morbidities and complications in administrative data sets.

Other barriers relate to practical implementation of report cards. To be effective, consumers must be aware of the data, they must be able to understand the data, they must view it as useful, and they must be able to act on the data.6 Based on the experiences to date with public reporting, several systemic barriers to success may be identified at each level. These include, in some states, having to pay for the report cards and the complex presentation of statistical comparisons. Discussion of results with patients is reduced by the skepticism by physicians. Patients may not trust the data or see the direct relevance to them as individuals; they are more likely to trust the opinion of neighbors and relatives who are “like them” than summary statistics released by government agencies.7 Media reports of single unexpected deaths may have more influence than rigorously collected and analyzed data. And even if understood, patients may not be able to actually choose a higher quality provider because of health plan restrictions or distance.

WHAT ARE THE POSSIBLE NEGATIVE CONSEQUENCES OF PUBLIC REPORTING?

As in all efforts that have good intentions, unintended negative consequences may commonly occur. One possible negative outcome may be restricting access of high risk patients to cardiologists and cardiac surgeons. If it is believed the risk adjustment methods do not adequately correct for overall patient risk, physicians and hospitals may avoid high risk patients to maximize their quality ratings. In one study in New York, 78 percent of interventional cardiologists reported that public release had, in some cases, influenced their decision to perform a PCI procedure on individual patients, and 83 percent agreed that public reporting might result in some patients not getting a procedure who would benefit from it.13 Similarly, in Pennsylvania, 59 percent of cardiologists reported greater difficulty in finding a surgeon to operate on severely ill patients, and 63 percent of surgeons were less or much less likely to operate on the sickest patients after public release than before.

A related issue is that certain patient subgroups may be diverted to lower quality providers as higher rated ones shun them because of perceived high risks. For example, African Americans and the mentally ill have been shown to be diverted to surgeons with higher mortality rates because they are perceived to have higher operative risks based on characteristics not captured in risk adjustment models; in New York, the racial difference in rates of CABG increased by 2.3 percentage points after public data release.14

Finally, the use of risk adjusted mortality rates that consider co-morbidities provide an incentive to “upcode” clinical conditions to increase the expected mortality rates. Evidence for this is limited and confounded by changes in the definitions of codes over time.1

Other potential negatives also have been suggested or demonstrated. Ratings based on outcomes provide an incentive to perform more procedures on low risk patients in whom the benefits may be limited and for which other options may exist. In addition, quality improvement efforts may be inappropriately diverted toward what is reported and away from other opportunities that represent broader but unreported aspects of quality.

SO WHAT ARE THE LESSONS?

What can we conclude from this information?

First, the boat has left the dock. Public reporting is here and will, with little doubt, expand. The recently passed healthcare reform law calls for major expansions in the transparency of quality and cost information, and the increasing popularity of consumer-directed health plans will increase the public’s demand for comparative data.

Second, the evidence is compelling that public reporting has and can lead to improvements in quality of care and patient satisfaction.

Third, we can increase these benefits and reduce the unintended negative consequences. Experiences to date suggest approaches for promoting success1,2 including, as examples, clearly defining the purpose of the data release; involving all relevant parties, including clinical leaders, in the development, oversight and interpretation of the effort; requiring reporting from all providers and requiring regular audits of reported data for accuracy; integrating public release with other quality improvement activities and other
forms of government oversight; educating the public as well as the providers about the values and the limitations of the information before it is released; carefully selecting the measures to be released, with an appropriate mix of process and outcome measures; carefully designing the presentation format, including the medium and the reporting formats (e.g., percentages, quartiles, etc.) to match the intended goals and the audience; and continuously putting pressure of low performing providers to improve.

The challenge, then, is to carry the call from Senator Moynihan to the next step. It is necessary but not sufficient to use information to show that we have problems. We must maximize the value and the use of the data as a basis for improvement.

References:

Dr. Mirvis is founder and director of the Center for Health Services Research and professor in the departments of Preventive Medicine and Internal Medicine at the University of Tennessee Health Science Center, Memphis, with research interests in healthcare delivery processes and health policy.

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Format Change
To avoid duplicate information and make the most of your time, the workshop will feature two panel discussions:

1. **Bureau of TennCare** – Heading up a panel discussion with representatives from AmeriChoice, AmeriGroup, and BlueCare/TennCare Select.

2. **Medicare Advantage** – A panel discussion including AmeriChoice, AmeriGroup, BlueAdvantage, HealthSpring, Humana and Windsor Health Plan. Cahaba will also participate on this panel to help clarify the differences between traditional Medicare and Medicare Advantage.

Cahaba GBA
We are pleased to announce that Cahaba GBA, the J10 A/B Medicare Administrative Contractor (MAC) for the state of Tennessee will participate at every location.

Commercial Plan Participation
You asked for it, so for the first time representatives from commercial carriers will address attendees. BlueCross BlueShield of TN, Cigna Healthplan and UnitedHealthcare are currently scheduled to participate. Others will be announced as added.

Registration *(includes continental breakfast and lunch)*
- $179 ......TMA/TMGMA Member Employees
- $299 ......Each Additional Attendee from TMA/TMGMA Members
- $299 ......Non-Member Employees

To register, visit [www.tnmed.org/workshop](http://www.tnmed.org/workshop).

Submit Your Questions in Advance!
In addition to addressing the top reasons claims are denied, updated policies and procedures, who to contact, and where to find information, representatives from the various insurance plans will address individual questions submitted prior to the meeting. All questions should be submitted in advance to phyllis.franklin@tnmed.org or faxed to Phyllis at 615-312-1895.
Don’t Be Sidetracked — Follow the Clues

By J. Kelley Avery, MD

In early December, this 60-year-old male with a history of atrial fibrillation, chronic back pain and hip pain on steroids, narcotics, and Coumadin presented to the Emergency Department with low back problems, described as “pain so bad this morning that I couldn’t walk.” The patient gave a history of a hip replacement about a year before and the worsening back pain just recently. IV Morphine was administered and an x-ray of the left hip was ordered. The x-ray image was not clear. The radiologist suggested additional views which were not ordered or performed; however, there was no evidence of instability or loosening of the hip replacement device. The patient was discharged with instructions for increasing his pain medication and advised to see his primary care physician the next morning. The discharge diagnosis was acute exacerbation of chronic hip pain.

An appointment was made by the patient’s wife for the next day. The morning of that appointment the wife called the primary care physician stating her husband was having difficulty waking up and would not be able to keep the appointment. The family physician listened to the symptoms of abdominal pain along with the back and hip pain. He recommended the family bring him to the ED of the hospital where he practiced, which was not the same as the one where the patient was the night before. The wife mentioned that perhaps the patient had accidentally taken too much medicine, although she thought they were following directions from the day before.

