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I’d like to start this first column by saying thank you to those of you who supported me for the presidency of the TMA. I appreciate your confidence in me and I will not let you down.

When Gov. Haslam signed the Tennessee Civil Justice Act into law on June 16, 2011, it marked a great victory for the House of Medicine here in Tennessee. The TMA had been advocating for significant liability reform for over a decade, and it had not been easy. During that time we pushed the issue to the top of our legislative agenda, called a special session of our House of Delegates, and raised nearly a million dollars to support the effort. In 2006 the AMA declared Tennessee a medical liability crisis state. We had to go to the Legislature and get something done.

At first, our strategy supported only bills that contained caps on liability awards. We knew about the law California passed in 1975 and we wanted that for Tennessee. But before long it became clear that caps were not politically achievable—at least in 2006. Instead, we made some compromises and supported improvements we could win.

By 2008, we had a bill that strengthened the filing and certification process for med-mal cases. There were no caps so we were skeptical about how effective this might be, but felt it would offer some help to physicians. When the bill was signed into law, we watched. The number of filed cases dropped 60 percent in the first year after the law went into effect. However, the larger cases were still being brought forward, so we still needed caps.

In 2010, Gov. Bill Haslam was elected and brought with him a majority of freshman Republicans in the Tennessee House. This, in turn, brought a change of leadership and composition to the House Judiciary Committee and its subcommittees—ending a blockade to our cap legislation that had been present for years. We encouraged Gov. Haslam to bring tort reform forward early in his first year and, since it was one of his campaign promises, he agreed. Despite resistance from trial lawyers and others, the Civil Justice Act passed in May. As of October 1, 2011, we will have caps on medical liability awards.

The process has been long and there have been a lot of people involved. All of the TMA’s leadership has been active in some way, the most prominent being our lobbyists, Gary Zelizer and Julie Griffin. We owe them our gratitude.

I’ve learned a few things along the way. I’m impatient and I like immediate results; politics doesn’t work that way. In politics, patience and persistence lead to success.

Be well, enjoy your practice, and let’s keep the TMA strong.

Share your thoughts with Dr. Minch at president@tnmed.org.
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Accountable Care Organizations (ACOs) are nothing new but just another twist on the HMOs or Health Maintenance Organizations of the 1980s. As one health care executive said, an “ACO is just an HMO in drag.”

The HMOs were the brainchild of Dr. Paul Ellwood, who coined the term for the Nixon administration in May 1970. The federal government enacted legislation that authorized and subsidized HMOs in 1972 and further legitimized them in 1973. These organizations were at risk for total health care and its costs. That means the only way they could make a profit was to provide health care at less than current costs by rationing and tight utilization, and then pocket the difference. The gatekeeper, whom many of us encountered, was a primary care doctor who got a bonus for decreased utilization of services and fewer referrals to specialists. This was based on two premises: first, that the average patient will over-use services unless access is restricted or expensive (co-pays); and second, that unrestricted access to specialists was one of the major causes of overly-expensive health care. Utilization and hospitalization were further tightly managed and enforced by RN Case Managers and the HMO chief medical officer MD, who pushed for early discharges and fewer tests. They used a reference book of discharge and management statistics by diagnosis, created by Millman and Roberts. Quality was not a major factor in decision-making, just lower costs. Many of us had less than favorable experiences with the HMOs for many reasons. Since the whole idea of an HMO was to save money, lower costs were frequently the only driving force behind patient care decisions. I practiced under this environment for several years and found it to be quite restrictive. The health care of patients would have been better served if the care had been quality and physician-driven. Patients did not like HMOs and rebelled against them as well. Except for Kaiser Permanente, Harvard Community Health and a few others, HMOs faded into oblivion.

How can ACOs possibly be our salvation despite being the offspring of HMOs? The key is that the HMOs were driven by corporate greed and not by physicians or good patient care parameters. Health care is becoming too expensive and soon the growth of expenditures will become unsustainable, unless we take action ourselves to contain costs before the government does with its arbitrary 20-30-percent cuts in Medicare. The private insurers will surely follow soon after, as we saw from Blue Cross in April of this year. This is where the ACOs come in. They are the creation of Dr. Elliot Fisher at Dartmouth College. He presented the idea of a quality-driven accountable care organization. A physician-led, quality-driven, cost-effective organization can make a difference. An ACO where every care provider is a gatekeeper and a stakeholder, with the patients’ best interests in mind, following best practices established from evidenced-based medicine, could deliver great, appropriate, timely, efficient and cost-saving care. We physicians can make better decisions as to what and where to cut in health care than a government bureaucrat. Case managers can be very effective when working in partnership with physicians. Quality can be efficient and cost effective and, when driven by physicians, it can be achieved.

One new aspect is that the hospital may or may not be part of the ACO. It would appear that a hospital partner would be essential, since hospitals are far more responsible for 36.8 percent of healthcare expense. The PPACA’s section 3022 states that as few as 5,000 Medicare beneficiaries are required to form an ACO. This is not enough to satisfactorily spread risk, so ACOs will initially bear little or no risk for the expense of care, rather just share with Medicare or even a private insurer the savings achieved. This brings into focus why ACOs may be the structure that will allow physicians to cope with the changes that are coming. Costs must be contained and reduced with health care consuming 17.5 percent of GDP. HMO physicians were the source of excess costs but with an ACO, physicians can be the source of intelligent quality-driven savings and better care. Since healthcare costs must and will go down, you might want to join one so you can have some input on where the cuts will occur.

The TMA Insurance Issues Committee will be watching as ACOs and exchanges form and the impact they have on physicians’ practices. Should unfair or illegal professional or business activities occur, you can be sure the TMA will be there for you.
To the Editor:

I enjoyed so much reading Dr. Phelps’ article in the latest issue of the Tennessee Medicine Journal about pain, “A Doctor’s Dilemma” (Tennessee Medicine, Vol. 104, No. 4, p. 7). This article certainly points out the dilemma that so many of us have in treating our pain associated patients, some of them surgical and some of them not. I think the article in its succinct format was one of the very finest articles I’ve ever read on this subject and I want to thank (Dr. Phelps) for presenting it to the membership.

John D. Witherspoon, MD, FACS
Nashville, TN
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[www.cms.gov/EHRIncentivePrograms/](http://www.cms.gov/EHRIncentivePrograms/)

For additional resources and support in adopting certified EHR technology, visit the Office of the National Coordinator for Health Information Technology (ONC):

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WILL THE TMA FORM AN ACO?

Q: I read with great interest the articles on accountable care organizations (ACOs) in the May 2011 issue of “Tennessee Medicine.” Great job; very interesting edition. Can the TMA or a local medical society form a Medicare ACO? If so, is the TMA going to form one?

A: No. The Tennessee Medical Association cannot form or participate in a Medicare accountable care organization (ACO).

Medicare ACOs are authorized by Section 3022 of the Affordable Care Act (ACA) of 2010, part of the Obama administration’s omnibus health system reforms. On March 31, 2011, the Centers for Medicare and Medicaid Services (CMS) released proposed rules on the Medicare Shared Savings/ACO Program. The rules are preliminary; the TMA was among organizations nationally submitting comments on the proposed regulations—you can read those at www.tnmed.org/TMA_hsr_acos. Comments were accepted until June 6; the final version, which may tweak the proposed rules, will not be released until later this year.

There are several reasons why the TMA cannot form or participate in a Medicare ACO:

1. The proposed rules provide that ACOs must be made up of Medicare participating providers. The TMA does not fall into any category of Medicare participating provider, i.e., physicians, hospitals, ambulatory surgical centers, nursing homes, etc. While the individual physician members of the TMA can participate in an ACO, the TMA cannot.

2. Individual participants in an ACO need legal representation leading up to the formation of an ACO and thereafter. First, Medicare ACOs are a veritable mine field of legal pitfalls. While the proposed rules do afford some protection from antitrust, fraud and abuse, and tax laws, the exceptions are narrow and uncertain; most ACOs will have the Federal Trade Commission or Department of Justice on speed-dial obtaining expedited review of questions related to the application of terms like “common service” or “Primary Service Area,” among others. Second, the division of any shared savings from the Program must be decided at the formation of the ACO and before the ACO applies with CMS for approval to participate. Individual and entity participants will need legal representation in negotiating the participant’s percentage of any savings (or losses!). Since the TMA is a not-for-profit tax-exempt organization, it is precluded by Internal Revenue Service regulation from representing individuals because it might be construed as a private benefit and inurement. The consequence of that would be the TMA perhaps losing its tax-exempt status.

3. If the TMA were allowed to form or participate in an ACO, it might find itself in competition with some of its members who chose to join another ACO or no ACO at all.

4. The TMA engages in lobbying. If the Association formed or participated in an ACO, it is foreseeable that situations would arise in that context whereby the TMA would be conflicted as to whether to take a position that would benefit its ACO versus one that might benefit physician members as a whole.

The TMA does remain committed to educating its members on ACOs and alternative payment methodologies as the nuts and bolts of health system reform are unveiled. Please visit our Health System Reform resource page online at www.tnmed.org/hsr. We also hope you had an opportunity to join us for the July 26th webinar, “Accountable Care Organizations: Are They a Good Fit for Tennessee Physicians?” The webinar explored Medicare ACOs and other options available for physicians. An archived version may be found on the TMA’s health system reform web page, www.tnmed.org/hsr.
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TMA Engages on Health Reform, ACOs

Now that the Affordable Care Act (ACA) is in effect, the TMA has updated its official position on health system reform and weighed in on elements of the law.

ACO RULES
In early June, the TMA submitted official comments to the Centers for Medicare and Medicaid Services (CMS) on proposed rules for Accountable Care Organizations (ACOs), a new shared-risk practice model incentivized in the new reform legislation. Overall, the TMA concluded that while the goals were “laudable,” the program as designed under CMS rules is too expensive and the regulations too burdensome. “We thought it was important that CMS knew there would be overwhelming challenges for Tennessee physicians to participate in Medicare ACOs,” said TMA General Counsel Yarnell Beatty. “Broadly speaking, we feel the startup costs and investments for operating a Medicare ACO would be prohibitively expensive and much more than the rules predict,” Beatty explained, adding the abundance of government oversight and unpredictable application of anti-trust laws were additional concerns. “Our basic conclusion is that the carrot is too small and the stick is too big to incentivize most physicians to participate in Medicare ACOs.”

Read the TMA’s comments to CMS at www.tnmed.org/TMA_hsr_acos.

The TMA’s concerns were echoed by the Tennessee Hospital Association. “The way the ACO regulations are currently written, there will be little or no interest in working towards becoming one,” said THA President Craig Becker. He said THA comments to CMS raised concerns about the cost, shared savings mechanism, and a “prescriptive approach” it said would stifle creative approaches to care delivery and discourage participation by Tennessee hospitals.

Based on feedback already submitted, Beatty said he is certain the CMS will make major revisions in the final rules covering ACOs.

TMA POSITION ON HSR
At its July quarterly meeting, the TMA Board of Trustees took another look at health system reform overall and began revising its formal stance on some of the main provisions of the Affordable Care Act. The Association’s original position was issued in mid-2009, before the law was passed.

(Continued on page 20)

New eHealth Member Benefit

The TMA’s objective was to take some of the legwork out of vetting qualified vendors and to provide an added level of safety net and transparency to the contracting process.

Partners in the VSP program to date include:
- NextGen
- AllScripts
- Sage

Additional VSP partners will be listed as they are added.

NEW ONLINE EHEALTH RESOURCE
Along with the VSP program, the TMA has also revamped its online eHealth resources for members; the new web page includes downloadable toolkits, articles, webpage links and resource guides to help you transition to electronic health information technology.

For more information about this program or to discuss your practice goals, please contact Angie Madden, director of e-Health Services, at angie.madden@tnmed.org or 615-460-1662. +
TMA Public Health Champion: Dr. Sullivan Smith

Sullivan K. Smith, MD, FACEP, of Cookeville, is the focus of the TMA’s inaugural quarterly Public Health Champion Spotlight.

