WOMEN IN MEDICINE
PROFILING TMA'S LEADING FEMALE PHYSICIANS

Q&A with Dr. Phyllis Miller
TMA’s First Female President

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CONTENTS

Cover Story
15 Women in Medicine: Profiling TMA’s Leading Female Physicians

President’s Comments
5 Stay with the Pack
― John Hale, Jr., MD

Editorial
7 “Medical Professionalism”: A Proud Banner Under Attack
― Bradley E. Smith, MD

Ask TMA
9 Can an Insurance Company Recoup Payments for Services Provided During Previous Employment?

Member News
11 Dr. James Gray Receives Award from Cookeville Hospital
12 Tennessee Physician Helps Launch Mobile Prescription App
12 Physician Spotlight: Phyllis Miller, MD

Special Features
21 Hope is not a Plan!
― Dennis Flint
23 Current Telemedicine Landscape in Tennessee
― Yarnell Beatty
25 In Their Own Words: Why do I Support the Physician Health Program?

For The Record
29 New Members
29 In Memoriam
30 Advertisers in This Issue; Instructions for Authors
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One of my favorite television shows when I was a child was *Mutual of Omaha’s Wild Kingdom.* The host was Marlin Perkins, a grandfather-type individual who was also the director of the St. Louis Zoo. Late night comedy shows had a running joke about Perkins standing on the bank of a river describing an animal while his young assistant Jim was in the river wrestling with the animal, be it an anaconda or an alligator. One thing this show emphasized every week, something that is universal to all creatures, was strength in numbers. The dynamic that was shown was that predator and prey lived in the same close area, drank from the same watering hole and appeared to totally ignore each other until the predator became hungry. The prey would often group together instinctively but occasionally a wildebeest or antelope would wander away from the group and become isolated and the lion would attack. Most of the time the prey’s fellow animals would ignore the agonizing sounds made by the dying animal and would actually continue eating while the predator fed on their kin.

See any similarities to the practice of medicine in Tennessee?

“Capitol Hill is a jungle with many predators.”

The leadership of your TMA is involved in many initiatives to keep you practicing medicine in a safe, friendly environment. You might casually read about some of them in this magazine, on our website, by email or on social media. You might feel like a part of the herd and take comfort knowing that someone is watching your back. Or you might take a more active role in your membership to help defend the practice of medicine and ward off threats.

Regardless of where you stand with TMA, two of our legislative priorities in the coming year should have every Tennessee physician on alert: passing our payer accountability bill and defining patient-centered, physician-led team-based healthcare in Tennessee.

Payer accountability was brought forward by TMA in the 2014 legislative session. In layman’s terms it says a deal is a deal. It seems a shame to have to make a law that says two sides will honor a contractual business agreement, but, as most physicians realize, that is not the case with insurance companies. Two years ago we nearly passed this legislation when the payers threatened to make the contracts so onerous it would defeat our purpose. They eventually agreed to work with us in summer session to try to compromise on language that would be agreeable to both sides, acknowledging our superior position. That never happened. The reprieve instead gave them time to organize their position and they worked again during the most recent session to prevent the bill from passing the legislature. The governor’s office did not support us either and officially killed our momentum by attaching an unreasonable fiscal note to the bill at the 11th hour.

Capitol Hill is a jungle with many predators.

As if leveling the playing field with the insurance industry is not enough of a challenge, nurse practitioners are once again trying to get independent practice authority in Tennessee. They are armed with the backing of the AARP, Institute of Medicine and a $150,000 grant from the Robert Wood Johnson Foundation. They have found a sponsor of their bill in Senator Becky Massey of Knoxville. We countered in 2015 with our patient-centered, physician-led team-based bill sponsored by Senator Joey Hensley, who is also a family physician. Our bill allows APNs to practice free from oversight on simple items if the supervising physician deems okay but on complex matters they must have 100% sign off by the physician. This would allow greater access to care (which is the nurses’ primary talking point in their campaign for independent practice) but maintain the safety and quality standards that our patients expect and deserve. Better collaboration with stronger oversight would also help to address our state’s prescription drug abuse epidemic by controlling the availability of pain medications and diet clinic proliferation.

The bottom line for me on the independent practice issue—and one that will hopefully resonate with our common sense lawmakers in 2016—is that we need to eliminate silos in order to achieve more efficient, higher quality patient care. We need to strengthen the relationships on a healthcare delivery team, not sever them. We need to acknowledge that every team member plays a valuable role, and that because of his or her experience and training and skill level, the physician is the quarterback.

Both the payer accountability and nurse independent practice issues require a tremendous amount of time and resources, and just like in the wild, predators are always waiting for a sign of weakness or apathy to pounce. We will proceed with the best interests of Tennesseans on our side, knowing that in the jungle of politics right doesn’t always win.

We must band together, defeat apathy and eliminate weakness.

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Share your thoughts with Dr. Hale at president@tnmed.org.
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“MEDICAL PROFESSIONALISM”: A PROUD BANNER UNDER ATTACK

By Bradley E. Smith, MD

Widespread public access to ethical, educated, scientifically based “Medical Professionalism” is more recent than the advent of “poison gas,” the machine gun, New York subways, scheduled passenger air travel, and a host of other markers of “modern civilization.” Earlier U.S. medical schools were frequently “diploma mills” run by owners for profit, and their students frequently had inadequate education and little or no clinical experience. This situation improved rapidly between 1925 and 1940 due to the combined efforts of medical associations, the Carnegie Foundation, the Rockefeller Foundation, and various government actions.

Throughout history, the most accomplished and altruistic healers had deplored the incompetent but well-meaning and the outright charlatans who pretended to be physicians. From earliest times, legitimate physicians issued codes of ethics and guidelines by which they hoped to guide other practitioners and the public.

By the mid-1930s, the definition of and adherence to the criteria for “Medical Professionalism” in the U.S. had been de facto delegated to the medical societies by the public, the courts, and the legislatures. The operative understanding was that “Medical Professionalism” is based on a contract between a community and its physicians.

