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TMA Alliance Report—Leadership and the Alliance—Heidi Dulebohn

New Members; In Memoriam

Advertisers in This Issue; Instructions for Authors; COA Instructions
May you live in interesting times.” The translation of the so-called “Chinese curse” has become a familiar saying in the American lexicon. People seem to use it with every new crisis but opinions differ about its actual meaning. To some, the phrase has negative connotations of chaos and insecurity. To others, it represents an opportunity for innovation and progress.

To me, the phrase represents both challenge and opportunity.

After the passage of the Affordable Care Act in 2010 along partisan lines, many physicians have been on an emotional rollercoaster as the law survived various legal and political challenges. The Supreme Court decision in 2012 affirming the individual mandate, but making Medicaid expansion optional for states, has made a complicated law even more complex. The re-election of President Obama last November ended all reasonable expectations of substantive changes to the law, at least until the 2016 Presidential election.

In Tennessee, political power is firmly in Republican hands and there is little political appetite for “Obamacare.” This affects Tennesseans in the implementation of two major parts of the law, healthcare exchanges and Medicaid expansion.

Tennessee has chosen to allow the federal government to run the “Healthcare Insurance Marketplace,” (the new name for healthcare exchanges) instead of developing a state-run exchange. Although an estimated 1.5 million Tennesseans who are currently uninsured may qualify for premium subsidies in the insurance marketplace, no state dollars and only $4.5 million in federal dollars ($3 million of which is targeted to outreach by Federally Qualified Health Centers) will be allocated to educate or assist the public in accessing the “Marketplace.” The remaining $1.5 million in federal grants to help uninsured residents “navigate” the federal Marketplace will be awarded in late August, less than two months before enrollment is supposed to begin on October 1. In contrast, Maryland is spending $24 million to facilitate enrollment, which is funded through a tax on insurers in the state.

The question of whether Tennessee would expand Medicaid loomed large over the last legislative session. On March 27, Governor Haslam announced he would not expand the Medicaid program but would instead seek an alternative “Tennessee Plan.” The Tennessee Plan would use federal dollars to subsidize uninsured low-income citizens to purchase private insurance, presumably through the insurance Marketplace, in a three-year pilot project. Tennessee is waiting for the federal government to decide whether to approve the Tennessee Plan with news expected by the end of summer. If approved in some form, the Tennessee Plan would then require action by the General Assembly to be implemented. The Governor has not indicated whether he would call a special session of the General Assembly, or wait until the next regular session in January for implementing legislation.

The TMA is actively engaged with state officials developing the Plan. Last April, your TMA House of Delegates voted to support expanded access to care for all Tennesseans with a resolution endorsing the Tennessee Plan. As your representatives, we believe physician input and leadership will be essential to any program that seeks to lower healthcare costs, while preserving or improving quality of medical care.

In addition to policy development, the TMA as the largest physician organization in the state can serve as an important information resource for our members and their patients. Uninsured citizens will need help as they attempt to navigate the new insurance landscape, and the TMA can help point physicians to resources available to their help patients. Much of the assistance in helping people enter the Marketplace will be in the private sector; hospitals, insurance companies, and nonprofits will take the lead. Helping people find their way through this complex plan will help everyone, but it will be a slow and painful process.

Yes, we live in interesting times.

But whatever difficulties lie before us, we must also recognize that there are great opportunities, as well. The Affordable Care Act has many flaws but it is the law. Physicians must rise to the challenge of change and the opportunity of leadership. We can demonstrate our leadership by working to expand access to affordable healthcare for all our citizens through the “Tennessee Plan” and the Health Insurance Marketplace today, and continue to work to modify and improve the ACA in the future. In this way, we can be of greatest service to our patients and the profession of medicine.

Share your thoughts with Dr. Young at president@tnmed.org.
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In Memory of John Brown Thomison, MD

By David G. Gerkin, MD
Editor

My grandfather would write, as a salutation, in each letter he wrote to me, “I take pen in hand to write these words,” an introduction that honored the recipient. I now approach my keyboard, since we no longer handwrite things—at least I rarely do—with great trepidation since I am honoring, in my small way, a man who was the greatest example I know of a “life well lived.” John Brown Thomison, MD.

John left us April 21, 2013, just four days after his 92nd birthday. Why trepidation? It is because I am humbled to have been his friend and struggling successor as editor of Tennessee Medicine.

I learned a lot from John in the time I knew him. He showed me that there are many things possible in this life if you use your wit and have the courage to move ahead. Because of all this, and because he is a gentleman and a scholar and a morally righteous man, he is worthy of our love, and admiration.

His obituary is published in a recent issue of Tennessee Medicine and the Tennessean, and the details of his family relationships, career as an editor, leader in organized medicine and a true medical professional, are well summarized there. Thus, I will not repeat those but will describe his gifts to me and society as an incredible intellectual, a Winston Churchill scholar and academic style, a duplicator of many skills, a faithful church member, bible scholar and medical professional leader.