Currently the emergency room director at Cookeville Regional Medical Center, Dr. Smith is the 2011 winner of the Fred H. Roberson Award, given by the hospital each year to the person who has contributed most to the long-term benefit of the local healthcare community. Dr. Smith helped formulate the hospital’s induced hypothermia protocol, the Code 37 team and the ER observation unit, and spearheaded a campaign to place AEDs throughout the community in the mid-1990s.

He is the founder of Volunteer Medical Group; serves as Putnam County medical examiner, Putnam County Rescue Squad medical director and medical director for the Tennessee Tech EMS education program; is a lieutenant on the Cookeville Police Department SWAT team, a member of the DEA Clandestine Laboratory Eradication Team, and an agent with the 13th Judicial Drug Task Force. A member of the Putnam County Medical Society, he is also past president of the Tennessee College of Emergency Physicians Board of Directors and a member of the Governor’s Task Force against Methamphetamine.

Dr. Smith was lauded by CRMC officials for his dedication to public health education, including issues such as methamphetamine use and bioterrorism threats. Most recently he traveled much of the state, urging state and local governments to ban the drug mephedrone, sold as “bath salts” or “plant food.” His efforts resulted in the removal of this dangerous product from store shelves.

A Cookeville native, Dr. Smith received his medical degree from the University of Tennessee, College of Medicine in 1986 and completed his residency at the University of Tennessee Memorial Hospital. He and his wife Rhonda have four children.

Medicare EHR Incentive Payments to Be Issued

CMS has begun issuing the first Medicare electronic health record (EHR) incentive payments. Providers who have successfully attested to having met meaningful use, and have met all the other program requirements, can expect to receive their 2011 incentive payments soon.

WHAT KIND OF PAYMENT CAN I EXPECT?
Participating Eligible Professionals (EPs) receive a payment based on 75 percent of their total Medicare allowed charges, submitted no later than two months after the end of the 2011 calendar year. The maximum allowed charges for a 2011 incentive payment is $24,000, which means the maximum incentive payment an EP can receive for the first participation year is $18,000.

NOTE: Incentive payments will not be made to an EP until the EP meets the $24,000 threshold in allowed Medicare charges.

HOW ARE PAYMENTS MADE?
Participants will receive their Medicare EHR Incentive Program payment the same way they receive payments for Medicare services, via electronic funds transfer or by paper check. Payments to Medicare providers will be made to the taxpayer identification number (TIN) selected during registration for the Medicare EHR Incentive Program. For electronic transfers, CMS will deposit incentive payments in the first bank account on file and it will appear on the bank statement as “EHR Incentive Payment.”

(Continued on page 20)

Routine CSMD Queries Help Verify Rx in Your Name

After receiving phone calls from members and others, the TMA is urging physicians to conduct routine queries of the state’s Controlled Substance Monitoring Database to keep track of prescriptions.

Two Tennessee physicians were recently alerted that their employees had been calling in prescriptions under the physician name and DEA number to various pharmacies, without their knowledge.

There is no current state law or AMA ethical opinion that requires or ethically obligates physicians to report such activity by non-physicians, only by colleagues. However, the TMA is warning members to be aware of this possibility.

“We encourage members to query the CSMD on a regular basis to view prescriptions under their name, to make sure they are accurate,” said TMA General Counsel Yarnell Beaty.

Members can also access a TMA law guide topic on the CSMD, which includes a link to the database and instructions on how to log on for the first time and how to query the database for prescription tracking information. The law guide is available at www.tnmed.org/lawguide. Member login required.

Do you know a TMA public health hero who deserves to be in our quarterly spotlight? Submit their name with a brief statement explaining the reason for your nomination to brenda.williams@tnmed.org.
Comments Needed on Proposed Leadership Election Changes

The TMA is asking for member comments—especially from those serving as delegates to the TMA House—on proposed changes to the Association’s leadership election process.

Bylaw Amendment No. 1-11, submitted by The Memphis Medical Society, was referred to the TMA Board of Trustees by the 2011 House of Delegates; in turn, the board referred the Resolution to the Committee on Constitution and Bylaws for review and recommendation.

PROPOSED CHANGES

The proposed Bylaw Amendment would change how TMA leadership elections are conducted starting in 2013. If adopted, regional nominating committees would be replaced by one statewide nominating committee appointed by the House speaker and the BOT chairman. Instead of the membership at large electing leaders such as president-elect, AMA Delegation and councilors, the House of Delegates would cast votes for those positions at the TMA’s annual meeting. The membership at large would instead be able to provide comments, including suggestions for nomination, on the statewide nominating committee’s recommendations before the slate of candidates is final.

SUBMIT COMMENTS

Member comments on this proposal should be submitted by the end of August to Yarnell Beatty, staff liaison to the Committee on Constitution and Bylaws, at Yarnell.beatty@tnmed.org.

AMA Reaffirms Individual Mandate, Adopts Other Policies at Annual Meeting

A two-thirds vote by the AMA House of Delegates reaffirmed the organization’s support for requiring most individuals to buy insurance, with financial assistance for those who cannot afford it.

That issue topped the agenda at the AMA’s annual meeting in Chicago in late June, which also included the adoption of new policies related to public health, medical education and health information technology. The individual mandate is a key element of the Patient Protection and Affordable Care Act (PPACA), the health system reform law adopted in 2010.

INDIVIDUAL MANDATE

After reviewing and rejecting alternative proposals, including one that supported voluntary insurance coverage offset by tax breaks, the AMA voted to stay with its previous position that covering the uninsured could not be successful without the individual responsibility mandate.

“The primary issue was to reaffirm that individual responsibility is needed, and that we need to work to amend the ACA to fit our stated goals,” reported TMA Delegate Barrett Rosen, MD, who covered the debate and discussion in Reference Committee prior to the final vote on the House floor.

Given the AMA vote and the ongoing implementation of health reform provisions, the TMA began reviewing and updating its official position on health system reform during its quarterly meeting in mid-July. “Any issue that is this critical and has the potential to impact physicians and patients in so many areas deserves our

(Continued on page 19)
31st Annual TMA Insurance Workshops – Register Now

Important insurance carrier information – as well as a new CEU credit course on 5010/ICD-10 – will be available through the TMA’s 31st Annual Insurance Workshops, scheduled in locations statewide from August 30 – October 5.

Join representatives from Cahaba GBA, commercial carriers, the Bureau of TennCare, TennCare MCOs and Medicare Advantage for valuable tips on how to:

• file a claim
• file a dispute/appeal
• read and utilize the remittance advice
• handle policy/process changes for providers
• obtain an authorization
• access claims reports/data from the plan
• audit vendors for each plan

Additionally, attendees will learn how to identify legitimate audit requests from each plan, as well as what to expect and what your rights are as a provider. The workshop will also include a 1 CEU credit course taught by Katherine Kannard on 5010 and ICD-10 basics.

DATES & REGISTRATION

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<tbody>
<tr>
<td>August 30</td>
<td>Memphis Fogelman Center</td>
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Cost is $179 for TMA/TMGMA member employees and $129 for each additional TMA/TMGMA member employee; and $229 for non-member participants. To register, visit www.tnmed.org/workshop.

GOT QUESTIONS?
Participants are invited to submit any questions they’d like the experts to address during the workshop in advance. Send your questions by August 22 via email to phyllis.franklin@tnmed.org or by fax to 615-312-1895.

BCBST to Continue Provisions Past Settlement Expiration

The national class action settlement between the TMA and Blue Cross Blue Shield of Tennessee (BCBST) in 2007 expired May 31, 2011, but BCBST has agreed to continue voluntarily honoring several provisions required by the settlement.

BCBST joins other national private payers, such as Cigna and Humana, who agreed to continue meeting some of these business practices when their national settlement agreements with physician groups expired.

“These lawsuits did succeed in changing certain business behaviors by insurance companies, not only going forward but there have been a lot of laws passed to help physicians that were based on settlement provisions from the class action lawsuits,” said TMA General Counsel Yarnell Beatty.

PROVISIONS TO KEEP
In lieu of any changes required under health reform laws, BCBST has agreed to:

1. Continue reduced precertification requirements and publish them on its website;
2. Send out any contract amendments with 60 days advance notice by certified mail, giving physicians 60 days to review and respond to the changes;
3. Allow provider agreement terminations without cause;
4. Continue paying separate administration fees along with vaccines and injections, and basing reimbursement on the costs of the vaccine;
5. No automatic down coding of E&M codes;
6. Publish its bundling and other computerized claim editing information on its website;
7. Continue providing the same amount of EOB and RA information;
8. Maintain its current practice of not changing confirmation of medical necessity;
9. Continue meeting settlement pharmacy provisions, including making the formulary information available, covering medications not included in the formulary when medically necessary, and covering off-label uses of FDA-approved drugs as long as they are not contraindicated for the off-label use intended and use is peer-reviewed;
10. Keep its commitment to ongoing investment in information technology as business dictates;
11. Provide physicians with copies of their provider agreements; and
12. Not include the Most Favored Nation Clause in its contracts with providers.

REPRESENTING YOU
TMA officials continue working with the company to improve relations between the insurer and physicians; a meeting with top BCBST executives is scheduled on September 9.

For more information, contact Yarnell Beatty at 800-659-1862 or yarnell.beatty@tnmed.org.
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Leadership materials and resources from the TMA’s inaugural “Presidents’ Retreat: Leading the Future of Organized Medicine” are now available online for members. The event focused on all aspects of leadership, from finances and legal responsibilities in running a medical society to membership recruitment and engagement, social media, and grassroots advocacy. Visit www.tnmed.org/presidents-retreat to access:
- Session Presentations
- Session Handouts
- Featured Session Videos:
  - We’re Having A Meeting - From invitations to evaluation: everything you need to know to run a successful meeting
  - Getting Your Message Out - How to evaluate and plan better communications strategies for your group
  - From the Roots Up - Build personal and organizational contacts and networks to meet your advocacy needs

AMA REAFFIRMS INDIVIDUAL MANDATE, ...

(Continued from page 15)

constant attention,” said TMA President Michael Minch, MD.

The HOD also reaffirmed AMA support for health insurance tax credits, health savings accounts, direct subsidies for the coverage of high-risk patients, and health insurance market regulation.

PUBLIC HEALTH
A host of new policies were adopted addressing public health issues, including votes in favor of:
- Legislation banning synthetic substances known as “bath salts;”
- Nutrition counseling for pregnant and postpartum patients;
- Development of advertising guidelines that promote a more realistic body image, especially in publications aimed at adolescents;
- Dietary guidelines for incarcerated adolescents and adults;
- A production halt and ban on products containing Bisphenol A (BPA);
- Stricter monitoring of mercury emissions from cement plants; and
- More research on the safety of full-body scanners at airports.

MEDICAL EDUCATION
The AMA HOD adopted a “Residents’ and Fellows’ Bill of Rights” to ensure a safer place for physicians in training to work and learn. The “Bill” spells out the expectations in areas of education, supervision, performance evaluations, safety in the workplace, compensation and benefits, duty hours, complaints and appeals, and protection when reporting violations.

Another new policy instructed the AMA to work with medical schools and organizations to improve the assessment of a potential student’s personal qualities, along with the traditional criteria, when evaluating their medical school applications.

HEALTH IT
Delegates to the AMA voted to advocate for standardizing key elements of electronic medical record (EMR) interface design, to make it easier for physicians working at multiple facilities to be able to use different systems. The new policy is in response to concerns that EMR products are difficult to navigate and use for retrieving important patient information, due to poor user interface design.

TMA REPRESENTATION
TMA leaders continue representing Tennessee physicians within the national organization.

David Gerkin, MD, of Knoxville, completed his long tenure and most recent service as chairman of the AMA Council on Constitution and Bylaws; TMA Delegation Chairman Chris Fleming, MD, of Germantown, is assuming the chairmanship of the Southeast Delegation to the AMA; and Lee Morisy, MD, of Memphis, current chairman of the AMA Council on Science and Public Health, will be a candidate for the AMA Board of Trustees in 2012.