This tacit agreement was: “We, the community, grant to you physicians certain special privileges and licenses. In return we expect you to live up to our trust, to behave responsibly and morally at all times, to attain and maintain your special skills at high levels of competence, and unfailingly to demonstrate respect for your patients, for your associates, and for yourself. In recognition of this contract, the community grants you extraordinary freedoms, the responsibility for setting standards for your peers, and for monitoring compliance and adherence to these standards.”

This body of codes and accepted behaviors was never entirely static. Medical discoveries and progress, for example, eventually pointed to change of many specifics. The Hippocratic School properly for their time conceived the edict against “cutting for stone,” which was very dangerous then. Medical advances eventually made this edict obsolete.

On the other hand, unilateral external forces have at times, in recent decades, eroded the old contract between community and physician. For example, in the ‘40s and ‘50s, specialists in my field of anesthesiology were denied “Board Certification” if they “worked on a salary” instead of requesting the then traditional “fee for service” mode of practice. The reason was that our “Board” felt that a specialist anesthesiologist could be unduly influenced in his or her standards of practice by the inevitable vulnerabilities of employment status. This position was eventually nullified by rulings of the Federal Trade Commission.

By the year 2013 only approximately 33% of all U.S. physicians still practiced outside of some corporate structure, either by contract or on direct salary. In addition to the FTC, this change has been brought on by external perceptions that solo medical practice was an inefficient “cottage industry” and that corporate practice would reduce the cost of medical care.

One of the most prominent anesthesiologists of the 20th century was suspended from the New York Society of Medicine for a year in the ‘50s because he allowed a respected lay publication to describe the training program for anesthesiologists at his hospital. (It was seen as “advertising.”) Today, thanks to the FTC, billboards, the Sunday newspaper, and “National Public Radio” carry advertising by medical doctors. While most advertisements are not misleading, medical societies find it very difficult to regulate their propriety or accuracy.

In the ‘60s if I had provided anesthesia for a woman having an abortion I would have been subject to imprisonment. As we all know, this ethical and legal prohibition was knocked down by statutes and upheld by the Supreme Court of the U.S. in the early ‘70s. In fact, by 2015 this trend has progressed to the point that there have been legal maneuvers to attempt to FORCE physicians to take part in abortions against their own moral convictions!

Another such earthquake in morality already in public debate is that of permitting or even mandating a role for physicians in assisting suicide and criminal executions, a role that has until now been considered unethical.

We see that multiple forces, sometimes with little heed to medical opinion, have eroded old concepts of what constitutes “Medical Professionalism.” Regardless, I believe we physicians still have left an easy guideline for decisions that rise above politics, business, and the furies of evanescent public outcry.

We should always pose to ourselves the question, “Are my planned actions based on my belief that they are in the best interests of this patient at this time?” A true “Medical Professional” will recognize that she or his obligation to that patient transcends the physician’s own welfare or that of her or his employer, and even in some instances, the interest of outside forces.

REFERENCE:
1 Edited and modified from: Sullivan, W M CMAJ, 162:673-675, 2000
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Yes, unless your participating provider agreement explicitly prohibits it from doing so, BCBST can recoup alleged overpayment dollars even if you are billing under a different provider number or tax ID number. BCBST’s provider manual includes a provision titled “Manual Overpayment Recovery,” which states that BCBST can recover overpayments from a provider when overpayment disputes are not resolved through “normal activities.” It also states that its ability to recover these overpayments can be transferred “from one line of business to another, one Provider number and/or NPI to another, or one tax identification number to another involving the same Provider.” This language means that even if a provider leaves employment at one entity and starts employment at another, BCBST can continue to recoup or withhold payments from that provider for a billing dispute totally unrelated to the new employment.

Keep in mind that all participating provider agreements with health insurers incorporate their provider manuals, payment policies, and many other documents by reference. This means that when you sign an agreement with a health plan, you are agreeing to all of the provisions in its provider manual as well as any changes it makes to it after signing the agreement. BCBST’s was the only provider manual with language explicitly allowing it to transfer overpayment recovery activities to other NPIs and TINs in order to recoup from a provider. However, the administrative guides and provider manuals from other health plans that TMA staff reviewed did not explicitly prohibit those health insurance companies from doing the same thing, so they could very likely conduct similar practices.

Unfortunately, there is no simple solution to this potential accounting nightmare. BCBST and all other health plans are within their contractual rights to recover overpayment dollars from providers, regardless of where they work or have worked in the past. For physicians who are employed by an entity, and thus have little to no control over the billing department’s operations, try including a provision in your employment agreement making the employer responsible for all costs associated with any potential overpayment issues related to services the physician provides while employed. That way the employer would be incentivized to resolve any disputes quickly, and the impact on the physician’s future payments from any health insurers would be reduced.

If you have had a similar experience or have any questions, please contact the TMA Legal Department at 800.659.1862 or legal@tnmed.org.
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James Gray, MD was presented with the 27th annual Fred H. Roberson Award on May 28 at Cookeville Regional Medical Center’s monthly board of trustees meeting. CRMC CEO Paul Korth made the presentation, citing Dr. Gray’s commitment and loyalty to the hospital, the betterment of healthcare in the community and his many years of providing medical services in the Upper Cumberland.

Following his residency and role as chief resident in obstetrics and gynecology at Vanderbilt University Hospital, Dr. Gray moved to Cookeville in 1980 where he joined OB/GYN Associates. He attended 4,494 obstetrical deliveries during his time in Cookeville and continued to provide medical care for women in the Upper Cumberland when he left OB/GYN Associates in 2004 to join the Tennessee Department of Health’s Upper Cumberland regional office. There he provided specialty consultations in obstetrics and gynecology and oversight of clinical care.

Dr. Gray now spends much of his time dedicated to volunteer work. As president of the Putnam County Medical Society, he spearheaded an effort to revitalize the physician organization – building its membership, offering CME events for providers, and ensuring that physicians in the county and region have representation at the state level for issues affecting healthcare and physicians. He has represented the group as a participant in the TMA Physician Leadership College.