To know the man as I have, you must look much further than his professional skills and practice life. He was one of the most eccentric men I have ever known, and I say this in a good way. It often is stated that it takes one to know one! I have been portrayed by some of my friends as “eccentric” (or weird, as described above). Their reason for this characterization of me are my OCD habits and the fact that I overprepare for everything, and from all the things I carry in my briefcase or “man purse” to face life’s challenges. Frankly, I like that portrayal! John’s life was based on rules, a little rigid sometimes, but ordered and firm.

My first real encounter with him, except for TMA functions I became part of as he was stepping down, was at my first and his last AMA meeting as a delegate. He was delegation chair and sat in the first chair in our assigned row at the House of Delegates meeting and never vacated that seat unless some event like an opera, a symphony, or a memorable food event was planned. He directed the delegation as he lived: with respect, but with order and firm guidance and “thumbs up and down” advice on votes. I initially was intimidated but it was clear he was revered by all.

My next encounter with Dr. Thomison, and one to shape my future, was when I became president of the TMA. One of the tasks required is to write the President’s page each month in the TMA journal. I was told by Jean Wishnick King, former managing editor, that he would edit all articles on a yellow notepad and cut and slash most, especially the President’s page, and mumble about how poor we literated. I worked harder on those articles than anything I had done, and one day he confided in me that he had made no corrections on my original monthly pages but said gingerly that he was “still looking at the opportunity to do so.” For me, it was a gesture of kindness or good luck. As a result of that and our relationship, he asked me to succeed him as editor.

I remember one example of the many absolute authorities he imposed as “the editor.” I submitted my President’s page to him electronically for review, a method he accepted reluctantly. I wrote in my e-mail, “Attached is my editorial” for whatever month it was and he swiftly replied, in no uncertain terms, “No one writes an editorial but the editor; yours is simply a page of the Journal!” I was kindly put in my place.

When I used to visit and converse with John B., I always thought he looked a little similar and had the same clever intellect as Winston Churchill. Recently I discovered he was a member of the Churchill Center and the International Churchill societies of Australia, Canada, the United Kingdom and the United States (www.winstonchurchill.org). One of the pictures on the website was of Churchill’s face drawn on a bulldog, and it looks exactly like John’s
We’re all a little weird. And life is weird. And when we find someone whose weirdness is compatible with ours, we join up with them and fall into mutual weirdness and call it love.

— Dr. Seuss

JAMA titled, “Worth a Prayer,” was an article that investigated the issue whether prayer is really an effective therapeutic tool for seriously ill individuals who worship God. The answer, says a Southern California internist who studied nearly 400 heart patients over a 10-month period, seem to be “Amen!—but not without some reservations.” The author quoted our John B. in his article: “Nevertheless, Dr. John Thomison, editor of the Southern Medical Journal, says he would like to read of further studies exploring this topic more thoroughly. Prayer, believes Thomison, is ‘about as benign a form of treatment as there is. There is no danger whatsoever.’”

Finally, I attended John’s celebration of life service at his church, the First Presbyterian Church of Nashville, and heard a touching description and honor to this incredible man. Dr. Todd B. Jones, the senior pastor, delivered a stirring revelation of this man. I contacted him for a copy, and he gladly obliged me and is allowing me to publish a few excerpts from his homily. What follows are his words and thoughts:

“Primum non nocere. I don’t use much Latin from the pulpit, but in this case it seems a forgivable sin to commit. It comes, of course, from the opening line of the Hippocratic Oath, an oath that every physician takes, and one I have become increasingly convinced should be an oath that every human being takes: ‘First, do no harm.’

John Thomison sought as well and as arduously as any to take Jesus’ words to heart, when Jesus said, ‘Be wise as serpents, be harmless as doves.’ So many people I know are precisely the opposite. John, all of his days, sought to be a gentleman. One of his colleagues said of John, ‘He hailed from that fortunate generation of physicians who were educated before they were trained.’ John received a classic liberal arts education before attending medical school, in an age when the liberal arts were a given necessity. John’s education demonstrated itself in everything that he did, and in every relationship that he enjoyed. He was the picture of grace, of decency, of civility, of learning, and in a word, of joy.

Grace inspires of us our very best and our most, and, of course, John was ever and always gracious. He said, ‘The learning process is voluntary, and mandatory education may be no education at all.’ What he understood was that life is about love, and love knows nothing of minimums. Love is about giving. John gave himself to the practice of medicine, all of his life, both a physician who practiced pathology but also a scholar.

John practiced medicine before medicine became a business, an industry, and he wrestled with all of the difficulties with that transformation and those changes. I think this is what is most interesting to me about John; he never stopped growing, he never stopped learning. I think he recognized that life is a gift and as such, John always felt responsible to value the gift, to handle it with great care.

So today, we have much to give thanks for the life, the witness, the friendship, the family ties that John has left behind. His is a remarkable legacy. He continued well into his nineties to use the computer, and when he had problems, he would grow annoyed, call Robert and insist that he come quickly to fix it. Robert found upon his wallpaper on his computer a wonderful image of Vincent van Gogh’s Starry Night. It is a lovely reminder of the grace, the beauty, and the hope that marked John’s life. We give thanks for that life this day, and we give thanks even more for the knowledge that we have that John Thomison knew that it was ‘well with his soul.’ Amen.”