The patient became less alert at home with his eyes rolling back into his head. EMS was called and the patient was taken to the nearest emergency department, the same one where the patient had been less than 24 hours earlier. The assessment was an overdose of pain medication. A central line was inserted. Narcan for reversal of the overdose was given and labs were ordered. There were no labs ordered to check for toxicity.

Many of the labs were abnormal including elevated WBC, low red blood count and hemoglobin, creatinine and bilirubin. The PT/PTT was 103 and the INR 70.2. This value was rechecked and reported to the physician. The wife was insistent that her husband be transferred as soon as possible to the other hospital where his doctors practiced. Arrangements for transfer were begun.

The patient was maintained in the emergency department. The PT/PTT was redrawn. The PT was 125 and INR 110.9. Again the results were reported to the emergency department physician. The staff was informed the family did not want the patient admitted to the current hospital and transfer was in progress, so the patient remained in the emergency department. Transfer was ultimately not possible because the receiving hospital did not have beds and the patient became worse, necessitating his admission to the ICU at the original hospital. The family physician was notified.

The physician in ICU recognized the patient was in shock (not from a drug overdose). He looked at the clues without a preconceived diagnosis. But it was too late. The patient died.

There was a six-figure settlement in this case.

LOSS PREVENTION COMMENTS

The emergency department is a busy place. The patient’s complaints were taken at face value. In this case, the patient was focusing on his hip and back pain for which he was being treated with pain medications. The assessment of acute exacerbation of chronic hip pain was accepted as the only problem and treated. Very little investigation was done.

During the second admission, the assessment of an overdose based on the original treatment was accepted as the problem. The abnormal labs provided a clue as to additional problems but were not acted on in a timely manner. In addition, the patient’s wife was applying pressure to transfer her husband because she wanted her husband’s physician to take care of him. The patient was not stable and the transfer was not possible.

The ICU physician recognized the patient was in shock (not from a drug overdose). He looked at the clues without a preconceived diagnosis. But it was too late. The patient died.

There was a six-figure settlement in this case.

The Case of the Month is taken from actual Tennessee closed claims. An attempt is made to fictionalize the material in order to make it less easy to identify. If you recognize your own case, please be assured it is presented solely for emphasizing the issues in discussion.
While the primary focus of every physician practice is meeting the needs of its patients, its leaders must also keep a careful eye on the organization’s own financial health and well-being. LBMC’s Physician Practice Consulting group provides you with the thorough financial check up and ongoing follow up needed to safeguard your organization’s economic health. As a single, comprehensive resource for multiple business and financial solutions, LBMC works closely with physician practices of all sizes to reach and maintain their financial visions and goals.

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PRACTICING MEDICINE

WHY PHYSICIANS MISPREScribe

By Roland W. Gray, MD

According to National Drug Czar Gil Kerlikowske, prescription drug abuse has become the number one drug problem in the United States. Currently in 15 states where the information is available, you are more likely to die of a prescription overdose than in an automobile accident. Most of these overdoses are from opiates and sedatives/hypnotics. Although Tennessee is not alone in dealing with this problem, there is a significant drug diversion problem here. Tennessee physicians currently write more prescriptions for hydrocodone than any other drug. As a result, Tennessee’s Board of Medical Examiners now requires every physician to have one hour of continuing medical education specifically addressing proper prescribing practices.

There are a number of theories as to why physicians misprescribe. One theory involves patient types. There are some areas of the state, particularly rural areas, where prescription drug abuse and diversion are principally significant. Physicians willing to easily prescribe for these patients soon find they have a practice full of drug-seekers. Another theory relates to a lack of current pharmacologic knowledge. The physician who does not keep up with current trends in medicine is not aware of the addictive potential of many of these drugs or the drug diversion problem. There may be problems within the practice system that lead to misprescribing. Last, there are family-of-origin issues which cause physicians to overprescribe. This is the category I will talk about in this article.

The American Medical Association divides the overprescriber into four categories. First, is the “Dated” physician. Again, this is the physician who doesn’t keep up with current CME and is unaware of the significance of the drug dependence/diversion problem.

There is the “Dishonest” physician. These doctors are willing to write prescriptions for cash. Fortunately, their numbers are small but they do contribute significantly to Tennessee’s drug diversion problem. They are best handled through the criminal justice system.

There is the “Disabled” physician who diverts drugs for his or her own use. These physicians are brought into our program and given the opportunity to recover from their dependence. Just three percent of physicians in this category are unable to return to the practice of medicine.

Finally, there is the “Duped” physician; this is the physician we see most frequently in the Tennessee Medical Foundation’s Physicians Health Program (PHP). The “Duped” physician is one of the nicest physicians you will ever meet. They always assume the best about their patients and are gullible, trusting and honest to a fault. It is not unusual for them to leave script pads lying around. Bottom line, they are codependent and are unable to say “no” to these patients. Interestingly, over 80 percent of the “Duped” physicians helped by the PHP are adult children of alcoholics (ACOAs).

Those who grow up in an alcoholic household tend to assume specific roles. First is the “Lost Child” – the child who fades into the background. There is the “Scapegoat” who acts out for attention. But the most common ACOA role of a “Duped” overprescriber is that of a “Hero” child. It is the role of the family “Hero” child to constantly seek approval and affirmation. These individuals are super responsible and over conscientious and in spite of their achievements, always feel inadequate. They avoid any kind of conflict. It is not hard to see how the “Hero” adult child who becomes a doctor is easy prey for the drug-seeking patient. Because of their psychological make-up they want all their patients to be happy with them. Obviously the easiest way to accomplish this with the drug-diverting patient is to give them whatever they want. The drug-seeking patient will go to great lengths and travel long distances to find physicians who are an easy touch for whatever drug they are seeking. In working with these physicians, the most effective treatment is therapy for their ACOA issues and to find out what causes them to seek approval from their patients.

All the overprescribing physicians I have talked to knew on some level there were problems with the way they were practicing medicine. To avoid misprescribing, the best analogy I can make is to take the same care you do when driving on wet slippery roads – slow down, be cautious and take your time. If you or any of your colleagues have a problem with overprescribing, please do not hesitate to contact State Volunteer Mutual Insurance Company (SVMIC) or the TMF for assistance.

Dr. Gray is medical director for the Tennessee Medical Foundation. To make a tax deductible contribution to the Physician’s Health Program (PHP), contact TMF at 615-467-6411, or write to the Tennessee Medical Foundation, 216 Centerview Drive, Suite 304, Brentwood, TN 37027. For more information on the TMF or the PHP, log on to www.e-tmf.org.
Meet the Medical Directors of UHC, CIGNA

As part of its strategic plan priorities, the TMA is working to improve relations with the insurance industry to benefit communication and advocacy on behalf of its members and their patients. To that end, Tennessee Medicine will be introducing you to your fellow physician contacts in some of the leading insurance carriers.