Leadership materials and resources from the TMA's inaugural "Presidents' Retreat: Leading the Future of Organized Medicine" are now available online for members. The event focused on all aspects of leadership, from finances and legal responsibilities in running a medical society to membership recruitment and engagement, social media, and grassroots advocacy. Visit www.tnmed.org/presidents-retreat to access:
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  - From the Roots Up - Build personal and organizational contacts and networks to meet your advocacy needs
TMA ENGAGES ON HEALTH REFORM, ACOS
(Continued from page 13)

“We’re already engaged on this issue,” Beatty said. “We support Congressman Phil Roe’s bill to repeal the IPAB (Independent Payment Advisory Board) and we’ve already come out and stated emphatically that we want the health insurance exchanges to be housed in Tennessee and not with the federal government. We’re already making our voices known on some of these issues. Now it’s time to formally compile all this information and put it into a more formal position statement,” he said.

Board members are expected to issue a final position statement later this month.

For more on the TMA and health system reform, as well as resources and links, visit www.tnmed.org/hsr.

Cong. Roe Sponsors Bill to Repeal IPAB

U.S. Representative Phil Roe, MD (R-TN) has introduced H.R. 452, bipartisan legislation to repeal the Independent Payment Advisory Board (IPAB) enacted in last year’s health care reform package.

The thought that the IPAB would be given so much authority to determine which benefits are covered and how much physicians are paid has generated great consternation within the medical community nationwide, including within the TMA.

Cong. Roe, a longtime TMA member who is passionate about the issue, said, “We cannot let an unelected board of bureaucrats run our health care system into the ground. The IPAB would be a disaster for seniors and providers because it would make cost, rather than medical necessity, the primary factor in whether care is offered. I will do all I can to ensure patients and their doctors, not Washington bureaucrats, make the decisions about what care they receive.”

To read letters of support written to Cong. Roe by organized medicine, visit www.tnmed.org/IPABletters.

MEMORIE EHR INCENTIVE...
(Continued from page 14)

IMPORTANT: Medicare Administrative Contractors (MACs), carriers, and fiscal intermediaries will not be making these payments. CMS is working with a Payment File Development Contractor to make these payments. Please do not contact your MAC regarding EHR incentive payments.

To view a checklist of how to participate in the Medicare or Medicaid EHR Incentive Program, look at the “Path to Payment” section of the EHR website, www.cms.gov/EHRIncentivePrograms.

LOCAL ASSISTANCE
Sixty-two Regional Extension Centers (RECs) across the nation are prepared to offer customized, on-the-ground assistance for eligible professionals and hospitals registering for the CMS EHR Incentive Programs. The REC for Tennessee participants is tnREC, available at www.tnrec.org.

For more information, contact TMA eHealth Services Director Angie Madden at 800-659-1862 or angie.madden@tnmed.org.
Former Sen. Dr. Bill Frist, Gov. Bill Haslam and Dr. Jack Lacey brief the media on the “AFib in America” project during the kickoff of the Governor’s Health and Wellness Task Force, chaired by Dr. Lacey.

Dr. Robert and Mrs. Sue Vegors enjoy wine samples at Crown Winery in Humboldt, during the June meeting of Consolidated Medical Assembly of West Tennessee.

TMA Senior Vice President Russ Miller presents an award check to Dr. Kirk McCullough from Vanderbilt, for winning the Resident/Fellow Section Poster Competition during MedTenn 2011. His winning abstract will be published in the September issue of Tennessee Medicine.

New University of Tennessee Health Science Center Resident Dr. Dana Petersen (left) talks with Memphis Medical Society President Dr. Jerome Thompson following UTHSC resident orientation in late June.
MEMBER NOTES

Four TMA members are among Tennesseans appointed by Governor Bill Haslam to serve on state boards and commissions. Neal S. Beckford, MD, an otolaryngologist from Germantown, and Mitchell L. Mutter, MD, a cardiovascular and internal medicine specialist from Lookout Mountain, were appointed to the Board of Medical Examiners. Jeffrey P. Lawrence, MD, a Franklin orthopaedic surgeon, was named to the Board for Licensing Health Care Facilities; and Barrett G. Haik, MD, a Memphis ophthalmologist, will serve on the Health Services and Development Agency. Drs. Beckford and Haik are members of The Memphis Medical Society; Dr. Mutter is a member of the Chattanooga-Hamilton County Medical Society; and Dr. Lawrence is a member of the Nashville Academy of Medicine.

Daniel S. Boyd, MD, of Germantown, has been named medical director for Lakeside Behavioral Health System’s new Neuroscience Center. A former 2008 “Physician of the Year” at Lakeside, Dr. Boyd is certified by the American Board of Psychiatry and Neurology. He is one of few psychiatrists in the Mid-South area certified for electroconvulsive therapy (ECT), and most recently was certified to perform Transcranial Magnetic Stimulations (TMS), both of which will be included in the new Neuroscience Center. Dr. Boyd is a member of The Memphis Medical Society.

Thomas F. Carter, MD, of Westmoreland, was honored during the city’s annual Fourth of July celebration. Surrounded by family and friends, the longtime family physician helped dedicate a new sign for the Dr. Thomas F. Carter Midtown Park, previously named in his honor. Now retired, Dr. Carter was the city’s only doctor for years. He is a direct member of the TMA.

Anuj Chandra, MD, DABSM, of Chattanooga, was recently included in Sleep Review’s “Best Doctors of 2011,” one of 10 sleep specialists included in the magazine’s annual listing. Double-board certified in sleep medicine, he is founder of the Advanced Center for Sleep Medicine, serving patients in Chattanooga and North Georgia. In 2008, he helped a patient organize Chattanooga’s first chapter of AWAKE (Alert, Well and Keeping Energetic), a support group for people with sleeping disorders. He is on the international teaching faculty of the National Sleep Medicine Course, an initiative to bring cutting-edge sleep medicine training to India. Dr. Chandra is a member of the Chattanooga-Hamilton County Medical Society.

Douglas C. Cobble, MD, a board certified pediatrician and pediatric sports medicine specialist from Greeneville, was recently chosen to appear in a series of television advertisements aimed at raising public awareness about heart attack symptoms. The ads focus on his own experience as a heart attack victim and patient. Sponsored by Mountain States Health Alliance, the spots began appearing on local television in July. Dr. Cobble was previously featured in his role as a physician in ads for Laughlin Memorial Hospital and MSHA. Practicing with Greeneville Pediatric Clinic, PC, he is a member of the Greene County Medical Society.

James D. Eason, MD, FACS, of Memphis, has been appointed by U.S. Health and Human Services Secretary Kathleen Sebelius to serve on the Advisory Committee on Organ Transplantation in the Health Resources and Services Administration. The committee makes recommendations to the Secretary on issues concerning organ donation and transplantation. Dr. Eason is program director of the Methodist University Hospital Transplant Institute and chief of Transplantation and a professor of Transplant Surgery at the University of Tennessee Health Science Center. He is likely best known as the surgeon who performed a liver transplant on Apple CEO Steve Jobs in 2009. A member of The Memphis Medical Society, Dr. Eason is also a member of the International Liver Transplantation Society, the American Association for the Study of Liver Diseases, the Transplantation Society and serves as councilor for the American Society of Transplant Surgeons.
MEMBER NOTES

Two TMA members were among those recently honored by Carnival Memphis during its 25th Annual Business and Industry Salute to Health Care. Ralph S. Hamilton, MD, founder and namesake of the Hamilton Eye Institute in Memphis, was given the Cook Halle Award – the highest honor given by the organization. Kevin T. Foley, MD, director of complex spine surgery at Semmes-Murphey Neurologic & Spine Institute, won the Chairman’s Award. Both are members of The Memphis Medical Society.

Mark Kadowaki, MD, FACS, of Kingsport, recently presented research at the 1st International Reduced Port Surgical Group Symposium in Philadelphia, PA. Dr. Kadowaki presented on incorporating reduced port/single port laparoscopic surgery and endoluminal surgical procedures into a private practice setting. Board certified by the American Board of Surgery, Dr. Kadowaki is a member of the American Society for Metabolic and Bariatric Surgery and the Society of American Gastrointestinal Endoscopic Surgeons. He is also an instructor and course director for advanced trauma life support. Dr. Kadowaki practices advanced laparoscopic and bariatric surgery with Surgical Associates of Kingsport and is a member of the Sullivan County Medical Society.

Roy King, MD, of Knoxville, has been chosen for Leadership Knoxville’s Class of 2012. The 10-month program focuses on servant leadership; members commit to the organization’s goal of serving as “catalysts for positive change” in the community. A member of the TMA Board of Trustees and the BOT Finance Committee, Dr. King is the board liaison to the Tennessee Society of Pathologists and the Tennessee Radiological Society Executive Committee. Specializing in pathology, cytopathology and dermatopathology, Dr. King practices with Knoxville Dermatopathology Laboratory. A past president of the Knoxville Academy of Medicine and the KAM Foundation, he is a member of the State Board for Licensing Health Care Facilities, the Rotary Club of Knoxville Board of Trustees, and the Webb School of Knoxville Board of Trustees.

Fazal M. Manejwala, MD, of Memphis, has been named medical director of the Obstetrics Department at Baptist Memorial Hospital, DeSoto. Board certified in obstetrics and gynecology, Dr. Manejwala practices with Memphis Obstetrics and Gynecological Association, PC (MOGA). He is a member of The Memphis Medical Society and a supporter of the Memphis Medical Foundation.

Heath R. Many, MD, FACS, of Knoxville, has been named cancer liaison physician to the Commission on Cancer for the cancer program at Parkwest Medical Center. Dr. Many is a board-certified surgeon practicing with Premier Surgical Associates, PLLC, of Knoxville and a member of the Knoxville Academy of Medicine.

Frank A. McGrew, III, MD, FACC, of Memphis, has been selected to be a Fellow of The Heart Rhythm Society. Certified in internal medicine and cardiovascular disease, Dr. McGrew is director of clinical research at The Stern Cardiovascular Foundation in Germantown. He is a well-known researcher and author in the cardiovascular field. Previous honors include Alpha Omega Alpha and Phi Beta Kappa. Dr. McGrew is a delegate to the TMA from The Memphis Medical Society, and a member of the Tennessee Chapter of the American College of Physicians.

Stephen T. Miller, MD, MACP, has been named the inaugural Robert S. Pearce Chair in Internal Medicine at the University of Tennessee Health Science Center (UTHSC) in Memphis. Dr. Miller, professor of medicine and vice chair of the UTHSC Department of Medicine, is also an educational leader at Methodist Le Bonheur Healthcare. Dr. Miller will step down as senior vice president of Research and Education at Methodist University Hospital, but will continue to serve as medical director for Graduate Medical Education, see patients at the hospital and teach in the Methodist Teaching Practice. He was founding director of the Division of General Internal Medicine at UTHSC and previously served as associate dean for academic programs at Methodist University Hospital. A delegate from The Memphis Medical Society, Dr. Miller is a past president of the Tennessee ACP.

Tennessee Medicine  ✦ www.tnm ed.org ✦ AUGUST 2011
Iris G. Snider, MD, of Athens, was recently honored with the Etteldorf Pediatric Alumni Award by the University of Tennessee-Memphis, the highest honor given to UT-Memphis pediatric alumnae. A former president of the Tennessee Chapter of the American Academy of Pediatrics and former member of the TennCare Medical Directors Advisory Committee, she was honored for her active work to provide quality care for Tennessee children. A member of the McMinn County Medical Society, Dr. Snider is a former member of the TMA Board of Trustees and numerous TMA committees, including the Legislative Committee, TennCare Hassle Task Force, the Ad-Hoc Task Force on Supervision in Remote Settings and the Insurance Issues Committee. Practicing with Athens Pediatrics, PC, Dr. Snider is immediate past chief of staff at Athens Regional Medical Center.

Kenneth C. Susong, MD, of Greeneville, was recently honored for 50 years in family medicine in Greene County. An anniversary reception marking his half-century in practice was held at his office, featuring photos marking milestones in his career. Still actively practicing, Dr. Susong is a longtime member of the Greene County Medical Society.

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.
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The TMA Wins Tort Reform and Other Victories

By Brenda Williams

After a 10-year battle for a better legal climate in Tennessee—and some initial reforms in 2008—the TMA has delivered on its promise to win comprehensive tort reform, along with a host of other legislative victories for doctors and patients.

The Tennessee Civil Justice Act of 2011, which the TMA supported as part of a coalition of business and healthcare industry groups, finally delivers long-sought limits on non-economic damages in medical malpractice cases. That was the most important victory in the General Assembly this year ... but there were many others.