And I repeat, AMEN, and offer Eternal Praise and Love.
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- File a dispute/appeal
- Handle policy/process changes for providers
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October 9 ..........Jackson ..........Doubletree Hotel
October 15 .......Kingsport .......Meadowview Marriott
October 16 ........Knoxville ..........Knoxville Convention Center
October 17 .......Chattanooga ....Chattanooga Marriott at the Convention Center
October 30 ........Nashville .......Nashville Airport Marriott

Registration: 7:30 am - 8:00 am
Workshop Hours: 8:00 am - 3:30 pm

This program has prior approval of the American Academy of Professional Coders for 6.0 Continuing Education Units. Granting of this approval in no way constitutes endorsement by the Academy of the program, content or the program sponsor.

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SPLIT PRESCRIPTIONS; TAX ID NUMBERS?

Q: I wrote a prescription for a patient for 90 pills; his insurance said it would pay for 60 pills and the patient would have to pay for the remainder. The pharmacy said it could not fill the prescription because its computer software will not allow a single prescription to be split into two prescriptions and asked that I split the prescription. Is this allowed? How do I help my patient get his medicine?

A: There is no Tennessee law or rule directly lending guidance to the question posed. According to the Tennessee Board of Pharmacy, the DEA’s opinion on “split scripts” over the years has been inconsistent and varies from office to office. Most of the software currently used by pharmacies will not allow a single prescription to be billed two different ways (insurer and patient); therefore, a single prescription like the one mentioned above may not be filled to meet the patient’s insurance benefit design unless it is split. The Board prefers that a prescription not be split but recognizes that some pharmacies will refuse it unless it is split. Currently the software used by Target and Walgreens cannot process a single prescription with two different payers and requires two prescriptions. The Board advises that the prescriber make his or her intentions clear on the prescription, such as “Script 1 of 2 - insurance portion” and Script 2 of 2 – private pay portion.”

As a reminder, current Tennessee law requires that a prescription for a Schedule II controlled substance be issued on a separate prescription order. It may not be included on the same order as other prescriptions. This includes all prescription formats (e.g. handwritten, printed, computer generated).

Q: A patient wants my tax id number (TIN) to file a claim with her insurance company. I’m not sure I should provide this number to her.

A: There is no legal prohibition on disclosing your federal business tax identification number (EIN or TIN) to another person. However, there are a surprising number of postings on the Internet containing warnings about tax identity theft and guarding a business tax ID number. If you search the internet, you should be able to find the articles. The TMA cannot advise you on what to do but once you have read the articles, you should consult with your practice attorney to make an informed decision.

Other questions? Contact the Legal Department at 800-659-1862 or legal@tnmed.org.
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The region’s best doctors have joined together into one extraordinary multi-specialty practice that is transforming care in our community. For physicians in specialties ranging from family medicine to cardiology to oncology, the new Baptist Medical Group means communication, collaboration, and access like never before. For patients and families across the region, it means just getting better.
Tennessee’s doctor shopping laws may inadvertently lead some physicians who treat patients in a federally-assisted substance abuse program to violate federal law. The Tennessee Medical Association, in its role as a legal advocate for members, is offering clarification on the obligations of those physicians when faced with a doctor-shopping patient.

THE UPSHOT
On close reading, the state’s doctor shopping law technically gives physicians treating mentally ill (including drug-dependent) patients the option of reporting them if there is knowledge they are doctor shopping for drugs. However, the federal substance abuse law prohibits doctors treating patients in a federally-assisted substance abuse program from disclosing their patient health information without their consent unless there is a court order.

State law may give physicians the impression that by opting to report doctor shopping substance abuse patients, they will not be violating the federal law. This is not the case; federal law trumps state law. Therefore, although the Tennessee doctor shopping law gives physicians of mentally ill patients the option to report them, doing so would still place them in violation of the federal law.

For further clarification, please contact the TMA Legal Department at 800-659-1862.

IN DETAIL
State Law
With Tennessee’s new Controlled Substance Monitoring Database law, which went into effect this year, physicians have more information at their fingertips to identify patients who may be doctor shopping for drugs. A doctor shopper is a patient who visits several different doctors in order to obtain drugs through fraudulent means. The Tennessee doctor shopping law (TCA 53-11-309(a)) says that prescribers with actual knowledge that a patient knowingly, willfully and with intent to deceive, obtained or has attempted to obtain a controlled substance from another prescriber within the previous 30 days must report that patient to law enforcement.

TMA Partners with MCAG - Get Your Share of the VISA/MasterCard Settlement!

A new Tennessee Medical Association partnership with MCAG (Managed Care Advisory Group), the top Third Party Filer in class action settlements, will help members more easily obtain – and possibly increase – their share of the current $7.25 million Visa/MasterCard settlement. Members need to act on this benefit by August 30, 2013.

For help filing your claim:
- Go to www.mcagvmc.com/portal, enter TMA Physician Services Code TN0627 and follow the instructions; or
- Contact the TMA’s Michael Hurst at michael.hurst@tnmed.org or at 800-659-1862.

THE LAWSUIT
The Visa/MasterCard settlement comes in a class-action lawsuit alleging both credit card companies charged excessive swipe fees to merchants from January 1, 2004 – November 28, 2012. If the proposed settlement is approved as expected in September 2013, merchants who meet the criteria will be eligible to receive a pro-rata payment based on the interchange fees associated with Visa/MasterCard transactions during that time period.