**JANICE HUCKABY, MD,** is the market medical director/CMO of UnitedHealthcare, Mid-South. Originally from West Virginia, she has spent most of her professional career in Tennessee, first as a practicing obstetrician/gynecologist in the Nashville area and then as an associate medical director for BlueCross BlueShield of Tennessee/VSHP. She assumed her current role in June 2008.

In addition to her responsibilities at United, she serves on the Mid Cumberland Family Planning Council for the State Department of Health and does community work at the Franklin Road Women’s Health Center. She and her two children live in Franklin. She can be reached at 615-372-3481 or janice_huckaby@uhc.com.

**MICHAEL RAYBECK, MD, FACS, CPE,** is the frontline medical director of utilization management in Tennessee for CIGNA Health Care. Dr. Raybeck is a general/vascular surgeon. He may be reached at 423-321-4422.

At CIGNA, we are committed to providing you information that can help manage patient care more effectively, and reduce the complexity of doing business with us. To preserve service quality, use the separate contact channels listed on the following pages for CIGNA and former Great-West Healthcare business.

Great-West Healthcare is now part of CIGNA including the former Great-West Healthcare provider network. CIGNA acquired Great-West Healthcare, the Healthcare Division of Great-West Life & Annuity on April 1, 2008. The former Great-West participating provider agreements are now in the name of a CIGNA company. Despite this change, you should continue to follow all current policies, processes and procedures until you have been notified otherwise. As integration progresses, we will proactively communicate changes that may impact you and your practice.
### IF YOU WANT TO:

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<td>Verify patient eligibility and coverage</td>
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<td>Inquire about patient coverage and covered services</td>
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<td>Predict the total cost of service and patient liability for specific medical procedures</td>
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<td>Request precertification for services</td>
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<td>View claim coding policies and payment guidelines</td>
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<td>Review medical or pharmacy coverage positions</td>
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<td>View the pharmacy formulary</td>
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<td>View sample ID cards</td>
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<td>Update address information</td>
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<td>Obtain a Provider Handbook or Reference Guide</td>
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<td>Request a copy of your contract</td>
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<tr>
<td>Inquire about precertification for services (CIGNA only)</td>
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<td>Request fee schedule information (CIGNA only)</td>
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<td>Verify patient eligibility and coverage</td>
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<td>Inquire about patient coverage and covered services</td>
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<td>Check the status of a claim</td>
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<td>Request precertification for services (CIGNA only)</td>
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<td>Submit claims electronically</td>
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<td>Receive electronic remittance advice</td>
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<td>Verify patient eligibility and coverage</td>
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<td>Check the status of a claim</td>
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<td>Request precertification for services</td>
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<td>Check credentialing status</td>
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<td>Request an exception to the prescription drug list</td>
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- 1.860.257.2030
- Existing Clearinghouse or contact Emdeon: www.emdeon.com
- 1.877.469.3263

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Log onto the TMA Insurance Resource Center for tools, tips and answers to your questions on both commercial and government insurance plans.

[www.tnmed.org/irc](http://www.tnmed.org/irc)
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<th>IF YOU WANT TO:</th>
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<tr>
<td>Submit or inquire about an Appeal or Provider Dispute</td>
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<td>1.800.663.8081 Appeal and Grievances Department Provider Dispute Resolution PO Box 668 Kennett, MO 63857 For California HMO Appeals: Great-West Healthcare Dispute Resolution Process PO Box 6039 Englewood, CO 80155</td>
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<td>Submit or inquire about Health Care Professional Credentialing</td>
<td>1.800.88CIGNA (882.4462)</td>
<td>1.866.396.6436</td>
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<td>Obtain information about available Medicare Plans</td>
<td>CIGNA Medicare Access* <a href="http://www.cignamedicare.com">www.cignamedicare.com</a> 1.800.577.9410</td>
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<td>Obtain information about organ and tissue transplant network</td>
<td>CIGNA LIFESOURCE Transplant Network® <a href="http://www.cigna.com/lifesource">www.cigna.com/lifesource</a> 1.800.668.9682</td>
<td>CIGNA LIFESOURCE Transplant Network® <a href="http://www.cigna.com/lifesource">www.cigna.com/lifesource</a> 1.800.668.9682</td>
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<td>Specialty pharmacy program (i.e., injectable medications for certain diseases)</td>
<td>CIGNA Specialty Pharmacy Program 1.800.351.3606</td>
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<td>Medical Management (including Precertification)</td>
<td>1.800.88CIGNA (882.4462), <a href="http://www.cignaforhcp.com">www.cignaforhcp.com</a> or refer to the patient’s ID card</td>
<td>1.800.663.8081, <a href="http://www.greatwesthealthcare.com/providers">www.greatwesthealthcare.com/providers</a> or refer to the patient’s ID card</td>
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<td>Contact a dental network</td>
<td><a href="http://www.cigna.com">www.cigna.com</a> 1.800.CIGNA24 (244.6224)</td>
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Selling Your Practice: Are You Making Every Dollar Count?

By T. Blake King, CPA, MAcc, CVA

The most controversial item during an acquisition remains the value of goodwill. Goodwill and other intangibles are the items that cannot be seen or easily counted. Calculating a value for goodwill is beyond the scope of this article but let’s agree to say that it is controversial — so controversial, in fact, that many acquirers choose not to even pay for goodwill or other intangibles. That leaves the selling physician with only a few items of value: accounts receivable, inventory, and equipment. If the practice has been writing off all purchases under a certain amount (usually $500-$1,000), there will be no way to track those items. Of course, when it comes time to sell, most practices just send an employee around to write down all the equipment items but how does the employee know when they were purchased or the price? The five-year-old exam table may look similar to the 10-year-old exam table. Another option would be to hire a professional equipment appraiser — this, of course, comes at an added expense and the appraiser is most likely going to want to know the age and purchase price of the items. If an equipment appraisal is required, a detailed list will help insure the appraiser does not miss anything and could help lower the cost.

TRACKING ASSETS

So, what should a practice do? If a physician ever wants to consider selling his or her practice, then he or she should devise a way of tracking hard asset purchases.

Even if you think you will never sell your practice, a tracking system should be put in place; it requires little effort and provides valuable information. It would not be prudent to track small supplies such as pens or paper, only hard assets, which are items in use for more than one year. This can be a very simple system using an Excel or handwritten spreadsheet or more complex software. I say the cheaper the better; therefore, any system should work as long as it contains a description (preferably a picture) of the item, a copy of the invoice showing date of purchase and cost, and some type of tracking mechanism. The easiest way to track is to label and number every piece of equipment. That number should then be put on the invoice and picture. Store these items in an easy to find place; digital storage is fine. That way when you go to sell your practice, it is a simple exercise to provide a listing of all assets and, in turn, you are able to demand more from an acquirer. While this may seem like an exercise in futility right now, it can pay heavy dividends when your practice is up for sale.