Dr. Gray’s dedication to healthcare in the community and region is further demonstrated through his work as a volunteer physician for the Remote Area Medical (RAM) Volunteer Corps and the Upper Cumberland Tennessee Regional Medical Reserve Corps Unit #1345. He serves as the Medical Coordinator of the Putnam RAM clinic, working with pre-med, pre-dental and other pre-health professionals for the clinic planned for March 2016.

In addition, Dr. Gray has been a strong supporter and physician lobbyist in support of a bill to repeal the 2001 TN Intractable Pain Treatment Act, and therefore, discourage the prescribing of opiates as first-line treatment for pain. He serves as an adjunct faculty member at the TTU Whitson-Hester School of Nursing, He is a volunteer caregiver at Magnolia Place adult respite care ministry at First United Methodist Church and is a volunteer consultant for the Power of Putnam Community Coalition. Dr. Gray and his wife Marilyn have two children and four grandchildren.

The Roberson Award is named for Mr. Fred Roberson who served on the hospital’s Board of Trustees for 27 years. The award is presented annually to the individual who best exemplifies the same dedicated and loyal service to Cookeville Regional Medical Center and its patients as was demonstrated by Mr. Roberson.
TENNESSEE PHYSICIAN HELPS LAUNCH MOBILE PRESCRIPTION APP

Dr. John Daniel Rudd, an internal medicine physician with Cedar Grove Medical Associates in Murfreesboro, Tenn., has launched a prescription app that connects prescribers, pharmacies and patients through a mobile communication platform.

The company, getRx, was founded by Dr. Rudd with his business partners, Kirk Finchem, a healthcare executive with Renal Advantage Inc., and Edward Hadley, an attorney with North, Pursell & Ramos.

“As a physician, one of the real hassles of the job has always been spending way too much time writing prescriptions, calling the pharmacy and not having quick access to my patients,” Rudd said. “I thought there had to be an app that could solve this common prescriber dilemma, but I couldn’t find anything in app stores or on the Internet. So, we invented one.”

The app is available through the Apple store, Google Play and Amazon.

MEMBER NEWS

PHYSICIAN SPOTLIGHT

Q&A: PHYLLIS MILLER, MD
Women’s Institute for Specialized Health, PLLC | Hixson, TN
TMA’s First Female President (2005-’06)
Chattanooga-Hamilton County Medical Society’s First Female President (1998)
President, Medical Foundation of Chattanooga (2011-’12)

Q: How was your experience as TMA president?
A: It was a great experience. I had a lot of doors opened and learned a lot of things about organized medicine. I had the opportunity to go to other states and meet with their medical societies. I also had the opportunity to meet many doctors across the state. We think our problems are just our problems, but I found we’re all fighting the same battles everywhere. There might be a little different nuance to it here and there, but we all have similar issues.

I think most women in leadership would say, first of all, we want the job because we’re qualified for it, secondarily because we’re women, but we do want to have equal opportunity with men.

Q: Has the landscape changed for female physicians practicing medicine in Tennessee?
A: Absolutely. When I first started, we were still very much in the minority, and there were not many women in leadership positions at all. Now, close to 50 percent of physicians, in general, are women, more so in some specialties than others. Women are still underrepresented in leadership positions, I believe, but there are many more than in the past. Women and men, everybody needs to do the best job they can do, but I think gender-wise we each bring a different perspective to the table.

There is a lot more acceptance of women in our professional organizations and a lot more participation and presence of women. The issues are kind of the same for everybody, but the issues of balancing family time with professional time...
is generally more challenging for women than men. Child care responsibilities still tend to fall more on women than men. This limits what women who have families can do with their time. Our families come first – as they should – but we can still support organized medicine through membership and being more active when time permits.

Q: What advice do you have for younger female physicians about decisions they are making for their career, and getting involved with organized medicine?
A: My main advice would be to stay focused, do the best you can at whatever you do, and realize your potential. Not everybody is going to be cut out to get really involved in organized medicine, but everybody needs to be a member of our professional organizations. I think it’s important for organized medicine to be strong, because without it we would have no representation at the table with insurance companies, politically or otherwise. I think it’s extremely important and that everybody ought to give to the extent that they can in both time and money.

For younger women, I would say put your family first, but support organized medicine by membership, and with active involvement. For those women who do not have families for whatever reason, being involved in organized medicine can be very fulfilling, while at the same time contributing to our profession.

Q: What brought you into positions of leadership?
A: I worked from the department level up to leadership in the hospital, the medical society, then the TMA. It began with somebody identifying me as a potential leader and asking me to become involved, and from there it just grew.

I found I enjoyed knowing what was going on and being involved in making things happen rather than sitting back and letting it happen to me. I was fortunate that somebody identified me as having some potential.

You give a lot of free time, but a side benefit is meeting great people, meeting like-minded people and others whose goals are the same. Everyone is working hard to make medicine as good as it can be.

Q: Who were your greatest professional influences?
A: When I went to medical school, there were six women in a class of 100, and when I first started my residency I think there were two of us in a class of 12 so we were very much in the minority. We didn’t have too many female role models. They were in the minority also. We had some, but most of my mentors were men. I always said it was the men who groomed me to be what I could be.

However, there were two women, in particular, who stood out. When I first went to medical school, I had a woman as a professor in gross anatomy. She had the six of us to her house for dinner one evening. I remember us expressing concern that our social skills might not be as good as they should be, since we spent all our time studying. She remarked, “If you girls can dissect a cadaver, I think you can pour a cup of tea.” Little things like that really made a difference.

I had a program director when I first started my residency program who was very influential. She was dynamic and very much from the old school. She left after six months, but I always said I learned more in those six months than I did my whole time there.

The men who were my mentors also – all of them – very much instilled a work ethic and pushed me to reach my potential. They were involved in the medical community and the community as a whole. So I couldn’t really name just one person. There were a number of them. They were great examples.

Q: How did serving as president of the TMA influence your views on medicine?
A: It was a busy year and took up every minute of my spare time, but it gave me a broader view of the non-clinical issues that medicine faced and the policies and politics. I think we spent the most time and effort stopping things from happening that would have been harmful to the practice of medicine.