YOUR OPTIONS
Once your practice receives an estimate of your Visa/MasterCard transactions (or instructions on how to access the estimates) for the time your business accepted Visa/MasterCard, you have about 30 days to act on one of three options:

(Continued on page 21)
Physicians Must Provide Info on Infant CPR

Effective July 1, physicians must now provide information and instruction regarding infant CPR to at least one parent or caregiver of a newborn infant. The TMA has received permission from learnCPR.org to allow members to distribute an approved instruction sheet to patients.

Download the approved instruction sheet at:
www.tnmed.org/infant-CPR-instructions.aspx

Please note: This instruction sheet may be distributed by TMA members only. The use of this instruction sheet by a non-member, even though he or she is in the same practice as the member physician, could be considered copyright infringement.

Available in other languages - contact legal@tnmed.org.

New ICD-10 Tools for Members

Helpful new tools to smooth out the transition to ICD-10 are now available on the TMA website: a transition toolkit and special software, priced at a discount for TMA members only.

This toolkit is designed as a virtual ICD-10 consultant, providing comprehensive tools and guidance to physician practices managing their own ICD-10 Transition. It is suitable for any size practice and specialty. This interactive, user-friendly program will guide you from the planning phases through implementation, saving all of your information and progress, and populating it to related projects so analysis can be instantly performed. Editing capabilities make it customizable to every practice.

THIS COMPREHENSIVE WEB-BASED APPLICATION INCLUDES:
• Organization and key stakeholder surveys
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Cost: $399 + $35 per provider

New Laws Affecting Physicians

The following bills passed by the 2013 General Assembly were effective July 1, 2013, and may be of special interest to physicians since they could require action or reporting. Others are for information only.

ACTION REQUIRED

Infant CPR Instruction for Parents
Requires hospitals, birthing centers, healthcare facilities, physicians, nurse practitioners, physician assistants or other healthcare practitioners who provide medical care to newborns, as well as obstetricians who provide routine care for the prenatal patients, to make available information and instruction concerning the appropriate use and techniques of infant cardiopulmonary resuscitation (CPR) to at least one parent or caregiver. Providers are not required to offer certified CPR classes. Immunity is provided. See our resource for members at left.

ACTION MAY BE REQUIRED

Prescribing Restriction for Nurse Practitioners, Physician Assistants
Prohibits a nurse practitioner (NP) or physician assistant (PA) from prescribing schedules II, III, and IV controlled substances unless such prescription is specifically authorized by the formulary or approved after consultation with the supervising physician. Establishes that an NP

(Continued on page 22)
Are You a “Top 50” Prescriber?

Physicians need to watch and respond immediately if they receive a letter identifying that they – or a prescriber they supervise – is on the state’s “Top 50 Prescriber” list. Failure to respond could result in disciplinary action or monetary penalties from the prescriber’s licensing board.

A new law, effective July 1, requires the Tennessee Department of Health (TDH) to use data from the state’s Controlled Substance Monitoring Database (CSMD) to identify and notify the top 50 prescribers in the state and their supervising physician, if applicable. TDH will identify the supervising physician from the midlevel provider’s profile on the licensure verification section of its website.

Abuse of prescription drugs is increasing at an alarming rate and TDH and the licensing boards are working hard to identify and discipline providers who abuse their prescribing privileges.


WHAT’S THE PENALTY?
The failure to respond or respond in a timely manner to the letter or a request for information may subject the prescriber and/or supervising physician to disciplinary action by his/her licensing board and a penalty of up to $1,000 per day.

WHAT’S IN THE LETTER?
The letter will contain the following information for the prescriber:

- The significant controlled substances prescribed;
- The number of patients who received the prescriptions;
- The total milligrams in morphine equivalents of controlled substances prescribed; and
- Any other information that TDH considers relevant.

HOW DO I RESPOND?
The prescriber and the supervising physician (when applicable) will have 15 business days to respond via registered mail or e-mail. The response must explain why the amounts were medically necessary for the patient where appropriate, and that the supervising physician has reviewed and approved the prescribed amounts.

WHAT HAPPENS NEXT?
The Health Department will consider the prescriber’s specialty and the ages of the patients to determine whether the explanation justifies the prescriber’s patterns, and may contract with an expert reviewer to determine if the explanation is acceptable. If charges are filed against the prescriber and/or supervising physician, any report of the reviewer will be discoverable by the licensee.

If TDH is not satisfied with the explanation, it will convey its concerns via registered mail to the individual(s). The prescriber and/or supervising physician will have another 15 business days to attempt to rectify those concerns.

If the concerns are not addressed by the second prescriber response, it may submit them to the member of the Controlled Substance Database Com-

(Continued on page 24)
TMA Public Health Champion: 
TN Health Commissioner 
Dr. John Dreyzehner

Tennessee Health Commissioner John J. Dreyzehner, MD, MPH, FACEOM, of Nashville, has been named a TMA Quarterly Public Health Champion for 2013. The honor recognizes TMA member physicians for their outstanding public health contributions across the state of Tennessee.