Mr. King is in the Accounting Services Department of DoctorsManagement, LLC. Contact him at 865-531-0176 or tking@drsngmt.com.

DoctorsManagement, LLC, is a TMA Corporate Partner. This information was supplied by DoctorsManagement exclusively and for the benefit of our members. The TMA does not accept responsibility for the information provided.
Smart Solutions to Ease Your Financial Pressure

By Garth Kilburn

To build a successful healthcare business, it takes more than talented doctors and good patient skills. There is a range of back-office business challenges that can make or break your practice, depending on how you deal with them.

HIPAA compliance standards and electronic remittance advice files have likely had a major impact on your back-office efficiency, which affects your bottom line. This growing complexity carries with it a direct impact on operational costs associated with staffing, continuous education, processing errors, and lost revenue opportunities.

A strong financial services provider can help reduce or eliminate these challenges through programs that offer dedicated services designed to take much of the manual process out of your back-office activities and streamline your cash conversion efforts.

AUTOMATING THE CLAIM PAYMENT PROCESS

The manual posting of claim payments can be a roadblock to a more efficient back-office and a more predictable bottom line. This entire remittance cycle can be automated. Automated remittance processing begins with the image capture of EOB documentation. A secure online module provides all the tools required for effectively managing the claim reconciliation process in the most efficient manner. The standard presentation of claim detail saves precious time. Balanced transaction files are provided for the automated posting. This means funds and associated information are available faster so you can forecast more effectively. Even the electronic remittance advice files from the payer are converted into the same standard human readable format and processed through the same dynamic claims process workflow.

The result is an automated remittance processing solution that delivers timely deposits, a consistent view of all insurance claims paid regardless of payment method or channel, claim reconciliation, automated posting, and a reporting database for monitoring the ongoing performance of your team and that of your payers.

STREAMLINE PATIENT PAYS

Collecting patient pays also does not have to be problematic. As with claim payments, streamlined collection, processing and paper check deposits from patient pays are handled accurately and efficiently. But that is just part of the solution. Technology options available allow your patients to remit online or over the phone by credit card or electronic payment via ACH. Even your back office can use this to accept payments over the phone. All of these options are designed to expedite the delivery of funds to your account. These payments can also be electronically transmitted for automated posting of receivables.

ACTIVATING THE POWER OF POINT OF SERVICE

How efficient could you be if you kept back-office disruption to a minimum? Need to deposit customer co-pays or outstanding balances at the point of service? This can be done right from your office through solutions that accommodate check, card, or cash. You simply scan your checks and transmit the image file for deposit. And because you often deal with cash, there are solutions that not only help you securely store your cash receivables but also make it quick and easy to transmit deposits for same-day credit.

BENEFITS THAT SAVE TIME AND MONEY

With First Tennessee’s healthcare solutions, you can take advantage of benefits that will save you time and money, including:

- Timely, accurate collection options that accommodate electronic payments, cash, and check.
- Acceleration of claim payments into cash for debt reduction or investment.
- Standardized payment information from payers, including automated conversion of internal medical codes to industry standards.
- Quick and easy online access to claim detail and image retrieval for EOBs received through the lockbox.
- Settlement files for the automated posting of claims and patient payments.
- Management reporting tools for effectively monitoring payer performance and coding errors.
- Electronic payment solutions provide for the timeliest, most efficient, and secure processing of payment transactions.

FINANCIAL FOCUS FOR A HEALTHY BOTTOM LINE

Workflow solutions facilitate compliance with certain HIPAA requirements, and you get a clear view of your financial position – how money moves in and out of your business, how quickly funds become available, and how to do it all with fewer dedicated resources.

Garth Kilburn is a Treasury Management Sales Executive for First Tennessee with 14 years of treasury management experience. To learn more about how these services can benefit your bottom line, contact your First Tennessee Relationship Manager or call us today toll-free at 800-246-3735. Certain services may be offered in conjunction with other third party service providers not affiliated with First Tennessee Bank or its affiliates.

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We’re available with loans and lines of credit to help with cash flow, upgrades, expansion, you name it. But money’s not everything. You also need advice. So whether your business is big or small, we’ve got the resources to help you make the right lending decisions for your company’s individual needs. To learn about the many ways we can help power your business dreams, drop by or visit ftb.com/lending today.

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ABSTRACT
Vitamin D deficiency has received increased academic interest because of its association with many common disease processes. The goal of our study was to document the prevalence of vitamin D deficiency. A retrospective chart review of 25-hydroxyvitamin D (ng/ml) levels at the University of Tennessee Health Science Center was conducted on general internal medicine patients over an 18-month period. The 25-hydroxyvitamin D deficient patients were divided into four groups: severe (<7 ng/ml), moderate (7.0-20.9 ng/ml), mild (21-31.9 ng/ml), and sufficient (>32 ng/ml). We found that an overwhelming majority of our patients were mildly to severely deficient (87 percent) with 17 percent severely deficient, 53 percent moderately deficient, 17 percent mildly deficient, and only 13 percent sufficient. The prevalence of 25-hydroxyvitamin D deficiency among this population was higher than expected based on the prevalence of 25-hydroxyvitamin D deficiency reported in literature. Based on this data, we believe a greater percentage of the general population needs to be studied in order to discover the true prevalence of vitamin D deficiency.

INTRODUCTION
The effects of vitamin D on skeletal health have been well documented. In children, vitamin D deficiency is known to cause growth retardation and classic signs and symptoms of rickets. In adults, vitamin D deficiency will precipitate and exacerbate both osteopenia and osteoporosis, cause osteomalacia and muscle weakness, and increase the risk of fracture. Vitamin D deficiency has also been associated with an increased risk of falling, and replacement of 25-hydroxyvitamin D has been found to decrease falls by up to 22 percent.

Several studies have evaluated the association of 25-hydroxyvitamin D levels with the incidence and mortality of cancer. Adults with 25-hydroxyvitamin D levels of <20 ng/ml that were followed for up to 19 years had a 30-50 percent increased risk of developing colorectal, breast, prostate, and many other cancers. Hypovitaminosis D has also been linked to several autoimmune diseases including rheumatoid arthritis, multiple sclerosis, and type 1 diabetes.

Evidence even suggests vitamin D may play an important role in cardiovascular and metabolic health. The Third National Health and Nutrition Examination Study (NHANES-III), a cross-sectional representative sample of the US population, showed the prevalence of hypertension, diabetes mellitus, obesity, and high serum triglyceride levels were all significantly higher when serum 25-hydroxyvitamin D levels were low. Low levels of vitamin D have also been associated with reduction in endothelial protective factors, an elevation in inflammatory cytokines, myocardial infarction, congestive heart failure, and calcified aortic stenosis. In addition, a reduction in vitamin D activity has been shown to result in both insulin resistance and reduced insulin secretion.