Q: What do you see as the biggest challenges and opportunities for the future of medicine?
A: I don’t know if there’s anything in particular that’s unique to women physicians other than the balancing act of family and work. For all of us, the changing landscape of how medicine is practiced is a challenge. The change to payment for outcomes is both a challenge and an opportunity. More and more physicians are going to an employment model, which has its pros and cons. This actually can often be attractive to female physicians, in particular, in that it takes away having to worry so much about the business of medicine and can allow for more defined work hours.

Electronic medical records is a huge issue for the future. The younger physicians are growing up with it and will probably be able to survive better than people like me. I think it will be years before EMR functions as it should. Interoperability is a challenge. Also, privacy of records is a concern. At the same time, EMR should allow us to gather more accurate data on which to make decisions.

Q: Why should more physicians join the TMA?
A: The TMA is the organized body that represents all of us. Collectively we can do more than we can as individuals.

One of the strengths of the TMA is the political process and the advocacy, because they are the boots on the ground and are there. We all have day jobs that limit the amount of time we can spend in the political process, so I think that’s where the TMA is valuable.

TMA also gives us opportunities to stay abreast of the changes in medicine such as insurance, ICD-10, etc.

The more members we have in TMA, the stronger the organization will be.
As more and more baby boomers hit the retirement age of 65, many things need to be evaluated. One of the major decisions a person should make when entering his or her senior years is selecting medical coverage options. For those approaching age 65, taking the time to review the types of coverage available and weighing the overall financial impact of those options will help you and your spouse plan as you move into the next stage of your life. Many costs that arise during retirement are due to unexpected medical procedures and high-price prescriptions.

Some in or approaching their Medicare years are under the misconception that Medicare is going to cover all medical expenses, but unfortunately that is not true. Medicare does not cover all medical costs, and the out-of-pocket expenses for medical care can still have a sticker shock effect. According to the Employee Benefit Research Institute's October 2014 Executive Summary, “In 2011 Medicare covered 62% of the cost of healthcare services for Medicare beneficiaries 65 and older, while out-of-pocket spending accounted for 13%, and private insurance covered 15%. Medicare was never designed to cover expenses in full.”

One part of Medicare that is often responsible for large out-of-pocket costs is prescriptions, especially when people fall in the donut hole. The Patient Protection and Affordable Care Act of 2010 (PPACA) includes provisions to minimize the size of this donut hole but it did not eliminate it all together. According to EBRI’s report, by 2020 those enrolled in Medicare will pay 25% of both name brand and generic prescription drugs when they are in the donut hole. In the future you could end up paying a greater percentage due to the financial restraints of Medicare and penny pinching efforts of employment-based retiree health programs.

When planning for retirement, out-of-pocket medical expenses should be put into a budget. Prescription costs alone can set some people back quite a bit. According to EBRI’s findings based on median drug prices, if a man retired at age 65 in 2014 he “would need $64,000 in savings and a woman would need $83,000 if each had a goal of having a 50% chance of having enough money saved to cover health expenses in retirement.” The savings total for women is higher due to their longer life expectancy.

The Tennessee Medical Association would like to remind members about the Tennessee Drug Card, a free prescription assistance program available to all residents with no age or income requirements. Although many routine medications may be covered by Medicare, it is always worth shopping around to see if there is a better rate through a program like this. When an individual falls in the donut hole, he or she can use this program to help offset the cost of high-price prescriptions.

Go to TennesseeDrugCard.com to print a free card or check the price of your medication using the Tennessee Drug Card. For questions call 1.888.987.0688 or email natalie@tennesseedrugcard.com.
WOMEN IN MEDICINE
PROFILING TMA'S LEADING FEMALE PHYSICIANS
Dr. Michel McDonald always wanted to be a doctor.

It was a calling she felt during childhood when she was treated by a dermatologist.

“It’s kind of funny when I see people from my childhood or high school and they say, ‘Wow, you really did grow up to do exactly what you said you would do.’ I was just always really committed to being a dermatologist,” she said.

Just a few decades ago, medicine was, like so many other fields, a male-dominated profession. Dr. McDonald’s experience, however, affirms that the field is changing for the better. She has never experienced or even noticed any gender bias in medical school, residency or practice at Vanderbilt Medical Group in Nashville. Teachers, colleagues and patients have always treated men and women the same from her perspective, indicating that much-needed balance has not only occurred but is embraced.

The number of female physicians has been steadily increasing in Tennessee and in the U.S. According to the U.S. Census Bureau, 32% of U.S. physicians are female. That’s nearly twice as many as in 1990 (17%) and a nearly six-fold increase since 1975 (American Medical Association). About one-third of all Tennessee physicians are female. TMA membership is 26% female.

The next generation of U.S. physicians appears to be even more gender neutral. The American Academy of Medical Colleges reported in November 2014 that 47% of students enrolled in U.S. medical schools were female, compared to 46% in Tennessee.

“The door is wide open,” said Dr. Nita Shumaker, a pediatrician in Chattanooga and member of the TMA Board of Trustees.

Dr. Shumaker was one of only two female chiefs of staff at Erlanger Health System, the ninth-largest public hospital in the country and the tri-state region’s only level one trauma center. She believes that while the industry as a whole has transitioned to become more equal in males to females, healthcare organizations are still slow to groom females into leadership positions like medical staffs, and within organized medicine.

“I’m really proud to see how many women we have in leadership currently in the TMA, but we’ve still had only one female president,” she said. “We’re on the cutting edge. I don’t think it’s that the system pushes women down. I think it’s a matter of women stepping out to make themselves available for leadership roles and taking on responsibilities. When we go to meetings it tends to be the same people at all the meetings because those are the people who bring themselves forward and say, ‘I want to help.’ Those people naturally get propelled to the top.”