Dr. Dreyzehner is being recognized for over 20 years of service and leadership in clinical and public health at the federal, state and local levels, most recently as an advocate for a healthier Tennessee as state health commissioner. Dr. Dreyzehner has been instrumental in tackling a variety of public health issues, particularly the Volunteer State’s prescription drug abuse problem and its consequences. Working with the Tennessee Medical Association and other stakeholders, he helped pass new laws aimed at monitoring controlled substance prescriptions and stemming the prevalence of Neonatal Abstinence Syndrome.

Dr. Dreyzehner serves as an adjunct faculty member at East Tennessee State University’s College of Public Health, visiting assistant professor in Public Health Sciences for the University of Virginia, and is founding faculty for the Healthy Appalachia Institute at University of Virginia-Wise.

Board certified by the American Board of Preventive Medicine in Occupational and Environmental Medicine, he is a Fellow of the American College of Occupational and Environmental Medicine and a Diplomate of the National Board of Medical Examiners. Along with the TMA, his other professional associations include the American Medical Association (AMA), and the Association of State and Territorial Health Officials (ASTHO).

Dr. Dreyzehner began his medical service in 1989 as a U.S. Air Force flight surgeon. Following honorable discharge as a major, he spent several years practicing occupational medicine, joining the Virginia Department of Health in 2002. He also concurrently practiced addiction medicine for several years while working on substance abuse prevention in his public health role. He joined Tennessee Governor Bill Haslam’s cabinet as Commissioner of Health in September 2011.

He graduated from the University of Illinois at Champaign-Urbana Magna Cum Laude with a Bachelor of Science in psychology. He received his Doctor of Medicine degree from the University of Illinois at Chicago, and earned his Master of Public Health at the University of Utah, where he also completed his residency in Occupational Medicine.

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.

Report Pharmacy Refusal to Fill Opioid Prescriptions

The Tennessee Medical Association is asking members for help in tracking and addressing pharmacy problems, specifically a nationwide trend in which pharmacists request additional information—in some cases a diagnosis or medical records—before filling an opioid prescription. If the information is not provided, the pharmacy may refuse to fill the prescription.

To help with advocacy efforts on this issue, members are asked to document and report any pharmacy request for information or records that you believe is inappropriately questioning your medical decision-making.

Report a problem by accessing our fillable PDF form at www.tnmed.org/uploadedFiles/Documents/PharmOpioidReporting%20Form.pdf. Please be as specific as possible in describing the problems you have encountered. The TMA Legal Department also asks for copies of any letters you have received from a pharmacy related to this issue. Please submit the completed form to legal@tnmed.org or fax to 615-312-1907.

ADVOCACY EFFORTS

The TMA is working in coordination with the AMA and other state medical societies regarding the diagnosis request, the refusal to fill and letters from pharmacies to some Tennessee medical practices. Pharmacy letters say they are only complying with DEA regulations and expectations regarding responsible dispensing for a legitimate medical purpose; however, at this time there is no uniform regulatory guidance for pharmacies and their pharmacists or for physicians receiving these requests.

Members have reported problems with pharmacists at Walgreens and Costco. Typically Walgreens insists the prescriber put a diagnosis on an opiate prescription before it will be filled. In some cases, the pharmacist also requests the medical record of the patient. Costco is refusing to fill any narcotic prescription unless a diagnosis is included.

QUESTIONS?

Contact the TMA Legal Department at 800-659-1862.
The IMPACT Committee of the TMA recognizes the following IMPACT donors who have become Capitol Hill Club members in the past month. We greatly appreciate all IMPACT contributors for their help in assuring that candidates supportive of organized medicine receive generous financial support from IMPACT. To join IMPACT as a sustaining member or the Capitol Hill Club, please contact Debra Maggart at 615-207-5424 or debramaggart@gmail.com, or log on to www.timpact.com.

Allan Bailey, MD, Nashville
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Jeffrey Patton, MD, Nashville
Ed Peterson, MD, Chattanooga
Rodney Poling, MD, Columbia
Perry Rothrock, MD, Cordova
Iris Snider, MD, Athens

In June, IMPACT received a CHC payment with the following note from Perry Rothrock, MD, of Cordova, honoring the late Robert D. Kirkpatrick, MD, former TMA president and IMPACT board member from Germantown, who died April 26, 2013:

Enclosed are my IMPACT Capitol Hill Club dues. In addition, please accept the additional check in memory of Bob Kirkpatrick. He was a very good friend and was always willing to help with any problems and I will miss him greatly. It was Bob who encouraged my participation in medical and political organizations, so he is responsible for whatever small contributions I am able to make. His statement that I have found most useful was, “Follow the money,” which is so true. He was very proud of the TMA and IMPACT organizations and it will be a great loss to not have him around. I feel very fortunate that I was able to know him. Thank you so much.

Sincerely,
Perry

33rd Annual TMA Insurance Workshops

Chairs are filling up for the TMA’s 33rd annual Insurance Workshops, scheduled statewide in October. Attendees can earn up to 6.0 hours of AAPC CEUs.*

Sponsored by Navicare, Inc., the sessions kick off October 8 in Memphis and will wrap up October 30 in Nashville. Workshops in each location begin at 7:30 a.m. with onsite registration, followed by the program at 8:00 a.m.