“A BANNER YEAR”

The TMA is proud of its accomplishments in the Tennessee General Assembly lately—and rightfully so, according to association leaders.

“After a great 2010 legislative session, the TMA followed with a stellar 2011!” said Legislative Chairman Charles White, Jr., MD, of Lexington.

Likewise from Board of Trustees member Michael Zanolli, MD, of Nashville, who called it “one of the most significant legislative sessions in memory,” and from President Michael Minch, MD, also of Nashville, who
Tort Reform

In 2008 the TMA delivered its first significant tort reforms, with laws enacting a notification and certification process for medical malpractice lawsuits. The number of lawsuit filings dropped significantly, which helped to lower medical liability insurance rates.

This year’s passage of The Tennessee Civil Justice Act of 2011 is the “cherry” on the top of the TMA’s legislative accomplishments. Newly-elected Governor Bill Haslam brought the reform package at the urging of the TMA and a coalition of business and health industry groups.

“The issue was never whether the Governor supported tort reform, because he ran on that agenda. But any new governor has multiple priorities, and only so many are going to fit with his first-year legislative agenda,” explained Zelizer. He said the 75-entity coalition of the state’s major health and business organizations (See “Tennesseans for Legal Reform,” opposite) encouraged the Administration to consider including tort reform in its package, but agreed to wait until 2012 if the Governor wanted to pursue other issues. That turned out to be the right approach and the Governor’s backing made the bill all the more potent.

Aided by a new Republican majority in the General Assembly, the measure easily slid past opposition efforts – led by the imposing Sen. Fred Thompson – and was signed into law on June 16.

“This is a monumental task for any governor to take on during his first year in office; we congratulate Gov. Haslam and his team, especially his general counsel Herbert Slattery, for doing what’s right to help our economy and, thereby, all Tennesseans,” said Dr. Minch.

Effective October 1, Tennessee will see major changes in its tort provisions. For the first time ever, awards for non-economic damages, such as “pain and suffering,” will be limited to $750,000. In certain catastrophic cases, non-economic damages will be limited to $1 million – including spinal cord injuries leading to paraplegic/quadriplegic; significant burns; loss of limbs; and death of a parent of a minor.

“This legislation is another win for patients and physicians,” Dr. Minch added. “The TMA strongly believes this additional tort reform will do even more to improve healthcare access, attract more physicians to Tennessee, and help reduce the cost of practicing medicine.”
Tennesseans for Legal Reform

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AmSurg
Associated Builders and Contractors, Inc.
Blue Cross and Blue Shield of Tennessee
Children’s Hospital Alliance of Tennessee
Community Health Systems
Covenant Surgical Partners
Daiichi Sankyo, Inc.
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Freestanding Ambulatory Surgical Centers of Tennessee
GlaxoSmithKline
Home Builders Association of Tennessee
Hospital Alliance of Tennessee
Hospital Corporation of America/Tri-Star Health System
Kirby Pines Retirement Community
Medtronic, Inc.
Methodist Le Bonheur Healthcare
Mountain States Health Alliance
National Federation of Independent Business
National Healthcare Corporation
Pfizer, Inc.
Pharmaceutical Research and Manufacturers of America
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TeamHealth
Tennessee Academy of Family Physicians
Tennessee Academy of General Dentistry
Tennessee Academy of Ophthalmology
Tennessee Academy of Physician Assistants
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Tennessee Alliance of Office Based Surgery Centers
Tennessee Association of Homes and Services for the Aging
Tennessee Association of Long Term Care Physicians
Tennessee Association of Mental Health Organizations
Tennessee Association of Nurse Anesthetists
Tennessee Business Roundtable
Tennessee Chamber of Commerce and Industry
Tennessee Chapter of the American Academy of Emergency Medicine
Tennessee Chapter of the American College of Physicians
Tennessee Chapter of the American College of Surgeons
Tennessee Chapter of the American Academy of Pediatrics
Tennessee Chiropractic Association
Tennessee College of Emergency Physicians
Tennessee Dental Association
Tennessee Dental Hygienists Association
Tennessee Group Practice Coalition for Advocacy
Tennessee Health Care Association
Tennessee Health Information Management Association
Tennessee Health Management
Tennessee Hospital Association
Tennessee Hospitality Association
Tennessee Jobs Coalition
Tennessee Medical Association
Tennessee Medical Association Alliance
Tennessee Medical Group Management Association
Tennessee Nurses Association
Tennessee Occupational Therapy Association
Tennessee Orthopedic Society
Tennessee Osteopathic Medical Association
Tennessee Pharmacists Association
Tennessee Physical Therapy Association
Tennessee Podiatric Medical Association
Tennessee Psychiatric Association
Tennessee Psychological Association
Tennessee Public and Teaching Hospitals
Tennessee Radiological Society
Tennessee Railroads Incorporated
Tennessee Retail Association
Tennessee Road Builders Association
Tennessee Section of the American College of Obstetricians and Gynecologists
Tennessee Society of Anesthesiologists
Tennessee Society of Oral and Maxillofacial Surgeons
Tennessee Trucking Association
The Neuro-Spine Committee
Universal Health Services, Inc.
PEER REVIEW PROTECTION

The list of victories continues with a restoration of peer review protections, after a judicial ruling last year called them into question. “We had heard anecdotally from physicians around the state that the (2010) Supreme Court decision had put a chilling effect on some types of peer review, and this legislation will certainly eliminate that concern,” explained Zelizer.

Working collaboratively with the Tennessee Hospital Association (THA), the TMA passed a bill that ensures records from a hospital or medical group Quality Improvement Committee (QIC) are confidential, privileged and protected from the legal discovery process.

PAIN MANAGEMENT

The proliferation of “pill mills” and pain treatment by mid-level practitioners were top-level priorities for the TMA this year. Working in tandem with allied health providers and with healthy support from lawmakers, the TMA was successful in passing a bill to regulate pain clinics.

“Pill mills are health care provider offices where pain medicine is prescribed without a careful history, physical exam and thorough attempt to find the source of the patient’s pain, such as obtaining an MRI or CT scan,” explained Charles “Graf” Hilgenhurst, MD, of Smyrna, president of the Tennessee Society of Interventional Pain Physicians. “I’m happy to see the TMA taking an active role in ‘raising the bar’ on this kind of practice,” he added.

Effective January 1, state certification and regulation will be required for pain clinics where more than half of the patients are treated with narcotics for more than 90 days a year; providers who do not abide by the rules will be subject to penalties, including heavy fines for physicians treating pain in an uncertified clinic. And a third provision: “To the best of our knowledge, no other state has included what Tennessee has – a prohibition on a cash-only basis of operation, other than for payment of co-pay, coinsurance and deductibles,” added Zelizer.

The TMA’s proposal to restrict interventional pain management to those with formal training in the specialty did pass an important Senate committee, but was held for summer study by the House Health Subcommittee. Dr.
Legislation we won:
- Enacted tort reform that establishes caps on non-economic damages in medical malpractice cases.
- Reinstated peer review protections that had existed for years but had been placed in doubt pursuant to a 2010 Tennessee Supreme Court decision.
- Law permitting hospitals and medical staffs to extend the requirement to sign verbal orders to up to 14 days after the order if a read-back provision and documentation of the read-back are included in the patient record.
- Established regulatory oversight of pain management clinics by the Department of Health with significant, potential penalties for clinics and healthcare providers who ignore the law.
- Required all appropriate healthcare providers serving in community-based settings to be more transparent about their license and professional capability by wearing a photo ID or supplying a document reflecting the provider’s name and professional title.
- Standardized restrictive covenants for physicians, whether employed by a group medical practice or a hospital.
- Authorized the Board of Medical Examiners, working in collaboration with the Board of Nursing and Committee on Physician Assistants, to study and recommend a standard of care for hormone replacement therapy and the promulgation of rules addressing any identified deficiencies in the oversight or delivery of such therapy.
- Supported the Tennessee Hospital Association in passage of the assessment fee that prevented the bulk of projected TennCare provider cuts.
- Mitigated recommendations for initial TennCare provider cuts for delivery of C-Sections and assessment of non-emergent conditions in the emergency room.

Bills we prevented from passing:
- Establishment of a medical marijuana law in the state.
- Enactment of a nursing home corporate practice of medicine exemption that would have allowed nursing homes to employ physicians without any safeguards.
- Expansion of the scope of practice for alcohol and drug counselors that would have added diagnosis to their professional responsibilities.
- Liberalization of statutes that provide some restriction on patients directly accessing physical therapy without first being diagnosed by a medical doctor.
- Broadening use of the term, Advanced Practice Nurse, which would have expanded prescribing privileges to non-nurse practitioners.
- Prescribing privileges to psychologists.
- Voluntary use of helmets by adults riding on a motorcycle.
- Establishment of regulatory oversight by the Board for Licensing Health Care Facilities for elective outpatient cosmetic surgical procedures.
- Establishment of regulatory oversight by the Board for Licensing Health Care Facilities of providers who deliver interventional pain management services.

Bills we amended (so the TMA could either support or remain neutral):
- Assured fast-track licensing for spouses of military personnel but who must still meet minimum state requirements for licensure.
- Streamlined access to the Controlled Substances Monitoring Database by law enforcement but with necessary safeguards still in place; established renewed focus by the boards on licensees who may be abusing their prescribing privileges.

For the full list of the TMA’s legislative accomplishments, visit www.tnmed.org/victory.
Hilgenhurst said the measure will be brought up again next year, adding that Medicare data indicates Tennessee mid-level providers perform some IPM procedures at a rate of five to 20 times that of their peers in other states.

“Patients should have every expectation that only qualified providers will be performing interventional pain procedures on them,” he said. “I certainly wouldn’t be comfortable having a procedure done on my spine unless I knew the person on the other end of the needle had been to medical school and received advanced training in the field.”

VERBAL ORDERS
Another successful TMA bill addresses the current 48-hour deadline for physicians to sign verbal treatment orders – a deadline doctors say is difficult to meet. The new law allows a healthcare facility to establish a policy that verbal orders can be signed up to 14 days after the order is issued, as long as a read-back requirement is performed and documented in the patient record.

This legislation was also passed with the help of the THA.

TITLE TRANSPARENCY
Based on a 2009 resolution by the TMA House of Delegates, the Association pursued and won a law that requires all appropriate healthcare providers to identify their credentials, so patients know exactly who is treating them. Beginning January 1, MDs and DOs, nurse practitioners, physician assistants, psychologists and dentists, as well as a number of other health professionals serving patients in unlicensed facilities, will have to either wear a photo ID or provide a handout spelling out their name and professional title, without abbreviation. For physicians, that will mean identifying themselves as a “medical doctor” or “osteopathic doctor,” rather than MD or DO.

“We believe this law should go a long way in clarifying the background and professional competency of healthcare providers in the state,” said Zelizer. “In fact, we were pleasantly surprised when the Tennessee Nurses Association came out in support of the legislation.”

For Dr. Zanolli, who sponsored the original resolution as a delegate from the Nashville Academy of Medicine, it is a victory that will foster increased teamwork among health professionals. “I consider the efforts by the TMA – enabling this legislation to be understood properly and constructively – a clear demonstration of leadership and cooperation for better health care in Tennessee,” he said.

TENNCARE CUTS
In two instances, the TMA helped lessen the impact of planned TennCare reimbursement cuts for providers. The Association worked behind the scenes to mitigate recommended cuts for caesarean-section deliveries, and for the assessment of non-emergent conditions in emergency rooms.

For the second year, the TMA also supported the THA’s proposal for a hospital assessment fee to fill a gap in the state budget. This revenue will keep the state from having to cut TennCare provider reimbursement by 8.5 percent and will preserve a $50 million fund that supports medical residency training in Tennessee.

“The TMA staff worked collaboratively with the THA to assure legislators that the medical community supported passage of this legislation,” said Zelizer.

SCOPE OF PRACTICE
Perennial quests by non-physicians to expand their scope of practice into the physician arena were defeated this year. Chief among them was a repeated effort by Tennessee psychologists to win prescribing privileges; the TMA also fended off bills seeking to legislate diagnosing by alcohol and drug counselors, prescribing by non-nurse practitioners, and direct patient access to physical therapists.