Dr. Shumaker’s leadership track began in Chattanooga approximately 20 years ago when she navigated her way through group mergers and acquisitions, transitioned to solo practice and helped grow her group into what is now a 50-doctor group. She’s never been shy about raising her hand to improve business operations and assume leadership positions on a medical staff or within her group. In addition to her chief of staff role at Erlanger, she has served as chief of pediatrics at the children’s hospital, secretary of the medical staff and vice chief of staff at Erlanger, and as President of the Chattanooga & Hamilton County Medical Society. She currently serves on the Erlanger Board of Directors and as Secretary-Treasurer of the CHCMS, and has attended TMA’s Physician Leadership College (now John Ingram Institute for Physician Leadership).

“You are either in control of your destiny or somebody else is, and I don’t follow well. How can you make changes and affect the world if you are not in a position to lead?”

Dr. Jane Siegel, a hand surgeon in Nashville and current Speaker of the TMA House of Delegates, thinks it’s historically common for women to feel more comfortable working in groups or organizing people rather than stepping into leadership roles themselves, and that overcoming that trait is the key to affecting change.

“Any leadership position is a good leadership position, and that’s why I would encourage more female physicians to seek out leadership training anywhere they can. It gives them tools to help deal with people’s perceptions of them in a leadership position.”

Opportunities for Females as Physician Leaders

Dr. Nita Shumaker in Chattanooga approximately 20 years ago when she navigated her way through group mergers and acquisitions, transitioned to solo practice and helped grow her group into what is now a 50-doctor group. She’s never been shy about raising her hand to improve business operations and assume leadership positions on a medical staff or within her group. In addition to her chief of staff role at Erlanger, she has served as chief of pediatrics at the children’s hospital, secretary of the medical staff and vice chief of staff at Erlanger, and as President of the Chattanooga & Hamilton County Medical Society. She currently serves on the Erlanger Board of Directors and as Secretary-Treasurer of the CHCMS, and has attended TMA’s Physician Leadership College (now John Ingram Institute for Physician Leadership).

“You are either in control of your destiny or somebody else is, and I don’t follow well. How can you make changes and affect the world if you are not in a position to lead?”

Dr. Jane Siegel, a hand surgeon in Nashville and current Speaker of the TMA House of Delegates, thinks it’s historically common for women to feel more comfortable working in groups or organizing people rather than stepping into leadership roles themselves, and that overcoming that trait is the key to affecting change.

“Any leadership position is a good leadership position, and that’s why I would encourage more female physicians to seek out leadership training anywhere they can. It gives them tools to help deal with people’s perceptions of them in a leadership position.”
SEPTEMBER IS WOMEN IN MEDICINE MONTH

The American Medical Association Women Physicians Section annually honors physicians who have offered their time, wisdom and support to advance women in medicine. View resources, learn more about the milestones of women in American medicine over the past 165 years and help celebrate this year’s theme, “Innovators and Leaders Changing Health Care,” at ama-assn.org.

You can also observe Women in Medicine month by sharing your stories with us at Facebook.com/tnmed or on Twitter @tnmed.

OPPORTUNITIES WITH TMA

Dr. McDonald’s first experience with organized medicine came at the behest of a colleague. She was asked to testify in front of the Board of Medical Examiners about a proposed law that would prohibit a certain local anesthesia to be administered in the office setting. She agreed, and her participation helped prevent the law from passing.

“I realized right then that if no one had gone down there, that change might have gone through, even when there was no good reason for it. It was a very scary experience, but it opened my eyes that sometimes people making the decisions aren’t the ones practicing medicine. It’s never good for them to hear only one side of an issue. They need education,” she said.

Not long after that initiation into legislative advocacy, Dr. McDonald was able to participate in the first class of TMA’s Physician Leadership College through a sponsorship from the Nashville Academy of Medicine.

“That’s what got me hooked,” she said. “I got to meet leaders of TMA and really see how they were working on issues and how I could really make a difference. Sitting on the outside you wonder why things don’t happen quicker, but once you get involved you see how much time and effort goes into big issues. That experience gave me the skill set to become more involved, and also the confidence that I could make valuable contributions.”

She later became President of the Nashville Academy of Medicine.

FIRST FEMALE SPEAKER OF THE HOUSE

Like Dr. McDonald, Dr. Siegel’s foray into TMA leadership began with the Physician Leadership College. Typical leadership college graduate classes have reflected a healthy mix of men and women, ages and ethnic backgrounds, which better reflects the makeup of Tennessee medicine, and gives younger physicians an opportunity to explore leadership roles.

Dr. Siegel plainly recalls her first impression of the TMA House of Delegates. It was not exactly welcoming on the surface for a young female physician, but turned out to be the catalyst she needed to pursue her own leadership path.

“The leadership at the podium seemed like an exclusive club of all older, white males, like you’d have to know someone to get in. It was kind of disillusioning in terms of even wanting to pursue any kind of a leadership role, but ironically it was some of the older physicians who suggested doing the leadership college.”

In April, Dr. Siegel became the first female physician to preside over the TMA House of Delegates as Speaker of the House.

“My getting to be Speaker was a direct result of the initiative TMA took in trying to mature into a more diverse, different-looking group that better reflects Tennessee medicine. Going forward, the more women and minorities we get in leadership positions the more they want to attract other women and minority physicians into the fold. I think it is really moving in a good direction.”
ADDRESSING THE CHALLENGES IN HEALTHCARE

Dr. Siegel’s ongoing frustrations in practice fuel her leadership style.

“When I reach a certain frustration level and feel like something needs to change, I don’t mind being the one to ‘kick the bear’ and make something happen,” she said.

Not only are physicians saddled with increasingly complex regulatory demands and government mandates, but also unjustly blamed at times for public health issues. TMA is an outlet for female physicians to push back, defend the profession and call for more individual and legislative accountability.

“The whole world from my perspective seems to be pointing fingers at doctors and assigning us responsibility for the poor health of the nation, when in reality there are other factors on which we have little influence, including public health policy and legislative policy, and even personal/individual behaviors,” said Dr. Shumaker. “There is power in numbers. With so many forces pushing against the house of medicine, the more voices we have saying, ‘Look, this is what we can control, but at some point these public health issues need to change so that future generations of Americans are healthier,’ then we will make progress toward better public health, which is why we became doctors in the first place.”