The association of vitamin D with many common disease processes has been well documented, and these discoveries stress the importance of detecting vitamin D deficiency in certain patient populations. A study recently done by William-Cleaves and Adams-Graves at the University of Tennessee measuring the prevalence of vitamin D deficiency in the sickle cell and endocrine populations showed 98 percent of these patients were deficient of 25-hydroxyvitamin D. In addition to confirming the data previously collected by our colleagues, the goal of our study was to document and raise awareness of the prevalence of vitamin D deficiency.

METHODS
A retrospective chart review was done on 1,217 patients in the general internal medicine clinic at the University of Tennessee over an eighteen-month period. Patients’ age, race, gender, and 25-OH vitamin D level were recorded. The patients with deficient levels were then divided into four groups: severe (<7 ng/ml), moderate (7.0-20.9 ng/ml), mild (21-31.9 ng/ml), and sufficient (>32 ng/ml). We included the same dates for this 18-month period that were used for the study done by William-Cleaves and Adams-Graves on the sickle cell and endocrine
patients at the University of Tennessee. The eighteen-month period allowed for variation in sun exposure based on the season.

RESULTS
The demographics of the patients broken down by race revealed: 870 African Americans (71 percent), 327 Caucasians (27 percent), and 20 who described themselves as Other (two percent). Their mean age was 57 years old. The study included 882 women (72 percent) and 335 men (28 percent). In total, 87 percent of the 1,217 total patients were deficient (<32 ng/ml). In the four categories of vitamin D levels, 17 percent were severely deficient, 53 percent were moderately deficient, 17 percent were mildly deficient, and only 13 percent were sufficient (Figure).

DISCUSSION
The prevalence of vitamin D deficiency or insufficiency has been estimated to include 1 billion people worldwide when 30 ng/ml or higher is considered sufficient. With an estimated world population of 6.75 billion, this estimate implies that only 15 percent are deficient or insufficient. The 87 percent prevalence of 25-hydroxyvitamin D deficiency we found is considerably higher than expected in a group of patients thought to be representative of a more general population. All 25-hydroxyvitamin D levels for this study were drawn using Labcorp laboratories, and deficiency was defined by a nationally recognized level set by this laboratory of <32 ng/ml. This defined lower limit of normal range is based on the Framingham heart study that measured 25-hydroxyvitamin D levels in 290 men and 469 women in the New England area and found 32.8±/-11.6 ng/ml and 28.4±/-11.6 ng/ml for a year-round mean of 25-hydroxyvitamin D level in serum. Jacques et al also found that only 15 percent of women and six percent of men had 25-hydroxyvitamin D levels less than <37.5 ng/ml. Most studies of the prevalence of 25-hydroxyvitamin D have been done on specific patient populations that may be at a higher risk for 25-hydroxyvitamin D deficiency. For example, Thomas et al studied the prevalence of 25-hydroxyvitamin D deficiency (<15 ng/ml) in 290 inpatients at Massachusetts General Hospital and found a prevalence of 57 percent. Another study of 150 patients with musculoskeletal pain in an outpatient clinic in Minneapolis found a vitamin D deficiency (<20 ng/ml) prevalence of 93 percent. Holick et al, studying postmenopausal women receiving osteoporosis therapy, found 52 percent prevalence of 25-hydroxyvitamin D levels <30 ng/ml. Orwoll et al focused on the prevalence of 25-hydroxyvitamin D deficiency in men over the age of 65 and found 72 percent of the 1,606 patients screened had levels <30 ng/ml. In addition, Visser et al studied prevalence in an elderly population and found 36.7 percent of the patients screened over the age of 65 had 25-hydroxyvitamin D levels <49.9 nmol/ml.

There is no consensus on the optimal levels of 25-hydroxyvitamin D as measured in the serum, but vitamin D deficiency is defined by most experts as less than 20 ng/ml. However, 25-hydroxyvitamin D levels are inversely related with parathyroid hormone until vitamin D levels reach 30 to 40 ng/ml, at which point parathyroid hormone begins to level off. This suggests that the level of sufficient 25-hydroxyvitamin D should actually be raised to 40 ng/ml. Dawson-Hughes et al argue that optimal level of 25-hydroxyvitamin D level for bone health is between 50 and 80 ng/ml based on the levels associated with maximal suppression of circulating PTH concentrations, greatest calcium absorptions, highest bone mineral density, and reduced rates of bone loss, fall, and fracture.

Although the patients seen at the University of Tennessee internal medicine clinic represent more of the general population than most previously conducted studies of the prevalence of 25-hydroxyvitamin D deficiency, this study is limited by the fact it was done retrospectively. It is unknown what factors prompted the collection of 25-hydroxyvitamin D levels on these patients. There was also a majority of African American and women patients included in this study. Further prospective studies are needed to assess the true prevalence of 25-hydroxyvitamin D deficiency in the general population and to further help establish the true definition of 25-hydroxyvitamin D deficiency.

CONCLUSION
We found a higher level of vitamin D deficiency than expected in the general internal medicine clinic patients who were tested at the University of Tennessee. This suggests the population at large may need to be screened to document the true (Continued on Page 57)
Two Newborn Infants With Middle Cerebral Artery Infarct Presenting with Seizures

By Jennifer Gibson, MD, and Des Bharti, MD, MBA, FAAP

INTRODUCTION
Perinatal stroke is a common cause of seizures presenting during the first 24 hours of life. Risk factors for perinatal ischemic stroke are associated with both the mother and the infant, and a definitive cause of stroke is often not determined. MRI is crucial to the diagnosis and is also predictive of neurological and developmental outcomes. These case reports summarize the history and hospital course of two neonates who presented with seizures during the first 24 hours of life and who were found to have middle cerebral artery infarctions without evident cause. Both cases were transferred from the same outlying facility during a seven-day period.

CASE 1
A term female infant was transferred from an outlying facility for seizures. The infant’s mother was a 22-year-old gravida 2, para 0, white female with unremarkable medical history. Her prior pregnancy had resulted in a spontaneous abortion. Maternal prenatal labs showed no abnormalities. She admitted to tobacco use during the pregnancy but denied alcohol and illicit drug use. The infant’s mother was admitted in labor; there was no history of birth trauma or toxin exposure at delivery. Apgar scores were 5 at one minute and 9 at five minutes respectively, and the infant required blow-by oxygen in addition to drying and stimulation. The infant was sent to the newborn nursery until about 18 hours of life; at that time, the infant experienced a generalized tonic-clonic seizure. A CT scan of the head was within normal limits, and cerebrospinal fluid obtained by lumbar puncture revealed a negative Gram stain and zero white blood cells. Blood cultures were drawn. The infant was given a loading dose of phenobarbital at 20 mg/kg, and transported to a tertiary care facility. Before transfer, the infant experienced a second episode of seizure activity.