PSEUDOEPHEDRINE
The most talked-about issue this year was the continued and growing abuse of methamphetamine in Tennessee. Administration and law enforcement proposals sought to make pseudoephedrine a prescription drug; the TMA backed efforts by others to use a real-time database for tracking pseudoephedrine purchases. The final law maintains pseudoephedrine as an over-the-counter drug but caps the amount of the drug that can be purchased without a prescription and implements the database for all Tennessee pharmacists, with the data made available to law enforcement.
The Tennessee Medical Foundation and the Physicians Health Program continue groundbreaking work with Tennessee’s impaired physicians, but have also expanded the scope of educational instruction to medical professionals on all aspects of professionalism and healthy practice.

Have I been hurt at work? The question is the same, but the answer is now different.

The Tennessee legislature has passed House Bill 1503/Senate Bill 932 and Governor Bill Haslam signed it on June 6, 2011. It became effective with his signature.

This bill changes the definition of a work-related injury or illness, thus changing what conditions will be covered under Tennessee workers’ compensation.

In the past, doctors who treated injured workers by serving on the employer/insurer “Three Doctor Panel” typically assumed that if the employer or insurer made the office appointment for the individual worker, the employer/insurer had concluded that a compensable work related injury or illness had occurred. The physician would thus ignore causation and focus on diagnosis and treatment.

THE NEW LAW
The 2011 revision to the workers’ compensation law says:

SECTION 8. Tennessee Code Annotated, Section 50-6-102(12), is amended by deleting the subdivision in its entirety and by substituting instead the following:

(12) “Injury” and “personal injury”:

(A) Mean an injury by accident, arising out of and in the course of

employment, that causes either disablement or death of the employee; provided that:

i) An injury is “accidental” only if the injury is caused by a specific incident, or set of incidents, arising out of and in the course of employment, and is identifiable by time and place of occurrence; and

ii) The opinion of the physician, selected by the employee from the employer’s designated panel of physicians pursuant to §§ 50-6-204(a) (4)(A) or (B), shall be presumed correct on the issue of causation but said presumption shall be rebutted by a preponderance of the evidence;

(B) Include a mental injury arising out of and in the course of employment; and

(C) Do not include:

(i) A disease in any form, except when the disease arises out of and in the course and scope of employment; or

(ii) Cumulative trauma conditions, hearing loss, carpal tunnel syndrome, or any other repetitive motion conditions unless such conditions arose primarily out of and in the course and scope of employment;

(b) Cumulative trauma conditions, hearing loss, carpal tunnel syndrome, and all other repetitive motion conditions shall not be considered an occupational disease unless such conditions arose primarily out of and in the course and scope of employment. The opinion of the physician, selected by the employee from the employer’s designated panel of physicians pursuant to §§50-6-204(a)(4)(A) or (B), shall be presumed correct on the issue of causation but said presumption shall be rebutted by a preponderance of the evidence. (Emphasis added.)

Thus, for injuries or illness occurring after June 6, 2011, physicians will be expected to determine and document causation and, thus, compensability under workers’ compensation as opposed to compensability under the employee’s health insurance.

The law now says injuries that can be defined by a specific event that occurred at a specific time (e.g., a laceration, fracture, etc.) are still covered under Tennessee workers’ compensation. However, the intent of this change is to exclude so-called cumulative trauma or repetitive motion conditions like some carpal tunnel syndrome, shoulder impingement and elbow tendinopathy injuries from the workers’ compensation system.

EVOLVING CAUSATION
In the last decade, other states (e.g., FL, AR, MO) have changed their workers’ compensation laws to only cover occupational illnesses if the industrial exposure is at least 51 percent of causation; otherwise (Continued on page 37)
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White Paper: TMA Membership Issues, Part I

By Douglas J. Springer, MD, FACP, FACG

I have been in the Tennessee Medical Association (TMA) for 32 years and have had the privilege of being on the Membership Committee, either as a member or as chairman, for the last 10 years. I have participated in Futures I and II where the TMA made giant efforts to forge ahead to become “reinvented and more relevant to all segments of its constituency.” This was a great success as a building block to further development of its membership and now is the time to act on the tools we have been given to recruit members and make this a strategically strong organization. Although I have been heavily influenced by the other members of the Membership Committee, current and past leaders of the TMA and the staff of the TMA, I offer these articles as a summary of these discussions and meetings, as well as my own thoughts on the importance of supporting our state’s physician association. In addition I have met with our local politicians and members of the Tennessee Hospital Association recently, and these people have also had an effect on my views.

MEDIocre WITHOUT MEMBERS

The TMA is a voluntary membership organization and its strength comes from dues-paying members.

Thus, no members= no dues and strategically we become mediocre at best. With this organization comes a large amount of physician advocacy to enact laws that will make Tennessee a safe place for doctors to practice and, in turn, protect patients from the perils of faulty thinking by politicians, trial lawyers and other special interest groups. If we do not make an effort to make this state a pleasant place to practice, doctors will not locate here. That, in turn, will weaken our practices through poor recruitment and destroy the depth of primary care and specialty medicine in our state, not only through decent access to care but through the variety of offerings of subspecialty care. Patients will not be well served in this scenario. The bottom line here is this: if we cannot fully fund our legislative efforts, we will begin to lose some of our recent gains. I am seeking to enlist your assistance to encourage every non-member in the state to join our efforts and make the TMA strategically relevant. I invite every member to make contact with every nonmember in the state.

To illustrate the importance of organized medicine, we need to compare ourselves to the legal lobby. The Tennessee Bar Association (TBA) cannot mandate membership, just as the TMA cannot force its members to join just because they receive a license to practice in the state. There are about 9,000-10,000 potential dues-paying physicians in our state and 50 percent of them belong to the TMA. Meanwhile, there are 19,000 lawyers in the state and 95 percent of them belong to the TBA (in upper East Tennessee, at least) for about the same amount of money the TMA asks of its members – about $600 (although this is higher in the metropolitan areas). For this amount, they are members of the local, state and national organizations and receive CLEs through this organization. They seem to “get it.” Interestingly, the politicians (some of whom are lawyers) also know these statistics.

How do physicians expect to have a competitively strong professional organization with numbers like ours? The “tort” lawyers in this state are upset with the laws that have been passed, to the point of recently hiring Senator/actor Fred Thompson as their lobbyist to change the discussion about capitation of liability claims and perhaps to dismantle the laws that are already in place. Thanks to the TMA and a coalition of like-minded organizations, they were unsuccessful this year and the TMA saw the long-awaited passage of tort reform that included caps on non-economic damage awards in medical malpractice cases. But what about next year?

The claims frequency has gone down but the severity is rising, and this should be of concern to all of us. The cost of defensive medicine has been estimated at 30 percent of testing; in a bad environment this will continue. Each one of us has benefited from the reduction of claims filed, with less aggravation from the frequency of lawsuits and important reductions in malpractice insurance payments that should have reduced our office overhead. We came close to losing identification of our malpractice limits but the lobbyists from the TMA blocked this effort by the trial
PRACTICING MEDICINE

lawyers. Without effective lobbying by the TMA, these gains will surely be lost. The TMA is the most influential and consistent lobbying organization representing all physicians at the state level.

EFFECTS OF FRAGMENTATION
There has been a tremendous change in the politicians’ attitude toward medicine in the last two years. In the past, each specialty could lobby for their individual concerns; not so now. The word of the day is “fragmentation.” It is written in every medical economics journal, and the politicians now know this term. Everyone is now aware that the more fragmented medicine is, the more quality and service are reduced and the more costs tend to increase. That said, the politicians are now asking what the “House of Medicine thinks in Tennessee,” rather than relying on its individual segments. The legislators do not want to make decisions that would only benefit a small part of medicine, but are now taking into account how any changes would affect “the whole of medicine” and “the patients the whole of medicine serves.” There has never been a better or more important time to be involved in an organization collectively, where your voice can be heard by other doctors and by the people who make the laws. It is the only way your voice can be heard.

When I listen to non-members talk about the reasons they have not joined, it is educational. A lot of them have no knowledge about what is done for them, or they are woefully misinformed. To be truthful, we have not been effective at telling our story throughout the non-member community. We have a responsibility to contact them in any way possible so that when our colleagues decide not to join, they have at least been fully informed. The old perennial excuses exist and must be dismantled. “I must join the AMA”—No, you do not. “The organization does nothing”—No, the TMA does a lot, and you need to tell your story. “My subspecialty organization does it all for me”—No, it does not; most subspecialty organizations only deal with Washington and have had little or no involvement with state laws involving legal and insurance reforms. As I stated before, the political trend is not to pay attention to the small parts of medicine but only to the whole of medicine. “I am a DO and my organization does it for me”—No, it does not, for all the reasons stated above; the greatest concentration of DOs in the state is in East Tennessee and most are members of the TMA.

NEW CHALLENGES
We have some new problems that have surfaced to make membership even more challenging. Hospital systems are rushing in to employ physicians across the state. Hospitalists have been added to most hospital systems. Both of these groups of physicians are no longer receiving information from their practice managers regarding overhead and the cost of doing business.

Young physicians have not had a chance to interface with organized medicine in some circumstances. Medical schools have somewhat isolated themselves from the general practice climate. Some smaller and/or rural medical societies have become defunct, so who do these physicians turn to for help with practice issues? Aggressive intervention by the TMA at all these levels is needed, but you can help if you personally know these doctors or interact with them through your local CMS. Even if you are an employed physician or your system is self-insured, you will benefit from the advocacy of the TMA. Employed physicians can still be sued and even if they do not have to directly pay their malpractice insurance, the time taken away from practice and the worry is significantly severe. The more fair malpractice laws that were enacted in 2008 and improved in this year make it 60 percent less likely that physicians will be dragged into court.

If you walk into the doctor’s lounge, go to a medical meeting, some group practice meetings and definitely a quarterly staff meeting, typically one half of the physicians are non-members. TMA membership has remained static for years — around 4,200-4,500 dues-paying members. We generally recruit 300 new members and can lose up to 400 members each year; the spread of this activity is 700! Even though the TMA has put in large efforts, they have not been met with droves of new members and retention of the members we currently enjoy. Why?

How do we reorganize our county medical society (CMS) structure to reverse this trend of ineffective recruitment and retention? We have a current membership position of 50-percent at 4,500 and the desired position of 100-percent at 9,000 dues-paying members. How do we close this gap?

LOCAL OWNERSHIP
My suggestions involve developing a consistent plan of action by every CMS to reduce variance and engage all constituents. We need to change our thinking from central ownership, where we rely on the Membership Committee and TMA staff to do our recruiting, to local ownership, where we transfer our efforts to aggressively recruit and retain members to the local level. We all can learn from the larger metro societies in our state because they have large membership and can afford these services much more than smaller societies. However, smaller societies can extract what is reasonable to do locally. The problems we have inefst both large and small societies and every CMS can do a better job of recruiting and retention. We need to continue to develop recruitment and retention resources by the TMA and use these tools locally. We need to develop a plan that is highly actionable and practical, easily tracked and measured, and must be local and robust.

Even though the TMA is the largest physician organization in the state, we have primary care and subspecialty organizations that relate to the TMA through shared advocacy and philosophy that make the TMA a more effective organization. It is these great working relationships that, if they are maintained and strengthened, will enhance medicine’s strategic focus and allow us together to accomplish the shared goal of enhancing the number and quality of physicians in Tennessee for the benefit of all our citizens.

Now is not the time for physicians to choose between their own specialty organizations and the TMA for maintenance of membership. We need each other and we should find ways to support each other in these difficult times with dwindling human and financial resources. Neither the TMA
nor the specialty societies (all of them) alone can impact the breadth of issues facing us. In fact, a weaker TMA would result in a reduced number of partnerships, less strategic focus, more fragmentation of medicine as each organization withdraws into their individual silos, more cost to the individual organizations as each struggles to remain relevant, and ultimately “less organized medicine.”

TELL YOUR STORY!
Finally, you are TMA ambassadors — go and tell your story; you have a good one to tell! Tell non-members about the tort reforms we have won, the insurance laws and prompt pay laws that have been passed, the changes in the RAC auditing system, the preservation of the lack of discovery of malpractice limits and all the other accomplishments TMA CEO Don Alexander has outlined time and time again. If you don’t know what those are, have him send them to you.