Another important industry trend and opportunity for TMA, Dr. Siegel believes, is helping physicians who want to remain autonomous dictate their own future, while also delivering value to a growing number of employed doctors. TMA must find a way to be relevant among physicians who choose employed practice and still fight to protect the physician-patient relationship, and advocate for the independent physician in the legislature and with insurance companies.

“I’m especially interested in getting employed physicians together under the TMA umbrella, because it’s going to be a huge segment of the physicians in the future. We need to help them organize, and I’d rather see them organize under the TMA banner than under their own banner.”

More doctors being employed by larger institutions and fewer independent practitioners or small groups means fewer opportunities or perceived needs for physicians to get together for collegial reasons. Dr. McDonald believes this actually creates opportunities for TMA to simply connect more physicians of different specialties, geographic areas and practice environments.

“That has been the best part of TMA for me,” she said. “I mainly knew dermatologists before TMA and have always been employed by a hospital. As you see more primary care and hospitalists and other specialties, employed physicians and solo practitioners, and hear about the different ways that people practice medicine, you can really understand someone else’s perspective that may be different from yours and why. I think that exposure has altered my position at times, in a good way.”

Physicians of either gender, any specialty, town or ethnicity tend to find common ground when it comes to addressing the pressures they all face.

“It’s easy when you are working so hard on your day-to-day practice and trying to raise kids or have some sort of personal life to lose sight of the fact that other people are truly encountering the same challenges,” said Dr. Shumaker. “The first step is getting everyone out of his or her office and having a way to socialize and mingle. You’re naturally going to have some people who are not so dismayed and afraid of what’s happening in medicine, so they are better prepared to adjust. From those people there will be some who eventually step into leadership roles.”

For Dr. Siegel, more time dealing with regulatory or insurance requirements means less time with patients. That, she says, is something that is universal among physicians in Tennessee and across the U.S.

“More and more we are drawn away from patient care and sucked into a computer program or endless dictation and documentation that has nothing to do with good patient care and everything to do with insurance companies and third-party issues. The biggest challenge is fighting for that face-to-face time with patients so you maintain communication and focus on the patient relationship.”

THOUGHTS ON DR. MCDONALD, SHUMAKER, SIEGEL AND THE FUTURE OF FEMALE LEADERSHIP WITHIN THE TMA?

“When I was president, we discussed and looked at whether to create a separate women physicians group within TMA. My thought and a lot of my colleagues, too, was I didn’t really want that. I just want us to be considered equally within TMA – not as a separate group, but just have the same opportunities within the organization. We are doctors first of all, and men and women second. I am excited to see them in their leadership positions, and I think we’re getting more representation.”

– Phyllis Miller, MD
Women’s Institute for Specialized Health, PLLC  |  Hixson, TN
TMA’s First Female President (2005–06)
ADVICE FOR YOUNG PHYSICIANS

EACH OF THESE POWER DOCTORS OFFERS HER OWN ADVICE FOR YOUNG PHYSICIANS LOOKING TO BREAK INTO A CAREER IN MEDICINE OR TAKE ON MORE LEADERSHIP ROLES.

“‘You don’t have to know everything when you start. Sometimes you feel like you have to be perfect at something or really well trained before you can jump in, and I think you can start into organized medicine and learn your way, gather your skills as you go. Also start off small and keep a balance. Do something if you are passionate about it. No one is going to send you to Capitol Hill the day you get involved or force you to do anything you don’t want to do. It can be really fun and rewarding.’

– Dr. Michel McDonald

“‘Get involved with your local medical society and go out to the events so you can meet other doctors, not just in your specialty. I think this relieves an enormous amount of stress going forward in medicine because you understand that there are other people who have the same concerns that you have, and you have other people that you can meet and call on. You cannot be a leader until you get involved and know what is going on. We’re stronger when we band together.’

– Dr. Nita Shumaker

“‘There are so many women now in medicine that there is always someone you can look to for advice or help moving forward in your career. I would also say that a career in medicine doesn’t have to be a sacrifice in terms of family. Women should feel confident in becoming involved in decision-making to advocate for themselves as well as for the men in the practice in terms of lifestyle balance. Sometimes women put themselves at a disadvantage by avoiding the limelight and kind of doing the work under the radar. Advocate for yourself and do not be afraid to step forward and put your ideas out there.’

– Dr. Jane Siegel
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Greetings to the Tennessee Medical Association membership. Throughout my more than three-year relationship with TMA, I have applauded the association’s aggressive efforts to ensure Tennessee’s doctors and staff are ready for the expected ICD-10 transition on Oct. 1, 2015 (a scant three months away as of this writing). CMS has made its position well-known by the amount of time, money and resources it has dedicated to external testing. In short, the government wants to avoid additional egg on its face at all costs. Everyone hopes this is the equivalent of Y2K, but hope is not a plan; planning is a plan. It is the best way to assure your success.

So…for those of you “hoping” for a delay, or “hoping” that providers and coders can somehow figure out ICD-10 with three months left until the door is closed I say to you, “Hope is not a plan.” The key to preparation is to find your ICD-10 reality. For your practice, we’re not talking about the 70,000 new codes in the entire ICD-10 code set. We’re talking about the 10 to 20 codes you most often use in your practice. Using a combination of the GEMS conversion tool (which can be found at CMS.gov) and code books, convert those ICD-9 codes you most frequently use into the range of ICD-10 codes you will use after Oct. 1 and identify the new documentation element requirements you do not currently capture.

Remember, the elevator speech about ICD-10 is that, “Doctors have to write down more stuff.” If you identify and incorporate the “more stuff” now, you are most of the way there. The other key component is your technology. By now, your EHR vendor should have updated your software with an effective ICD-10 coding engine so you can start dual coding five encounters a week to make sure you get into the documentation rhythm. If you do these simple, easily achievable things, you will have met most of the implementation challenges by Oct. 1 and be ready to go.