On arrival at the tertiary care facility, the infant was noted to be active and irritable but in no distress; vital signs and physical examination revealed no abnormalities with the exception of mild diffuse irritability. Ampicillin and Amikacin were initiated pending blood and cerebrospinal fluid culture results. To rule out herpes encephalitis as a possible etiology for seizures, a repeat lumbar puncture to obtain cerebrospinal fluid for herpes PCR was performed, and the infant was started empirically on Acyclovir.

During her hospitalization, the infant continued to demonstrate seizure activity; she received a second loading dose of phenobarb followed by a maintenance dose. EEG performed on day two of life demonstrated eight electrographic seizures consisting of rhythmic discharges beginning in the left temporal region and spreading to the frontal and central head region. The seizures ranged in duration from one to 10 minutes, and jerking of the right leg was noted with one event. An MRI performed on day two of life showed abnormal diffusion signal in the left parietal cortex involving the left Sylvian fissure and the
posterior-lateral left thalamus; these regions are in the anatomic distribution of the left middle cerebral artery, and the findings were consistent with ischemia or infarction (Figures 1A and 1B).

Once a maintenance dose of phenobarbital had been established, the infant experienced no further clinical seizure activity. A repeat EEG on day six showed no electrographic seizures but was remarkable for multifocal sharp waves arising independently from each hemisphere. The infant’s blood cultures and herpes PCR were found to be negative, and antibiotics and acyclovir were discontinued. Her neurological status remained stable throughout her hospitalization. The infant was discharged on a maintenance dose of phenobarbital at 5 mg/kg and with instructions to follow-up with pediatric neurology, physical therapy, and hematology-oncology as well as her primary pediatrician.

**CASE 2**

A term female infant was transferred from an outlying facility on first day of life for seizures and a CT scan suggestive of right middle cerebral artery infarction. The infant’s mother was a 28-year-old gravida 2, para 0, white female with pregnancy complicated by gestational diabetes managed through dietary changes. Maternal prenatal labs showed no abnormalities. She denied tobacco, alcohol, and drug use during her pregnancy but the infant’s meconium was positive for cannabinoids.

The infant’s mother was admitted to the outlying facility in labor; however, the baby was delivered via Cesarean section secondary to arrest of progression of labor. Apgar scores were 9 at one minute and 9 at five minutes respectively, and the infant required only warming, drying, and stimulation in the delivery room. Shortly after delivery, the infant was noted to have a seizure lasting approximately four minutes which involved tonic-clonic movements. A CT scan of the head was suggestive of right middle cerebral artery infarction. The infant received a 20 mg/kg loading dose of phenobarbital, and blood culture was drawn. Cerebrospinal fluid obtained by lumbar puncture showed a negative Gram stain, protein 102 mg/dL, and 40 white blood cells/µL. The infant received Ampicillin and Gentamicin before transfer to a tertiary care facility.

On arrival to the tertiary care facility, the infant was not in any distress. Vital signs were stable. Physical examination was remarkable for generalized mild hypotonia and head lag. During the transfer and subsequent evaluation, the infant was noted to experience multiple seizures consisting of left-sided jerking and hypertonia of extremities and smacking of the lips with the tongue moving to the left side. To control the seizures, the infant received a second dose of phenobarbital at 10 mg/kg followed by Ativan at 0.1 mg/kg and a single dose of Fosphenytoin. Ampicillin and Amikacin were initiated pending blood and cerebrospinal fluid culture results. The cerebrospinal fluid was negative for herpes PCR.

Early in her hospitalization, the infant continued to experience seizure activity and was placed on a maintenance dose of phenobarbital. An EEG performed on day two of life showed bilateral cortical multifocal sharp waves. An MRI performed on second day of life showed signal alteration diffusely throughout the cortex of the right parietal lobe, a portion of the temporal lobe, the area adjacent to the inferior right Sylvian fissure, and the right thalamus. These findings were located in the distribution area of the right middle cerebral artery consistent with ischemia or infarction.
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(References 2A-2D). With these findings, a hypercoagulability workup consisting of D-dimer, protein C, fibrinogen, anti-thrombin III, and Factor V Leiden levels was performed; the maternal blood was also tested for anti-cardiolipin antibodies. The hypercoagulability workup was significant only for a mild elevation of D-dimer (D-dimer 777 ng/dL, protein C 41%, fibrinogen 352 mg/dL, anti-thrombin III 77%, Factor V Leiden mutation negative, maternal anti-cardiolipin IgM antibodies negative).

The results of the infant’s meconium drug screen were discussed with her parents. The mother reported marijuana use about nine months prior to her pregnancy but denied any use during the pregnancy. The father reported that many of their neighbors use methamphetamine or cocaine but denied substance abuse in their home. Once a maintenance dose of phenobarbital was established, the infant did not experience any further clinical seizure activity. An MRI on day of life eight showed a reversal in the previously-noted abnormalities of the posterior right frontal, right temporal, and right occipital lobes; however, diffusion abnormalities consistent with ischemia or infarction remained in the right parietal lobe and the posterior limb of the right internal capsule. The infant’s blood cultures, cerebrospinal fluid cultures, and herpes PCR were negative. The antibiotics and Acyclovir were discontinued. Her neurological status remained stable throughout her hospitalization. The infant was discharged on a maintenance dose of phenobarbital at 5 mg/kg.