REGISTRATION
Visit www.tnmed.org/workshop for registration and cost information.

QUESTIONS?
For more information, contact phyllis.franklin@tnmed.org or by fax to 615-312-1895.

CONTENT
Join representatives from the Bureau of TennCare, BlueCross BlueShield of Tennessee, UnitedHealthcare, CIGNA (Health-Spring), Humana, Humana Military, Amerigroup, and Windsor Cahaba GBA for valuable tips on how to:
- File a claim
- File a dispute/appeal
- Handle policy/process changes for providers
- Obtain an authorization
- Access claims reports/data from the plan
- And much more!

DATES & LOCATIONS
October 8 – Memphis Marriott East
October 9 – Doubletree Hotel, Jackson
October 15 – Meadowview Marriott, Kingsport
October 16 – Knoxville Convention Center
October 17 – Chattanooga Marriott at the Convention Center
October 30 – Nashville Airport Marriott

*T This program has prior approval of the American Academy of Professional Coders for 6.0 Continuing Education Units. Granting of this approval in no way constitutes endorsement by the Academy of the program, content or the program sponsor.
Incoming residents at East Tennessee State University’s Quillen College of Medicine were greeted by Dr. Frederick Clayton of Johnson City, who welcomed them on behalf of the TMA and the Washington-Unicoi-Johnson County Medical Society. A pulmonologist, Dr. Clayton is secretary/treasurer for the WUJMS.

TMA Practice Solutions Director Angie Madden was an invited presenter at New York Presbyterian Health System in June, educating medical staff leadership on ICD-10 education and physician engagement. Behind Ms. Madden is Wanda McKnight, executive director of the Tennessee Health Information Management Association (THIMA), who also presented to the group.
MEET
Professional Relations Committee Chair
Dr. Ron Kirkland

PERSONAL
Official Title/Position: Past Chairman of the Board of The Jackson Clinic, Past Chair of the Board of the American Medical Group Association (AMGA) 2008, Current Chair of the Board of the American Medical Group Foundation (AMGF) 2013-2014.
Company/Years: With The Jackson Clinic since 1984; served as board chairman from about 2002 until 2007.
Practice Interests/Specialties: General ENT, currently working in office only - no surgery or call.
Most Important Accomplishment: With wife Carol, raising four children who have become Christians.
Family: Wife of 45 years, Carol; four married children and six grandchildren.
Currently Reading: The Framing of the Constitution of the United States by Max Farrand.

COMMITEE
Years as Chair: Two.
Why Agreed to Step into Leadership Role: I am concerned about the future of our nation’s healthcare system and felt I should do what I could to improve it.
Goals/Philosophy as Committee Chair: Work with capable and interested committee members to improve the relationships between our TMA, our Tennessee physicians, and their various organizations; and to improve the relationships between our TMA and our fellow non-physician healthcare providers and their various organizations.
Most Important Accomplishments of Your Committee: So far, we have identified and begun to build on the areas of alignment between our TMA and many of the various physician organizations in Tennessee while we seek resolution of our differences, as well.
Importance of the TMA/This Committee: Our TMA is the only organization that represents the interests of all Tennessee physicians. As such our TMA must weigh in on the many issues that challenge our profession today so that we physicians can be the architects of the high quality healthcare system that our patients deserve. The PRC may be able to help ensure that physician leaders are, in fact, the above-mentioned architects rather than bureaucrats. By accomplishing this we should also increase the value of TMA membership to prospective members.

Interested in serving on a TMA Committee? Visit http://tnmed.org/TMA_committees/ or email Audrey.Smith@tnmed.org.

New Campaign: “Talk with Your Doctor” About Smoking

In coordination with a national “Tips from Former Smokers” campaign by the Centers for Disease Control (CDC), Tennessee physicians are asked to participate in a new “Talk With Your Doctor” campaign to help their patients quit smoking.

Tennessee Health Commissioner John Dreyzehner, MD, has sent a letter to physicians outlining the state’s participation in this campaign and offering links to resources and tools providers can use.

Television commercials for the “Talk With Your Doctor” campaign are airing, encouraging the public to engage their healthcare providers in conversations about the dangers of smoking and the benefits of smoking cessation for public health.

Resources from the Tobacco Quitline, Smokefree.gov and the main CDC websites available for download include waiting room posters, brochures, stop smoking tips, and QuitLine referral cards.

For details and resources, visit www.tnmed.org/new-quit-smoking-campaign-talk-with-your-doctor.

TMA Congratulates Web Survey Winner

Congratulations to Mr. Whit Dowlen, a student member of the TMA at the University of Tennessee Health Science Center in Memphis, winner of a $50 Visa gift card for completing our web survey. Mr. Dowlen’s name was randomly drawn from among 106 survey respondents. Thanks to all who participated – your input is helping us with a new TMA website design for later this year!
STATE DOCTOR SHOPPING LAW CONFLICTS WITH FEDERAL LAW
(Continued from page 13)

Forcement. However, section (b) of that statute says that a prescriber may report a patient with a mental illness, which includes drug dependency. The physician of a mentally ill patient is therefore not required to report the patient, but is rather given the option to do so depending on the physician’s assessment of the circumstances.