Regardless of what you think about ICD-10, please remember the diagnosis codes you submit are your public face to the outside world. You could be the best physician in your specialty in the state of Tennessee, have the best outcomes, the best staff, and provide the best care but no one will know it when they focus on your data to measure your effectiveness. DHHS Secretary Burwell made an earth-shattering statement on Feb. 13 when she said, “30% of Medicare fee-for-service reimbursement will convert to a value-based performance model by the end of 2016.” (Next year!) Your ICD-10 acuity reporting is at the very heart of the ability to measure cost-effective quality of care. Think also in terms of ACO membership. If you submit unspecific diagnosis codes, not only will they not meet the medical necessity benchmarks for payment, but you also present yourself within an unsophisticated practice that doesn’t really know what’s wrong with the patient. This concept holds true for Patient Centered Medical Home Status, PQRS, managed care contract negotiations and a host of other scenarios that measure you based upon the acuity levels of your patients as illustrated by your coding habits. Ultimately, better data should translate to better care and at the end of the day, that is what is most important.

Without being a “doom and gloom” merchant, it is worth noting what happens if you are NOT ready for ICD-10 on Oct. 1.

- Loss of productivity – In countries that have already implemented ICD-10, there was an average 20% drop in provider productivity (taking more time to “hunt and peck” for required documentation and codes).
- Overworked billing staff – Can your practice absorb a dramatic increase in following up on claims issues? Can you afford an increase in pended, denied and appealed claims due to ICD-10-related issues?
- Loss of revenue due to lack of medical necessity – If you perpetuate sloppy ICD-9 coding habits that routinely mean an “unspecified” code selection, expect this problem to increase exponentially in ICD-10.
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There have been winds of change blowing towards a friendlier climate for telemedicine in Tennessee. Our General Assembly addressed the topic two years in a row through the enactment of substantive legislation, and the Tennessee Board of Medical Examiners is closing in on the promulgation of final comprehensive rules for telemedicine. This article takes a snapshot of the regulatory landscape of telemedicine in Tennessee as of summer 2015 and presages what it will look like when the BME’s pending rules are finalized.

Telemedicine has received a lot of attention. Critics see it as an imposition on the personal aspect of the physician-patient relationship, the disintegration of continuity of care, and the road to the proliferation of online “pill mills.” Proponents see it as a way to expand access to care efficiently, ease workforce challenges and respond to surveys increasingly indicating that patients want it.

Barriers are the myriad of ways regulators have handled it in different states and the glacial pace at which the federal health programs and commercial health insurers have embraced it, especially with respect to reimbursement. Thawing is likely to occur in response to patient and employer demand for access to telemedicine and a better confidence in the technology involved.

Like it or not, Telemedicine is a rapidly growing industry. A Tennessee law that passed during the 2014 legislative session addressed the commercial health insurance aspect of telemedicine. It requires health insurers to cover/reimburse for telemedicine consistent with in-person encounters. The law requires health plans to provide coverage under a health insurance policy or contract for covered healthcare services delivered through telehealth. The law excludes telephone, e-mail, and fax from the definition of telehealth. It does not allow health plans to exclude healthcare service from coverage solely because it is provided through telehealth and is not provided by an in-person encounter between a healthcare provider and a patient. It requires these plans to reimburse healthcare providers who are out-of-network for telehealth care services under the same reimbursement policies applicable to other out-of-network healthcare providers.

Public Chapter 261, enacted this year, attempts to place telehealth on the same footing as in-person encounters. It also prohibits health provider licensing boards from establishing more restrictive standards for professional practice of telehealth than for in-person encounters. The new law requires a physician who practices telemedicine to be licensed to practice in Tennessee.

The provisions of Public Chapter 261 aimed at the licensing boards, standard of care parity and controlled substance prescribing were reactions to the Board of Medical Examiners’ proposed comprehensive telemedicine rules released in February 2014. The original rules were constraining to the practice of telemedicine. For instance, they required that an in-person encounter take place before a telemedicine encounter could take place, that an annual face-to-face examination take place, that a facilitator be present with the patient, and that only board certified physicians could even practice telemedicine (except those with a telemedicine license).

After reviewing scores of public comments filed during two rulemaking hearings, including two sets of comments submitted by TMA, the final version of the Board’s rules, expected to undergo legal review and be effective sometime in 2016, will be more telemedicine friendly than the original proposed rules. In monitoring the Board’s debates, I conclude that a more palatable balance between public safety protection and broad telemedicine access has emerged.

Some of the changes incorporated into the final version of the Board’s rules include the ability to verify patient identity using industry-standard electronic means instead of requiring a facilitator to be in the room with the patient. The Board deleted its blanket requirement that a patient be seen in person before a telemedicine encounter can take place. A blanket prohibition on prescribing controlled substances vanished with the passage of Public Chapter 261. These issues were sticking points in rules established by the Texas Board of Medical Examiners that have been the subject of recent litigation. As of this writing, telehealth provider Teledoc was successful in obtaining a temporary injunction prohibiting implementation of the Texas Board’s telemedicine rules based on antitrust and Commerce Clause reasons.

(Continued on p.27)
STAY ON THE ROAD TO
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OCT 1, 2015

STEPS TO HELP YOU TRANSITION

The ICD-10 transition will affect every part of your practice, from software upgrades, to patient registration and referrals, to clinical documentation and billing.

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- Test Your Systems and Processes—Test within your practice and with your vendors and payers

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In the midst of the Tennessee Medical Foundation’s “Five Years … Five Reasons” support campaign, the TMF has been asking some of its most dedicated supporters why they believe in and financially contribute to the program – and why they believe other physicians should do the same. Below are a few thoughts from one of our TMF champions, Dr. J. Mack Worthington, MD, FAAFP.

Dr. Worthington, formerly of UT Memphis and currently UT College of Medicine in Chattanooga, first became acquainted with the Tennessee Medical Foundation Physician Health Program via a phone call from then-TMF Medical Director Dr. David Dodd. He was serving as founder and director of the residency program at UTCOMC and Dr. Dodd had a program participant who needed his help.