DISCUSSION

Perinatal ischemic stroke is classified as a focal disruption of cerebral blood flow secondary to arterial or cerebral venous thrombosis or embolization which occurs between 20 weeks of fetal life and the 28th postnatal day, and which is confirmed by either neuroimaging or neuropathological studies.1 The incidence is estimated to be one in 2,300-5,000 live births, but the condition is likely under-diagnosed.2 The neonatal period demonstrates the highest risk of childhood ischemic stroke, and four clinically-relevant stroke syndromes have been described: symptomatic neonatal arterial ischemic stroke, symptomatic neonatal cerebral sinovenous thrombosis, presumed perinatal ischemic stroke, and periventricular venous infarction. Presumed perinatal ischemic strokes are diagnosed in infants who present outside the neonatal period but who demonstrate symptoms and neuroimaging consistent with a perinatal stroke (most commonly an arterial ischemic stroke); and periventricular venous infarctions are associated with a germinal matrix hemorrhage that compresses the medullary veins draining the periventricular white matter.3 The most common type of perinatal stroke is believed to be arterial ischemic stroke; 83 percent of these strokes involve the middle cerebral artery distribution with two-thirds involving the left middle cerebral artery.4 Perinatal stroke has been found to be more common in males and in black infants.5 Establishing a cause for perinatal ischemic stroke is usually difficult. Although in most cases at least one potential risk factor can be identified, the cause is likely multifactorial. Both maternal and neonatal factors must be considered. Probable maternal risk factors include primiparity, infertility, chorioamnionitis, prolonged rupture of membranes, preeclampsia, intraventricular growth retardation, and maternal trauma.6 Other suspected maternal factors include gestational diabetes and oligohydramnios. Maternal cocaine abuse has also been identified as a potential cause of perinatal stroke.4 While fetal distress, prolonged labor, forceps and vacuum-assisted delivery, Cesarean section, Apgar score of less than seven, and neonatal resuscitation are commonly associated with neonatal stroke, it is unclear whether these factors are true causes of stroke. Neonatal risk factors include prothrombotic states, cardiac abnormalities, and infections. Prothrombotic states include protein C deficiency, Factor V Leiden, and elevated lipoprotein levels as well as the transfer of maternal antiphospholipid antibodies or disseminated intravascular coagulation.7 Measurements of prothrombotic factors should be delayed until at least three months of age to allow levels to normalize. However, maternal antiphospholipid antibody levels should be obtained shortly after delivery because the levels decrease during the postnatal period.8 Cardiac abnormalities include congenital structural abnormalities, cardiomyopathy and arrhythmia. Bacterial meningitis, congenital infections and chorioamnionitis have all been linked to cases of neonatal stroke.9 Abnormal placental vasculature is also a potential cause of perinatal stroke.4

The most common presentation for ischemic perinatal stroke is seizure activity, which often manifests on the first day of life.1 These seizures are typically multifocal and clonic and are frequently asymmetric and consistent with the hemispheric involvement (meaning the side opposite to the area of ischemia is typically affected). Ninety percent of seizures confirmed with electroencephalographic (EEG) recording are not recognized clinically.2 Other possible presentations include lethargy, apnea, poor feeding and decreased tone. Presentations outside the perinatal period at about four-to-eight months of life include infantile spasms and cerebral palsy.1

While a thorough neurologic examination is helpful in the diagnosis of perinatal ischemic stroke, neuroimaging is a key diagnostic tool. Cranial ultrasound may be useful in detecting stroke but may not demonstrate extremely anterior or posterior cerebral infarctions, and computed tomography (CT) exposes the infant to radiation and may miss small lesions, especially during the first 24 hours after the insult.1 Conventional and diffusion-weighted magnetic resonance imaging (MRI) are the most useful tools in the diagnosis of perinatal stroke. Evidence of stroke is visible on MRI within 24 hours of the ischemic event; and serial MRIs performed within 48 hours of birth and at seven-to-10 days of life are ideal for the characterization of perinatal ischemic stroke.2 MRI allows for the precise determination of the anatomic arterial distribution of the lesion.1 Changes noted on early MRI also have predictive value for outcome: changes in the thalamus and basal ganglia are predictive of motor deficits, and significant subcortical white matter injury with basal ganglia injury is predictive of cognitive impairment.2

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Treatment for perinatal stroke consists of supportive measures. Blood sugar and temperature should be normalized; and ventilation, oxygenation, blood pressure, and blood volume should be maintained.\(^3\) Seizures may worsen brain injury and often recur in the absence of treatment, so anticonvulsant therapy should be implemented. Multiple doses of several anticonvulsants may be needed to control seizures.\(^2\) Recurrence of perinatal ischemic stroke is seen in less than one-to-two percent of infants and is typically associated with either congenital heart disease or a prothrombotic state.\(^5\)

Newborns who experience strokes recover better than older children and adults who suffer from similar brain injuries; however, they often face long-term neurological and developmental deficits.\(^2\) Neurologic deficits or seizures occur in 50-75 percent of survivors of perinatal stroke; deficits in language, vision, cognition and behavior are seen in 20-60 percent of survivors.\(^1\) Stroke is also the leading cause of congenital hemiplegia, the most common form of term cerebral palsy.\(^3\) Commonly, neurologic deficits emerge outside of early infancy and continue to evolve throughout childhood.\(^1\) Surveillance for morbidities as well as initiation of early rehabilitative therapy is crucial for perinatal stroke survivors. A team of healthcare providers including primary care, neurology, physical, speech, and occupational therapy, pediatric psychiatry and orthopedic surgery may be necessary.\(^2\) Follow-up care with a hematologist may also be needed for prothrombotic work-up.

Lee and associates followed 36 infants with perinatal stroke over 12 months and reported cerebral palsy in 58 percent, epilepsy in 39 percent, language delay in 25 percent, and behavioral abnormalities in 22 percent.\(^4\) A delayed presentation of stroke had relative risk of 2.2 for cerebral palsy. Predictors of cerebral palsy included large stroke size and injury to Broca’s area, internal capsule or basal ganglia. Neonates presenting in the immediate neonatal period, with specific radiological findings and a lack of symptoms are reported to have increased risk for cerebral palsy. Monagle and associates recommend anticoagulation in children with cerebral sinus venous thrombosis without significant intracranial hemorrhage. Unfractionated heparin, low molecular weight heparin or vitamin K antagonists are used for a minimum of three months. For neonates with ischemic stroke in the absence of a documented ongoing cardioembolic source, anticoagulation or aspirin therapy is not recommended.\(^6\)

The infants mentioned in our report are representative of those neonates who suffer perinatal ischemic stroke. Both infants presented on the first day of life with seizure activity and were diagnosed with middle cerebral artery infarction on MRI. Typically, infants develop left-sided strokes but one of the infants in our report had right-sided middle cerebral artery infarct. The infant in Case 1 did not seem to have any of the maternal risk factors for arterial infarction and, while the infant’s low initial Apgar score and requirement of resuscitation with oxygen in the delivery room may be a potential risk factor, it may not be the primary etiological factor for the stroke. The infant in Case 2 had the risk factor of maternal gestational diabetes. The positive meconium drug screen for cannabinoids also raises the question of substance abuse during the pregnancy in spite of parental denial. The infant in Case 2 also demonstrated some factors associated with perinatal stroke such as arrest of progress of labor and requirement of Cesarean section. However, one minute and five minute Apgar scores were normal, and minimal resuscitation was required. This infant also had a negative prothrombotic workup with a negative maternal anti-cardiolipin antibody. Both infants had negative blood cultures, cerebrospinal fluid cultures, and herpes PCR analyses. The neurological exam on these two infants was essentially unremarkable on the day of discharge. In both cases, the infants required anticonvulsant medications for seizure control. The close follow-up care with a neurologist and a hematologist was recommended for both families.\(^+\)

References:

Dr. Gibson is a pediatric resident, Department of Pediatrics, at East Tennessee State University; Dr. Bharti is a professor of Pediatrics at East Tennessee State University, Johnson City, TN.