We can be an awesome force if we work together. We need a change in practice philosophy with regard to TMA membership. Membership should be viewed as a cost of doing business in the state. We must convert office thinking to the mindset that the TMA is a “must expense” and should be viewed as overhead. Membership in the TMA is an “insurance policy” that you hope you will never have to use, much like homeowners and car insurance, and it should be a practice priority, not something to be paid if there is enough money left over each quarter or only in times of crisis. Part II will introduce some thoughts about accomplishing the above-mentioned tasks. +

NEW WC LAW REQUIRES MDS TO DOCUMENT CAUSATION
(Continued from page 33)

coverage is by the employee’s health insurance. This year Oklahoma and Kansas made similar revisions to their workers’ compensation laws.

This change is designed to lower employers’ cost of doing business and make Tennessee more attractive to new industry. It is also consistent with the evolving science of causation of these conditions.

For physicians who have not monitored the current literature on causation of these conditions, the best reference to have and use, in my opinion, is Melhorn and Ackerman’s Guides to the Evaluation of Disease and Injury Causation, published in 2008 by the American Medical Association. This text summarizes the current literature and shows that, for many conditions that in the past have routinely been treated in the Tennessee workers’ compensation system, workplace exposure (ergonomic stress) accounts for a very small amount of the multi-factorial nature of causation.

The key word in this revision to the law is the word “primarily,” which has not been further defined in the act but seems to indicate the legislature intended to make Tennessee like the other states mentioned above, in which 51 percent or more of causation must be the industrial exposure. The TMA Legal Department agrees with this statement, as do the private attorneys I have consulted.

Physicians should remember that if the same condition is treated under an employee’s health insurance, studies have demonstrated that the outcomes are better than if the condition is treated under workers’ compensation. Thus, in addition to changing who the physician bills for continued treatment to reflect current science, the new law should actually improve patient outcomes.

Causation analysis requires extra time, effort and documentation. Physicians should appropriately reflect this extra effort when choosing a level of service Evaluation and Management code for billing for the initial office visit. Employers have been and will still be financially responsible for the initial office evaluation of appointments they schedule, even if the physician determines the condition is not causally related under this new law’s definition. +

References:

Board-certified in orthopaedic surgery and emergency medicine, Dr. Talmage practices with the Occupational Health Center in Cookeville, TN. He is a member of the Tennessee Medicine Editorial Board.
Most physicians enter the profession with a singular motivation: to help others.

Physicians must prove their commitment to that ideal by withstanding years of training and work demands that test their resolve at every turn. And while our medical system often reveals their personal strengths, it also can expose the fragile nature of their humanity.

I have learned...

"I have learned it is all right for doctors to ask for help, for we are human beings also—sometimes faulty ones, but still humans."

—R.B., M.D.
The TMA Submits Comments in Response to ACO Proposed Rules

By Ashley Shields, JD

On March 31, the Centers for Medicare and Medicaid Services (CMS) released its proposed rules for Medicare ACOs. While the regulations are not altogether surprising, many have been met with concern and further questions from organized medicine. The TMA has submitted comments to CMS, outlining its concerns and providing suggestions for what is hoped will be a considerably different set of final rules.1

TMA VOICES CONCERNS

Prohibitively high start-up costs resulting from required investments in technology to capture and report so-called “patient satisfaction” data, among other things, are the first issue of concern for the TMA. CMS estimates these costs, along with first year operating costs, will be approximately $1.75 million, while many commentators have argued this is an unrealistically low figure.2 The concern is that all but the largest and most highly-capitalized healthcare entities will be able to risk investing in a Medicare ACO during the crucial initial three-year period.

Other concerns highlighted by the TMA: cumbersome government oversight requirements, a lack of patient accountability, retroactive and restrictive beneficiary attribution, and what the TMA sees as flawed quality measurement and savings sharing rules. The fear is that the proposed voluminous regulations regarding governmental oversight — everything from the application process to ACO structure and marketing, to a new species of antitrust law — will prevent even those entities willing and able to participate from doing so. This fear is not unfounded: both the Mayo Clinic and the Cleveland Clinic — both were models for the government in enacting the Medicare ACO project — have made clear they will not participate under the current proposed rules.3

CHANGES MADE

For its part, the government had begun to respond to some of these concerns before the comment period was even over. In May CMS announced three initiatives designed to address the stumbling blocks to bringing larger entities such as the Mayo Clinic into the Medicare ACO program, as well as assist smaller, less-capitalized groups with forming their own ACOs from the ground up. For those who already have a coordinated care organization of some form in place, CMS has provided a Pioneer ACO Model. More relevant to Tennessee providers, the Center for Medicare and Medicaid Innovation may offer an Advance Payment ACO Model that would help fund start-up costs for a new ACO. If so, it would combine with the third newly-announced initiative, the provision of free Accelerated Development Learning Sessions, to at least make implementation smoother.

While these new initiatives could go a long way toward addressing the concerns about actually creating a Medicare ACO, finding a satisfactory answer to the medical community’s questions regarding oversight and structure of ACOs may prove more difficult. For example, while the new Pioneer ACO Model will allow for the potential of prospective — rather than retrospective — assignment of beneficiaries, entities developing a standard ACO under the Shared Savings Program will be faced with retrospective assignment alone. CMS favors retrospective assignment for two reasons: the importance of awarding shared savings based on actual utilization of services (which, CMS argues, can only be measured retrospectively); and its assertion that allowing prospective assignment of beneficiaries could lead to the ACO treating beneficiaries differently from the general population. Practitioners argue, however, that if patients are not assigned to an ACO at the start of the attribution period it will be difficult to achieve the type of savings that can only come from real-time, ongoing accountability.

The new CMS initiatives offered in response to criticism are just the beginning of the next phase of ACO rulemaking, which, after the considerable backlash, will likely be slow in coming. We have little choice but to wait for the publication of the final rules later this year.

References:
1. Read the TMA’s comments to CMS on proposed ACO rules on the TMA’s Accountable Care Organization Resource Page at http://tnmed.org/hr-acos.

Ms. Shields is assistant general counsel for the TMA. Contact her at ashley.shields@tnmed.org or 800-659-1862.
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Form I-9 Paper Audits – Is Your Practice Next?

By Philip Dickey and Tom Reesor

Immigration and Customs Enforcement (ICE) raids are not what they used to be. There was a time when ICE investigators surrounded buildings, kicked in doors and herded workers into interrogations and, ultimately, onto buses and planes for deportation. Now the approach is towards increased paper audits and administrative fines; some have called this focus on paper audits “silent raids.”

Moreover, ICE has now focused its efforts on auditing and investigating employers to determine if they are satisfying the Form I-9 requirements. Driving this is a whole new crop of ICE investigators, Notices of Inspection (NOI) and fines. Recently, the Department of Homeland Security’s Immigration and Customs Enforcement issued a strategic plan for worksite enforcement through fiscal year 2014. ICE intends to create a “culture of compliance” through education, I-9 audits, and criminal and civil sanctions. Reportedly, over 2,335 NOIs have already gone out to employers in 2011, and the year is young.

The employer (that’s you) will be informed of the inspection in person or by certified mail, generally, at least three days before it occurs. ICE investigators may also use subpoenas and warrants. Investigators must be provided with the requested documents; employers who refuse or delay an inspection will be in violation of the law. Always remain courteous and professional with ICE investigators but consider calling your attorney or another professional who can assist you, because simply cooperating and turning over all documents promptly will not earn you favor with ICE.

As you know (we hope), all employers in the U.S. are required to verify the work eligibility and identity of all employees within three days of hire. Remember, Section 2 of the Form I-9 seeks documentation that “proves” individuals or new hires are who they say they are, and that they are eligible to legally work in the U.S. It makes no difference if the employee is your mother, your spouse or your best friend – you still must maintain a properly executed Form I-9.

The fines for “simple” or “technical” I-9 violations can range from $110 to $1,100 per violation. Substantive violations can be much higher, in the hundreds or thousands of dollars. Employers and their managers also can face criminal charges if they deliberately neglect their legal responsibilities in this area. So take heed; look back and conduct an independent Form I-9 audit. Some items can be corrected while others should be explained. However, if corrections are improperly made, it can worsen an already bad situation.

So, what should you do? Since no one knows the exact “profile” of a company most likely to be targeted for an ICE audit, consider these tips:

1. Complete the Form I-9 within three days of an employee beginning work for pay.
2. Keep Form I-9s in a single binder that is separate from employee personnel files.
3. Use a current Form I-9; current valid forms include Rev.08/07/09Y and Rev.02/02/09N.
4. Do not accept documents with an outdated expiration date.
5. If the document(s) presented by the new hire is on the List of Acceptable Documents, reasonably appears to be genuine and relates to the person presenting it, you may accept that document to complete the Form I-9.
6. Making copies of the documents presented is acceptable, but not in lieu of completing Section 2 of the Form I-9.
7. Make certain the person(s) in your practice who completes the Form I-9 is properly trained.
8. Strike through any information to be corrected with a colored pen, and then date and initial. Never backdate.
9. Keep Form I-9s for a minimum of three years from date of hire or one year from termination, whichever is longer.
10. Conduct a self-audit of your Form I-9s to make sure they are correctly completed. There is argument whether “fixing” incomplete or erroneous Form I-9s after being given a NOI is a good thing. Will ICE look favorably upon these corrections? The best thing to do is fix Form I-9 problems before investigators darken your door.

Mr. Dickey is a partner and director of Human Resource Services for Doctors-Management, LLC. Contact him at pdickey@drsmgmt.com. Mr. Reesor, of Knoxville, has over 30 years’ experience with the U.S. and Tennessee Departments of Labor, Wage & Hour Divisions and is an independent labor consultant for employers on wage and hour and immigration issues.

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Likewise, physicians spend the majority of their day with their patients, leaving little time for handling their own complex business and financial matters. Complex issues with accounting, tax services, financial planning, and other financial matters require a dedicated approach handled by an experienced team.

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The University of Tennessee Obstetrics & Gynecology Resident Physician Work Efficiency

By Joseph T. Santoso, MD; Jonathan T. Whaley, MD; Rye Esteep, MD; and Jim Wan, PhD

ABSTRACT

Objective: Physicians in training are commonly evaluated on their medical knowledge and clinical skills but rarely in work efficiency. We developed a Resident Efficiency Score (RES) to study the clinical productivity and efficiency of residents.

Methods: Physician Post Graduate Year (PGY) 1, 2, 3 and 4 trainees rotating on the gynecologic oncology service recorded their clinical work (using the Relative Value Units (RVU) and Medicare 1997 Evaluation and Management guideline) and their working hours. RES was calculated using total RVU per work hour logged (RES=RVU/hour).

Results: From July 1, 2007 to June 31, 2008, 36 residents rotated thru the gynecologic oncology service and were included in the study. The residency included 23 female and 13 male residents, consisting of 23 Caucasians, nine African Americans, two East Indians, one Hispanic and one Iranian. These residents, under the supervision of three gynecologic oncology faculty members, evaluated 1,168 new, 7,011 clinic and 1,568 hospital patients during the study period. Residents’ average weekly hours were similar: PGY 1 (55), PGY 2 (53.5), PGY 3 (60.5), PGY 4 (53.4) (p=0.88). Overall resident work efficiency increased from PGY 1 (RES 4.4) to PGY 2 (RES 5.6) to PGY 3 (RES 6.2), and regressed in PGY 4 (RES 5.2) (p=0.04). Work efficiency was similar among all PGY years in the operating room (p=0.5) and on the weekend (p=0.18).

Conclusion: In this study, resident physicians worked more productively up to the third year and then regressed. RES may be a useful tool in helping resident to evaluate their clinical work efficiency.