Federal Law
The federal substance abuse law (42 USC 290dd-2/42 CFR 2.13) prohibits doctors who are treating substance abuse patients in a federally-assisted substance abuse program from disclosing their patient health information without their consent, even to law enforcement for any reason, unless there is a court order. A substance abuse “program” is defined in the federal regulations as any individual or entity, including an identified unit within a medical facility, which holds itself out as providing alcohol or drug abuse diagnosis or treatment, or whose primary function is to do so. A substance abuse program is considered “federally assisted” if:

1. It is conducted in whole or in part, whether directly or by contract or otherwise by any department or agency of the United States;
2. It is being carried out under a license, certification, registration, or other authorization granted by any department or agency of the United States including but not limited to:
   a. Certification of provider status under the Medicare program;
   b. Authorization to conduct methadone maintenance treatment; or
   c. Registration to dispense a substance under the federal Controlled Substances Act to the extent the controlled substance is used in the treatment of alcohol or drug abuse;
3. It is supported by funds provided by any department or agency of the United States by being:
   a. A recipient of Federal financial assistance in any form, including financial assistance which does not directly pay for the alcohol or drug abuse diagnosis, treatment, or referral activities; or
   b. Conducted by a State or local government unit which, through general or special revenue sharing or other forms of assistance, receives Federal funds which could be (but are not necessarily) spent for the alcohol or drug abuse program; or
4. It is assisted by the IRS through the allowance of income tax deductions for contributions to the program or through the granting of tax exempt status to the program.

If your substance abuse program or services fall within any of these categories, then you are prohibited by federal law from releasing any identifying information on your substance abuse patients to law enforcement.

QUESTIONS?
We hope this explanation of the state and federal laws has cleared up any concerns you may have with doctor-shopping patients in substance abuse programs.

Please contact the TMA Legal Department with any additional questions at 800-659-1862 or legal@tnmed.org.
TMA PARTNERS WITH MCAG - GET YOUR SHARE OF THE VISA/MASTERCARD SETTLEMENT!
(Continued from page 13)

Option 1: Do Nothing. Ignore the notice and/or miss the deadline and you will receive no money, but will be bound by the terms of the settlement from that point forward.

Option 2: Accept THEIR Estimate and Return Claim Form. The Settlement Administrator will estimate your interchange fees for the claim period based on data provided by the credit card companies. You have the option to return a completed claim form to the Settlement Administrator instructed them to base your claim on their estimate. You will receive funds and will be bound to the go forward language of the settlement. However, the data used to create the estimate is incomplete and therefore might not be an accurate representation for your claim. That is why we recommend...

Option 3: Reject the estimate and submit your own documentation of your actual transactions from 2004-2012. With this option you may receive an increased reimbursement from the settlement. This option will also bind you to the go forward language of the settlement.

FAQS

What's the benefit?
This is where your new benefit from the TMA and MCAG comes in. The best part for you is that MCAG works on a contingency basis. They only get paid if you get paid!

What do I need to do?
1. Review and submit the agreement between MCAG and the TMA
2. Provide as much of the following information as possible:
   a. All TINs or EINs
   b. Current Credit Card Processing Company (e.g. First Data, Trans First, Vantiv, Heartland etc.)
   c. Current Merchant IDs
   d. Previous Credit Card Processing Companies dating back to 2004
   e. Previous Merchant IDs.
3. Please send all information ASAP. It will allow MCAG to build your file of transaction which is necessary to file for and additional claims. The deadline is August 30, 2013.

What will MCAG do?
1. MCAG has partnered with many of the top 50 card processors and acquirers, including several of the top 10. If you process Visa/MasterCard transactions with one of MCAG’s partners, then MCAG will work with your credit card processing company(s) to build as much of the nine-year interchange fee history as possible based on your actual data.
2. If MCAG is able to acquire your data from one of our processing partners, MCAG will evaluate the estimate from the settlement administrator of your interchange fees and actual transaction volume for the nine-year settlement period and compare it with the actual interchange fees and transaction volume for the same nine-year period.
3. MCAG will file the most advantageous claim for your organization based on data available.
4. MCAG will meet all deadlines as outlined in regards to the settlement.
5. MCAG will file, track, and reconcile each claim to ensure proper reimbursement under the terms of the settlement.
6. MCAG will collect and distribute the allocated funds under the terms of the settlement (on average this takes a year from the time the settlement filing date closes).

How much money can my business/organization expect to receive from this settlement?
MCAG estimates that claims will total about $800 for every $1 million dollars of Visa/MasterCard sales transactions over the nine-year period. Your pro-rata recovery will depend on your claim amount and the total claim amount filed into the settlement against the fund.

What if my practice closed or sold during the settlement time period?
If you had a business that sold or closed in 2009 (as an example), you are eligible to regain monies for the time it was open. You may use MCAG to help you here, as well.

Can I make a claim for other businesses accepting these cards?
If you have other businesses that accept credit cards, those would be eligible for monies, too, and you are welcome to have them jump on with our program as well. Simply use the instructions provided above.