For all correspondence, please contact Dr. Bharti, PO Box 70578, East Tennessee State University, Johnson City, TN 37614; e-mail: bbharti@etsu.edu.
The prevalence of vitamin D deficiency. We plan to conduct a prospective study to define the prevalence of this disorder and to help us further determine the factors associated with this widespread and growing condition.

References:

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"Waiting Between Cases"
_Acrylic on canvas, 16 X 20_
That look of resignation immortalized on canvas shows the familiarity of the painter with a world privy to only a few.

Paul J. Marsidi, MD
_Uunion City_

“For Your Eyes Only”
_Acrylic on canvas, 24 X 36_
I tried to capture the light reflecting off the healing hands and focused eyes of a surgeon in a dimly lit room, revealing the intensity that accompanies the work being done.
A Lullaby

Swollen little bellies, red infected eyes
Tangled hair a nest for lice
A mother’s pleading, her voice breaking
And eyes meeting mine.
Tiny hands reach for my stethoscope
As I listen for the familiar rhythm of life
Struggling to find hope in a world
Of pain, suffering, loss and death.
Beautiful young mouths
Already scarred by decaying teeth,
Heads full of bright dreams,
A future so many will never see.
Their cries pierce my conscience
And forever become a part of me.
Through their brokenness I see inside myself and I find purpose.
Contentment, joy, peace and fulfillment
Flood my senses and heal my soul.
Their need strengthens my hands
Sharpens my mind
Softens my heart
And sings to my soul a lullaby.

"A Lullaby"
I wrote this poem while in Guatemala as a medical student. I was working with an American physician, Dr. Jim Street, in the mountains near the town of Santa Cruz del Quiche.

Lisa J. Broyles, MD
Johnson City

Physician poets, writers, songwriters, artists and photographers are welcome to showcase their work in “The Art of Healing.”
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For membership information contact Sarah Higgins at 865-249-8835, 865-604-9288 (cell) or sarahshiggins@aol.com; or TMAA Executive Assistant Judy Ginsberg at 615-385-2100, ext. 151, 800-659-1862 (toll free) or tm aa@tn med.org

TMAAllianceReport

Sweeping Bylaws Amendments, Other Changes Approved for AMAA

By Jo Terry, AMAA Director

Your Tennessee Alliance delegation, led by Immediate Past-President Robin Hutchins, represented our members at the AMA Alliance House of Delegates June 12-15 in Chicago. As a member of the AMA Alliance Board of Directors, it was my privilege to participate with our state group. In a year of turmoil for the family of medicine, the national organization proposed and the delegates approved sweeping amendments to bylaws. These changes will promote the message of inclusion with value placed on services for the individual member. Membership categories were simplified to give every member “regular” status with voting privileges, the right to hold office, and to directly participate at the national level. The AMA is moving from a House of Delegates structure to an annual meeting, which will provide the opportunity for any member to attend the annual meeting. This streamlined structure gives more flexibility for the organization to adapt to change, and to address important health promotion and advocacy issues as they arise.

The AMAA’s focus on 21st Century medical families and work/life balance will continue and expand. Families at every stage of life are encouraged to take advantage of the educational resources and support that are offered. There is no other organization whose primary focus is on the interests of today’s medical family.

Newly installed AMAA President Susan Todd (TX) is promoting a closer relationship with the AMA. Now that the Alliance has passed more inclusive membership language, AMA President Cecil Wilson (FL) has invited Susan to participate more actively on the AMA Board of Trustees — a first for the Alliance. Perhaps the Alliance will finally be recognized as a vital and equal partner of physicians for our years of work to promote the better health of our communities and support the medical family.

While the domestic partner issue has created tremendous controversy and discomfort in some states and counties, other components have had friends and family of medicine categories for years. The Alliance at the national level has realized that being an exclusive, rather than inclusive organization will not attract today’s medical students’ and residents’ spouses and partners. Our work—and its importance—will not change! Who and what our members look like are of far lesser importance.

Last year, I participated in the AMAA’s strategic planning process for the Board of Directors. These bylaws changes reflect part of the long-term plan for the AMAA in our effort to break down roadblocks to membership and participation by the individual physician and his or her spouse or partner. We want to attract members! When someone asks, “Can I join you in supporting and promoting the Alliance?” the answer should be simple: “Yes!”

Those interested in joining the Alliance may contact their county Alliance or the TMAA office at 615-460-1651 or tmaa@tnmed.org. You may also contact the AMAA at 312-464-5020 or go to www.amaaalliance.org and click on “Membership.”

For membership information contact Sarah Higgins at 865-249-8835, 865-604-9288 (cell) or sarahshiggins@aol.com; or TMAA Executive Assistant Judy Ginsberg at 615-385-2100, ext. 151, 800-659-1862 (toll free) or tm aa@tnmed.org

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IN MEMORIAM

H.R. ANDERSON, MD, age 87. Died May 28, 2010. Graduate of University of Tennessee Health Science Center. Member of Nashville Academy of Medicine.

JAY FREDERICK LEWIS, MD, age 78. Died June 2, 2010. Graduate of Vanderbilt University Medical School. Member of Chattanooga-Hamilton County Medical Society.

WILLIAM G. WHITE, MD, age 95. Died June 7, 2010. Graduate of University of Virginia College of Medicine. Member of The Memphis Medical Society.

S. MARTIN BRONSON, MD, age 91. Died June 15, 2010. Graduate of Medicinische Fakultaat der Univ Basel. Member of Carter County Medical Society.

BRIAN E. MCCRUDDEN, MD, age 70. Died June 15, 2010. Graduate of University of Western Ontario Medical School. Member of Consolidated Medical Assembly of West Tennessee.

ROBERT B. HAGOOD, JR., MD, age 96. Died June 26, 2010. Graduate of Washington University School of Medicine. Member of Chattanooga-Hamilton County Medical Society.

THOMAS J. WHITE, JR., MD, age 92. Died June 26, 2010. Graduate of University of Tennessee Health Science Center. Member of The Memphis Medical Society.

AMA PHYSICIAN RECOGNITION AWARD
Louis Seibert, MD, Brentwood
CORRECTION

In the TMA Annual Awards section of the TMA 2009-2010 Annual Report issue (Tennessee Medicine, June/July 2010, Vol. 103, No. 6, p. 38), TMA Distinguished Service Award winner Dr. Robert Kirkpatrick was incorrectly cited as a fellow of the American Academy of Emergency Medicine (AAEM). He should have instead been cited as a fellow of the American Academy of Occupational Medicine (AAOM).

Tennessee Medicine regrets the error.

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