INTRODUCTION

According to the Accreditation Council for Graduate Medical Education (ACGME), a primary goal of residencies is to increase individual responsibility and resident efficiency when caring for patients. In addition to increasing clinical responsibilities, residents are generally evaluated by objective standardized tests and subjective evaluation from their faculty. Currently, the standardized testing relies on scheduled multiple choice testing to evaluate residents’ knowledge base. As resident physicians graduate and enter the workforce, they must rely not only on their medical knowledge and skills but also on their work efficiency to maintain a successful practice. However, most resident evaluations lack the ability to objectively measure efficiency. Recent literature in general surgery has noted resident inefficiency as a future site of focus for improved resident training.1 A literature review reveals a few previous studies in efficiency measurement predominantly focused in emergency medicine; however, these studies attempt to measure resident productivity by assessing the number of patients seen per hour2-4 or number of procedures.5 More recently, a retrospective study evaluating emergency medicine residents using Relative Value Unit (RVU) was conducted to more accurately record the complexity of each patient. In 1992, the federal government-in an attempt to standardize physician payments-established the Resource Based Relative Value Scale (commonly known as RVU). The Medicare Fee Schedule for each procedural code has assigned RVU, reflecting the complexity of medical work performed and documented.

In our study, we developed a Resident Efficiency Score (RES) to assess the productivity of Obstetrics and Gynecology residents in both the surgical and non-surgical setting using Relative Value Unit (RVU) per hour, prospectively. Further, we hypothesize that the training received in our Obstetrics and Gynecology Residency will supply improved medical proficiency as residents advance, as shown through a positive correlation with post-graduate year.

METHODS

Our OB/GYN program has a total of 36 residents in the department during the study year. As part of work-hour and efficiency monitoring, each resident rotating thru Gynecologic Oncology service was asked to document the number of working hours daily. The study was approved by our Institutional Review Board. Each resident rotated for a month annually through the Gynecologic Oncology service. PGY 1 residents were
paired with a PGY 4 under an attending physician at the University hospital. PGY 2 and PGY 3 residents were placed individually under faculty members in additional teaching hospitals. The attending physicians rotated thru different hospital and clinics on a half-weekly basis. Using a report form (Appendix), residents documented the number of operating cases (with CPT codes) and number of in- and outpatient interactions daily.

Twice weekly, the residents’ work hours and workload were reviewed together with the faculty. Proper coding instruction was given. Thus, we obtained 100-percent compliance from residents in reporting their work hours and load. In contrast to the real-world billing with 90 days global, the resident was given a credit for postoperative care. For example, the resident receives CPT code 99231 for seeing a post-operative patient because it still constitutes work for the resident. It would be difficult to apply strict compliance to the coding regulation since residents rotated every four weeks. For the purpose of this study, all residents were given credit as primary surgeon in calculating their surgical workload. Work hours were defined as working hours involving patients. Thus, didactic or administrative work was excluded. All residents took the same amount of vacation as directed by residency regulation. The number of shifts on-call and on weekends was similar among residents.

Using the Current Procedural Terminology, version 2008 (American Medical Association, Chicago, IL), we derived the RVU workload of a resident on a particular day. The inpatient and outpatient level of service (thus RVU) were calculated following the 2007 version of Evaluation and Management Guideline from the Centers for Medicare & Medicaid Services. The RVU was then divided by the number of working hours the resident reported to generate the RES. We defined the total RES as overall workload (surgery, clinic, rounding) divided by total work hours. Surgical RES was defined as all surgical workload divided by hours spent during surgery. Non-surgical RES was defined as clinic and rounding workload divided by non-surgery hours. Finally, we performed subset analysis on RES during weekdays and weekends. Analysis of variance (ANOVA) was used to assess for multiple comparisons. P-value < 0.05 is considered significant.

RESULTS
From July 1, 2007 to June 31, 2008, 36 residents rotated thru the gynecologic oncology service and were all included in the study. There were 23 female and 13 male residents: 23 Caucasians, nine African Americans, two East Indians, one Hispanic and one Iranian. These residents, under appropriate supervision of three gynecologic oncology attending physicians, evaluated 1,168 new patients, 7,011 clinic patients and 1,568 hospital patients during the study period.

Residents’ average weekly hours were similar (p=0.88) and none exceeded the 80-hour limit. Overall resident work efficiency increased from PGY 1 to PGY 2 to PGY 3, and then regressed in PGY 4 (p=0.04). Surgical work produced higher RES values than non-surgical work. Work efficiency was similar among all PGY years in the operating room (p=0.52) and on the weekend (p=0.18). The data are shown in the Table.

DISCUSSION
Overall, our residents are highly productive despite work-hour limitations imposed by ACGME. In the era of work-hour restriction, our residents seem to accomplish more clinical work hours in less time. In comparison with previous study using a comparable RVU system, these OB/GYN residents produced between 4.4 to 6.2 RVU/hour, while emergency medicine residents produced 3.51 to 3.61 RVU/hour. This difference may be explained by the fact that our residents performed more procedures than emergency medicine residents and the RVU method tends to give higher RVU for surgery than non-surgery encounters. In our study, OB/GYN residents seemed to produce more RVU per hour in surgery than in a non-surgical setting (clinical and hospital rounding). This difference may be again due to the design of the RVU system, rewarding procedural patient encounters more than non-surgical encounters.

PGY 1, 2, 3 and 4 seemed to be equally efficient in the operating room, likely secondary to the design of the study and rotation. In the study design, we designated all residents present and scrubbed in the surgery as the primary surgeon coding. Thus, both PGY 1 and PGY 4 received the same RVU since they were both operating simultaneously. In the design of rotation, all three attending physicians agreed on the principal of teaching residents in a closely supervised manner. Thus, attending physicians rarely allowed residents to be inefficient, spending unlimited time performing procedures. Our average duration for abdominal radical hysterectomy with lymphadenectomy

<table>
<thead>
<tr>
<th>Number of Residents</th>
<th>PGY 1</th>
<th>PGY 2</th>
<th>PGY 3</th>
<th>PGY 4</th>
<th>p-value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean weekly work hour</td>
<td>55.0</td>
<td>53.5</td>
<td>60.5</td>
<td>53.4</td>
<td>0.93</td>
</tr>
<tr>
<td>Resident Efficiency Score:</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Total</td>
<td>4.4</td>
<td>5.6</td>
<td>6.2</td>
<td>5.2</td>
<td>0.04</td>
</tr>
<tr>
<td>Non surgery</td>
<td>1.9</td>
<td>2.6</td>
<td>3.0</td>
<td>2.4</td>
<td>0.02</td>
</tr>
<tr>
<td>Surgery</td>
<td>3.1</td>
<td>3.6</td>
<td>3.6</td>
<td>3.5</td>
<td>0.52</td>
</tr>
<tr>
<td>Weekdays</td>
<td>1.8</td>
<td>2.5</td>
<td>3.1</td>
<td>2.3</td>
<td>0.01</td>
</tr>
<tr>
<td>Weekend</td>
<td>2.0</td>
<td>2.8</td>
<td>2.9</td>
<td>2.6</td>
<td>0.18</td>
</tr>
</tbody>
</table>

PGY = Post Graduate Year of the resident physician
is two hours and 13 minutes. Interestingly, there was increasing non-surgical efficiency (clinic patients and rounding in hospital) among different PGY residents observed during the weekdays but not on the weekend. We could only postulate that the efficiency difference came mainly from seeing clinic patients, not rounding, with no clinic encounters occurring on the weekend. The largest gradient in non-surgical efficiency was noted between PGY 1 and PGY 2 residents, as the learning curve is the greatest initially. Our data indicates the most efficient class within our residency was the PGY 3 class. PGY 4 was less efficient than PGY 3. We can only postulate this decreased efficiency is most likely due to additional administrative work placed on PGY 4s, which was not accounted for in our RES system.

With recent changes in work-hour reform, inquiries into resident productivity and efficiency as a component of physician training have developed. Studies delving into the impact of resident work-hour reform revealed an increase in faculty workload secondary to decreased resident workload.7,8 When considering resident productivity in conjunction with reports of resident inefficiency,9 there is significant support for the evaluation of resident efficiency within the training guidelines. Similarly, evaluations of operative volume in surgical programs with and without work-hour reforms demonstrated a lack of association between work hours and volume of operative cases. This study further recommended the assessment of the consequences of work-hour reform on surgical training and education.10 Although some studies have attempted to look at resident productivity, we are unaware of a previous study using the RVU system to evaluate surgical and non-surgical resident workload prospectively. Brennan, et al., published their retrospective study using RVU per hour.7 Their main limitation was work-hour estimation using past annual emergency room experience and the workload was estimated from billing data retrospectively. We improvised in our study by collecting the data prospectively. The use of RVUs in the evaluation of physician productivity initially showed success in the evaluation of faculty productivity in the setting of resident training. In the study reported by Albritton, et al., resident supervision was shown to improve faculty productivity. It was concluded that RVUs may be a valid tool for the assessment of faculty clinical productivity in an academic medical center.11

In our opinion, RVU is the most accepted system to estimate physician workload with universal incorporation as part of medical billing in the United States. Therefore, we use the RVU to evaluate resident physician workload in this study. In contrast to practicing physicians, the difficulty encountered using RVU in this study is found in coding for residents, who work only one month annually in their gynecologic oncology rotation. Thus, we modified the quantification of workload by giving the resident credit for postoperative work (in contrast to common use with no billing charges within 90 days after a major surgery). With the weekly RVU generated in this study, it was tempting to multiply this RVU to the 2008 Medicare conversion factor ($38.09 per RVU) to estimate the potential income generated by our residents. However, this approach would overestimate their Medicare reimbursement since we did not follow the Medicare post-operative 90 days global period and assigning residents as primary surgeon for the reason noted above. Thus, the residents’ RVU in this study should not be compared directly to the RVU of practicing physicians.

Our study has several limitations. First, RVU may be an inaccurate measure of a resident’s productivity. Before this study, we reviewed previous studies incorporating number of procedures or patients as a measure of workload. We feel the number of patients seen may not reflect the severity of each patient, possibly providing an inaccurate representation of the amount of workload. RVU has been well validated and accepted as a billing practice in the United States. Thus we feel RVU, though not perfect, is better than other measurements we considered. Secondly, residents’ efficiencies mirror their attending physicians’ efficiencies. The three gynecologic oncology faculty members rotated in a half-weekly rotation. Thus, each resident worked with various attending physicians at similar rates. Therefore, the influence of efficiency or inefficiency from the different attending is minimized. A third limitation is that our data relies on the work hours as reported by each resident; potentially, this self-reporting may be under- or over-reported. However, the resident is self-restrained knowing the faculty evaluated resident logs twice weekly and interacted with residents daily. The fourth limitation is the Hawthorne effect. These residents were aware their work efficiency was monitored, thus they may have performed more efficiently. Indeed, residents were observed to spend less idle time than before the period of the study. This Hawthorne effect was also observed in another study.7 On the contrary, in a retrospective study which did not demonstrate the Hawthorne effect, Chung and Ahmed documented that surgical residents were inefficient in their work habits.9 The fifth limitation is RES may be an inaccurate measurement of overall resident workload. Indeed, RES is only a measure of clinical work efficiency. Resident workload may also include non-clinical responsibilities such as administrative, teaching, research and others which are not measured in RES. Further, there is a bias in that RVU methodology tends to be higher in surgical than non-surgical encounters. However, by using RVU similarly for all residents, we think it equalizes the bias for all residents. Finally, our study’s findings are limited to our institution and demographic distribution; therefore, our study may not be applicable to other residency programs.

CONCLUSION

We are continuing to accrue more resident data. In the future analysis, we would analyze the potential correlation between RES with the resident’s gender, age, standard test score and other variables. We hope others would replicate our study to confirm the
presented findings. We also hope program directors may consider adapting this work efficiency score as another tool in educating OB/GYN residents.

References:

APPENDIX

Drs. Santoso, Esteep and Whaley are with the Department of Obstetrics & Gynecology, and Dr. Wan is with the Department of Preventive Medicine, University of Tennessee, Memphis, TN.