“In order to get back into practice, to get his license, he had to go back to do additional training,” said Dr. Worthington, who also shared that his initial reaction was that he could not take on monitoring someone through an addiction illness. “But knowing that the TMF, after speaking with Dr. Dodd, would provide that part, I was very willing to take this physician into my residency program to give him the training he needed so he could get back into practice. That was very satisfying to see how well he did and how successful he became, and how it enabled him to regain not only his license but also his family and his life. It was amazing to see, and I was happy to be a part of it,” he said.

Since then, several TMF PHP participants have been through UTCOMC’s residency program and have successfully gone back into practice in their communities. “I tell each one of them to stop and think about what this has meant to them and that they should be giving back to support the care and treatment of other physicians who will go through the program,” Dr. Worthington said.

Dr. Worthington was convinced enough to serve on the TMF Board of Directors from 2006 to 2012, including two years as Board President. He’s a current donor as well and believes physicians in Tennessee, especially those whose lives and careers were restored by the program, should be contributing to the PHP so it continues as a resource for doctors in crisis.

“Because the PHP is needed, this program needs to continue being successful,” he said. “There are still going to be doctors affected by alcohol and drugs, and I can’t think of any better way to support your fellow physician than to participate in this program.”

To join Dr. Worthington in supporting the mission and the work of the TMF Physician Health Program, contact Vince Parrish at 615.467.6411 or vincep@e-tmf.org, or give online at e-tmf.org/donations.php.

If you or a colleague need assistance from the TMF Physicians Health Program, please contact TMF Field Coordinator Jeanne Breard, RN, at 615.467.6411.
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HOPE IS NOT A PLAN! (Continued from p. 21)

- CRANKY DOCTORS!! – Your duties are difficult enough as it is without playing “catch-up” because you were not prepared for ICD-10.
- Breakdowns across the practice continuum – You do not want interruptions in daily workflow, order entry, referrals, reporting, etc.

So when it comes to ICD-10, please don’t be like the doctor whose receptionist runs back and says, “There’s an invisible man in our waiting room!” And the doctor says, “Tell him I can’t see him.”

Do the easily accomplished, high-impact steps noted above. You still have time if you start right now. ICD-10 is not going away and please remember…”Hope is not a plan!”

Dennis Flint is an award-winning, nationally known speaker, consultant, and educator and is the managing partner of The Talon Group. He has addressed numerous TMA conferences and has actively participated in more than 60 ICD-10 implementation engagements across the country. He can be reached at dftalon77@gmail.com or 970.390.8970.

CURRENT TELEMEDICINE LANDSCAPE IN TENNESSEE (Continued from p. 23)

The Tennessee Board’s rules also remove blanket requirements for a face-to-face encounter to occur every fourth visit, and for a provider to carry ABMS board certification in order to conduct a consultation or referral by telemedicine.

The “kinder, gentler” telemedicine climate in Tennessee should provide both growing pains and opportunities for Tennessee physicians to address their patients’ needs.

National ACO (NACO) is a Los Angeles-based, physician-owned and governed, Medicare Shared Savings Program (MSSP) and Accountable Care Organization (ACO) founded by physicians, Andre Berger (CEO) and Alex Foxman (President/Medical Director) that was approved for CMS’ MSSP program in January 2013.

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National ACO was a minority ACO that met shared savings in 2013 of approximately $6.1 million, of which 50% is paid to NACO/Physician Participants. A recent report identified National ACO as one of the top 10 most successful ACOs in the nation. The deadline for joining and participating in the NACO 2016 Medicare Shared Savings Program is Sept. 1, 2015.

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The constant pressure to perform at high levels can lead physicians to problems with chemical dependencies or other addictions and behavioral changes. The consequences of their intensely personal conflicts can extend outward, affecting their patients and communities in ways they never intended.

As I reflect on this...

"As I reflect on this, my 10th year of sobriety, I attribute the successes I have had in practicing medicine the last ten years wholly to changes in my lifestyle since going through treatment. Without those changes, I don't think I would be alive today, and if I were alive, I don't think I would be practicing medicine or enjoying my life."

-J.S., M.D.

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IN MEMORIAM

ARTHUR R. ANDERSON, JR., MD,
age 95. Died July 4, 2015. Graduate of Vanderbilt University College of Medicine. Member of the Nashville Academy of Medicine.

MELVIN L. BLEVINS, MD,
age 66. Died May 17, 2015. Graduate of the University Tennessee Health Science Center. Member of the DeKalb County Medical Society.

HAMEL B. EASON, MD,
age 85. Died May 9, 2015. Graduate of the University Tennessee Health Science Center. Member of The Memphis Medical Society.

CLARK E. JULIUS, MD,
age 76. Died June 8, 2015. Graduate of the University of Iowa College of Medicine. Member of the Knoxville Academy of Medicine.

WILLIAM B. MACGUIRE, JR., MD,

JOHN M. MILLER, MD,
age 84. Died May 20, 2015. Graduate of the University of Tennessee Health Science Center. Member of the Washington-Unicoi-Johnson County Medical Society.

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KEITH D. PETERSON, MD,
age 68. Died May 13, 2015. Graduate of the University Tennessee Health Science Center. Member of the Montgomery County Medical Society.

WILLIAM K. ROGERS, MD,
age 94. Died June 5, 2015. Graduate of the University of Rochester School of Medicine and Dentistry. Member of the Knoxville Academy of Medicine.

ARCH Y. SMITH, MD,
age 90. Died June 24, 2015. Graduate of the University Tennessee Health Science Center. Member of the Chattanooga-Hamilton County Medical Society.
INSTRUCTIONS FOR AUTHORS

Manuscript Preparation – Electronic manuscripts should be submitted to the Editor, David G. Gerkin, MD, via email at katie.brandenburg@tnmed.org. A cover letter should identify one author as correspondent and should include his/her complete address, phone, and e-mail. Manuscripts, as well as legends, tables, and references, must be typed, double-spaced on 8-1/2 x 11 in. white paper/Word document. Pages should be numbered. The transmittal letter should identify the format used. If there are photos, e-mail them separately in TIF, JPEG or PDF format along with the article; photos and illustrations must be high resolution files, at least 300 dpi.

Responsibility – The author is responsible for all statements made in his work. Accepted manuscripts become the permanent property of Tennessee Medicine.

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