For reprints, contact Dr. Santoso at the University of Tennessee-West Clinic, 1588 Union Avenue, Memphis, TN 38104; phone: 901-322-0251; email: jsantoso@westclinic.com.
Treating Vitamin D Insufficiency in Primary Hyperparathyroidism: A Cautionary Tale

By Warit Jithpratuck, MD; Linda H. Garrett, PhD, FNP-BC; Alan N. Peiris, MD, PhD, MRCP(UK)

ABSTRACT
Vitamin D deficiency is a poorly recognized pandemic and can be associated with primary hyperparathyroidism, which is not infrequently found in the general population. No formal guidelines exist to guide therapy for suboptimal Vitamin D status in patients with hyperparathyroidism. However, there are many potential benefits to achieving a Vitamin D replete state before parathyroid surgery. Previous reports have indicated that Vitamin D status can be improved without adverse effects in hyperparathyroidism. We report accentuation of hypercalcemia and hypercalciuria with Vitamin D treatment (weekly 50,000 IU ergocalciferol x 8 weeks) in a 64-year-old Caucasian male veteran with primary hyperparathyroidism, osteoporosis and Vitamin D insufficiency. The exacerbation of hypercalcemia and hypercalciuria resolved with cessation of Vitamin D therapy. We propose that clinicians consider using modest doses of Vitamin D such as 1,000 IU daily for replacement in patients with hyperparathyroidism and Vitamin D insufficiency. The exacerbation of hypercalcemia and hypercalciuria resolved with cessation of Vitamin D therapy. We propose that clinicians consider using modest doses of Vitamin D such as 1,000 IU daily for replacement in patients with hyperparathyroidism and Vitamin D insufficiency. We recommend that serum and urine calcium be monitored if such treatment is implemented.

INTRODUCTION
Vitamin D deficiency is a poorly recognized pandemic associated with increased morbidity and health care costs. Primary hyperparathyroidism is not uncommonly found in the elderly population. As such, the simultaneous presence of both conditions poses a frequent therapeutic dilemma. Kandil, et al., reported significantly greater parathyroid hormone levels and parathyroid adenoma weight in patients with hypovitaminosis D. Moreover, Ozbey, et al., suggests Vitamin D deficiency can delay post-operative recovery of parathyroid function. Patients with Vitamin D insufficiency may also be more likely to encounter “hungry bone syndrome,” emphasizing the importance of adequate Vitamin D replacement before parathyroid surgery. Vitamin D deficiency is associated with higher preoperative PTH levels and late-onset hypercalcemia after minimally invasive parathyroidectomy. Redman, et al., suggested that pre-operative Vitamin D testing would avoid confusion regarding the etiology of persistently elevated parathyroid hormone levels following surgery. As such, many clinicians routinely treat Vitamin D deficiency in hyperparathyroidism. However, the potential adverse effects of replacing Vitamin D in patients with primary hyperparathyroidism have not been well studied.

We describe the exacerbation of hypercalcemia and hypercalciuria in a veteran with Vitamin D insufficiency and primary hyperparathyroidism following weekly ergocalciferol therapy.

CASE HISTORY
A 64-year-old male veteran was referred to the endocrinology clinic for hypercalcemia. The patient reported multiple renal stones in the past five years and one episode of acute pancreatitis, but denied peptic ulcer disease. Past medical history included coronary artery disease, hypertension, post traumatic stress disorder and degenerative joint disease. Medications included atenolol, bupropione, buspirone, lisinopril, simvastatin, zopicem tartrate, theophylline and aspirin. The patient denied taking over-the-counter calcium or Vitamin D. The patient was asymptomatic when seen and denied constipation or mental status changes. Family history was positive for renal stones but negative for hypercalcemia.

On physical examination, his vital signs were as follows: blood pressure 133/88 mm Hg; heart rate, 81 beats/min; and respiratory rate, 19/min. There were no neck masses and remainder of the examination was normal.

Laboratory evaluation yielded the following results (reference ranges provided parenthetically): intact PTH level 446 pg/ml (15-65 pg/mL), calcium level 11.4 mg/dL (8.4-10.2 mg/dL), ionized calcium 5.8 mg/dL (4.5-5.6 mg/dL), phosphorus level 2.0 mg/dL (32-100mg/mL), urine calcium 340 mg/dL, creatinine clearance 95 ml/min. Complete blood count and chemistry profile were normal apart from the calcium and phosphorus levels as mentioned above. Theophylline level was less than 1ug/mL (5-15ug/mL).

Sestamibi scan revealed uptake consistent with a parathyroid adenoma in the right inferior region. DEXA scan revealed osteoporosis with most marked changes noted in both radii.

Ergocalciferol 50,000 international
units was prescribed weekly for two months’ duration and subsequently switched to Vitamin D3 2,000 IU oral daily for three weeks without calcium supplementation. Elevation of his serum calcium from 11.4 mg/dL to 12.1 mg/dL and increase in urinary calcium from 340 mg/day to 535 mg/day was noted approximately three months later. The patient was asymptomatic; however, given the alterations in serum calcium, all Vitamin D sources were discontinued. His serum calcium decreased subsequently to 10.8 mg/dL with an associated serum albumin of 4.3 mg/dL. (Table).

**DISCUSSION**

Our patient with Vitamin D insufficiency and primary hyperparathyroidism demonstrated exacerbated excretion of both urinary calcium and serum calcium on Vitamin D replacement. Interestingly, these changes occurred without a major shift in parathyroid hormone levels. The temporal relationship to Vitamin D replacement and subsequent decline in serum and urine calcium following cessation of such therapy in the absence of alternate interventions strongly suggest Vitamin D replacement was a prime contributor to these abnormalities.

Vitamin D deficiency has been defined as 25(OH)D < 20 ng/mL and Vitamin D insufficiency < 30 ng/mL. Persistent Vitamin D deficiency may delay bone recovery after parathyroidectomy, especially in patients with advanced hyperparathyroidism. The traditional treatment for Vitamin D deficiency has been 50,000 IU ergocalciferol for eight weeks. Given the existence of osteoporosis, our patient had been placed on a dose of 50,000 IU per week of ergocalciferol for Vitamin D insufficiency. Tucci, in a study involving 56 patients with primary hyperparathyroidism using a very similar replacement regimen with ergocalciferol, failed to demonstrate adverse effects with regard to calcium. The relatively low baseline Vitamin D levels consistent with marked Vitamin D deficiency (approximately 14 ng/mL) in Tucci’s study may be one possible reason for the observed differences. Interestingly, Grubbs et al., treated 301 patients with hyperparathyroidism (with both Vitamin D insufficiency and deficiency) with a median dose of 400,000 IU ergocalciferol over 28 days and did not observe increased serum calcium, concluding that Vitamin D replacement was safe in patients with hyperparathyroidism.

Grey, et al., in a study of 21 patients with mild hyperparathyroidism, reported that two patients showed significant increases in urine calcium while the group’s mean urinary calcium levels did not change with Vitamin D replacement. Isidro, et al., in a study of 27 patients with asymptomatic hyperparathyroidism, noted an increase in urine calcium over a period of one year without a change in serum calcium with modest doses of calcifediol (480-960 IU daily).

Many clinicians routinely treat Vitamin D insufficiency in primary hyperparathyroidism, although the need for potential modification of therapeutic guidelines has not been extensively studied. In the absence of such formal guidelines and to address the optimum mode to treat Vitamin D insufficiency, we propose that Vitamin D status be checked in all patients with hyperparathyroidism. Vitamin D deficiency in most of these patients could be treated with 1,000 IU Vitamin D3 daily pending surgery. Monitoring serum and urine calcium would be prudent even with modest Vitamin D replacement in patients with hyperparathyroidism. It is difficult to know currently if lesser degrees of Vitamin D deficit should be treated in the setting of hyperparathyroidism. In any event, a more intensive approach to treating Vitamin D can be adopted following normalization of serum calcium postoperatively. Such an approach may reduce postoperative hypocalcemia and PTH elevation, as well as treat underlying illnesses likely to be promoted by a Vitamin D deficiency such as osteoporosis.

**CONCLUSION**

We conclude that treatment of Vitamin D in patients with hyperparathyroidism can be problematic and, in some instances, be associated with exacerbation of hypercalcemia and hypercalciuria. Well-designed prospective studies are needed to address this issue. Pending such information, monitoring of serum and urine calcium every two-to-four weeks, at least initially, may be prudent with any form of Vitamin D replacement.

**References:**

4. OzbeY N, Erbil Y, Ademoğlu E, et al.: Correlations between Vitamin D status and biochemical/clinical and pathological parameters in primary hy-

**TABLE. Correlation of Calcium Level and Doses of Vitamin with Therapy.**

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<td>10.8</td>
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</table>

Dr. Jithpratuck is an Internal Medicine resident with the Department of Medicine, Mountain Home VA Medical Center; Dr. Garrett is with the East Tennessee State University College of Nursing; and Dr. Peiris is chief of Endocrinology with the Mountain Home VAMC and Professor of Medicine at the Department of Internal Medicine at ETSU’s James H. Quillen College of Medicine.

Acknowledgements: This material is the result of work supported with resources and the use of facilities at Mountain Home VAMC. The contents of this paper do not represent the views of the Department of Veterans Affairs or the United States Government.

For reprints, contact Dr. Peiris at Mountain Home VAMC, Department of Internal Medicine, East Tennessee State University, Building 2, PO Box 70622, Johnson City, TN 37614; email: alan.peiris@va.gov.

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CO RRECTIONS
Charles Leonard, MD, was inadvertently omitted from the listing of the TMA Constitution & Bylaws Committee in the TMA 2010-2011 Annual Report (Vol. 104, No. 6, p. 31).

Charles Eckstein, MD, was incorrectly identified as George Eckstein, MD, in the Annual Awards section of the Annual Report (Vol. 104, No. 6, p. 38). The error was corrected in the online version.

Tennessee Medicine deeply regrets the errors.

IN MEMORIAM

SAM H. HAY, SR., MD, age 96. Died February 15, 2011. Graduate of Vanderbilt University School of Medicine. Member of Stones River Academy of Medicine.

CHARLES MARSHALL COWDEN, MD, age 79. Died May 18, 2011. Graduate of University of Tennessee Health Science Center. Member of Nashville Academy of Medicine.

GEORGINA A. ABISELLAN, MD, age 76. Died May 19, 2011. Graduate of Facultad de Medicina de La Havana. Member of Nashville Academy of Medicine.

JACK SEGAL, MD, age 90. Died May 19, 2011. Graduate of University of Tennessee Health Science Center. Member of The Memphis Medical Society.

LUCIEN WILLIAMS TRENT, MD, age 90. Died May 28, 2011. Graduate of University of Tennessee Health Science Center. Member of Knoxville Academy of Medicine.

J.C. GAW, MD, age 88. Died May 30, 2011. Graduate of University of Tennessee Health Science Center. Member of Warren County Medical Society.

AMA PHYSICIAN RECOGNITION AWARD

Physicians who earn the American Medical Association (AMA) Physician’s Recognition Award (PRA) have been recognized by the AMA for their commitment to patient care and lifelong learning through continuing medical education (CME). The Tennessee Medical Association would like to commend our members who have earned the AMA PRA recently by demonstrating that they earned an average of at least 50 CME credits per year. Congratulations to the following:

Kimberly A. Klippenstein, MD, Nashville
Elsie P. Ollapally, MD, Brentwood
Trudy Papuchis, MD, Mount Juliet
Ralph E. Wesley, MD, Nashville

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Manuscript Preparation — Manuscripts should be submitted to the Editor, David G. Gerkin, MD, 2301 21st Avenue South, Nashville, TN 37212. A cover letter should identify one author as correspondent and should include his complete address, phone, and e-mail. Manuscripts, as well as legends, tables, and references, must be typewritten, double-spaced on 8 ½ x 11 in. white paper. Pages should be numbered. Along with the typed manuscripts, submit an IBM-compatible 5-1/4” high-density diskette containing the manuscript. The transmittal letter should identify the format used. Another option is you may send the manuscript via e-mail to brenda.williams@tnmed.org. If there are photos, e-mail them in TIF or PDF format along with the article.

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References — References should be limited to 10 for all papers. All references must be cited in the text in numerically consecutive order, not alphabetically. Personal communications and unpublished data should be included only within the text. The following data should be typed on a separate sheet at the end of the paper: names of first three authors followed by et al, complete title of article cited, name of journal abbreviated according to Index Medicus, volume number, first and last pages, and year of publication. Example: Olsen JH, Boice JE, Seersholm N, et al: Cancer in parents of children with cancer. N Engl J Med 333:1594-1599, 1995.

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