Who do I call if I have more questions?
Contact MCAG’s David Macpherson at 800-355-0466, ext. 2255, or at dmacpherson@mcaginc.com.
NEW LAWS AFFECTING PHYSICIANS
(Continued from page 14)

or PA may only prescribe or issue a schedule II or III opioid at the initiation of treatment for a maximum 30-day non-refillable course of treatment, unless specifically approved after consultation with the supervising physician. Requires the Commissioner of Health at least annually to identify and send correspondence to the 50 top prescribers of controlled substances requesting the prescriber (and the supervising physician if the prescriber is a mid-level practitioner) to justify the elevated use of controlled substances. Failure to either respond or to respond with a legitimate explanation would subject the prescriber (and supervising physician) to potential disciplinary action. (Learn more in our related “Top 50 Prescriber” article in this section).

Reporting of a Patient Who Makes an Actual Threat of Bodily Harm
Requires mental health professionals to report any patient who makes an actual threat of bodily harm against a reasonably identifiable victim or victims to local law enforcement, who shall then report the patient to NICS for purposes of prohibiting the purchase of a firearm when a background check is conducted.

Pain Management Clinics Cannot Dispense Controlled Substances
Prohibits pain management clinics from dispensing controlled substances with the exception of no more than a three-day course of a schedule IV or V sample.

INFORMATION ONLY
Immunity for Voluntary Healthcare Providers
Provides good faith immunity for healthcare providers serving at certain programs; authorizes collection of certain charges for voluntary provision of healthcare services when forwarded to the sponsoring organization.

Assault Against a Healthcare Provider
Adds healthcare provider to the list of persons where, if an assault or an aggravated assault is committed while acting in the discharge of the provider’s duty, the maximum fine is increased to $5,000 and $15,000 respectively.

Replaces Current Universal Do-Not-Resuscitate Order Statute
Replaces current do-not-resuscitate (DNR) order with a new provision authorizing physician orders for scope of treatment (POST). Defines POST as written orders on an approved form that specifies, in the event of cardiac or respiratory arrest, whether cardiopulmonary resuscitation should or should not be attempted and specifies other medical interventions that are to be provided or withheld. Authorizes nurse practitioners, clinical nurse specialists or physician assistants to issue a POST under certain circumstances.

Proof of Immunization Against Meningococcal Disease
Requires certain, new incoming students at any public institution of higher learning who live in on-campus housing to provide adequate proof of immunization against meningococcal disease.

QUESTIONS?
Contact the TMA Legal Department at 800-659-1862 or becky.morrissey@tnmed.org.
Yasmine S. Ali, MD, MSCI, FACC, FACP, of Nashville Preventive Cardiology, PLLC, has been named chair of the American College of Physicians' Tennessee Council of Young Physicians (TCYP). The TCYP was organized in September 2008. The Council is composed of two representatives from each TN region and a chair. Dr. Ali is a former TMA Resident/Fellow Section Governing Council member and Young Physician Section vice-chair, former representative to the TMA Board of Trustees and delegate to the TMA House. Dr. Ali is president of Nashville Preventive Cardiology, PLLC, and a member of the Nashville Academy of Medicine.

Allen F. Anderson, MD, of Tennessee Orthopaedic Alliance in Nashville, has been elected by his peers to the 2013 ISAKOS (International Society of Arthroscopy, Knee Surgery and Orthopaedic Sports Medicine) Board of Directors. The appointment was made during the recent ISAKOS Congress held in Toronto, Canada. He is a member of the Nashville Academy of Medicine.

Delmon E. Ashcraft, Jr., MD, and Shauna Lorenzo-Rivero, MD, both of the Chattanooga area, are among the winners of Parkridge Health System's annual Frist Humanitarian Awards. The recognition is presented to outstanding employees, physicians and volunteers who demonstrate extraordinary concern for the welfare and happiness of patients and their community. Dr. Ashcraft is an OB/GYN with Parkridge East Hospital; Dr. Lorenzo-rivero is a colon-rectal surgeon with Parkridge Medical Center. Both are members of the Chattanooga-Hamilton County Medical Society.

Jeanne F. Ballinger, MD, FACS, of Nashville, has been named one of the Top Doctors in Nashville by Nashville Lifestyles magazine. Certified by the American Board of Surgery in general and laparoscopic surgery, she is a member of the Nashville Surgical Society as well the Society of Laparosendoscopic Surgeons. She is a member of the H. William Scott, Jr. Society, the Southeastern Surgical Congress, the Nashville Academy of Medicine, and the Southern Medical Association. In 2010 she was honored by the Hope Lodge Association with the Dr. George R. Burns Physician Humanitarian Award. A general surgeon at St. Thomas Hospital, Dr. Ballinger practices with Nashville Surgical Associates, where she specializes in breast cancer surgery and laparoscopic surgery for treating diseased gallbladders, spleens, and colons. She is a former president of the American Cancer Society Board of Davidson County, and a volunteer with Second Harvest Food Bank. Dr. Ballinger is a member of the Nashville Academy of Medicine.

James H. Calandruccio, MD, a surgeon with The Campbell Clinic in Memphis, has joined the board of directors of Trezevant, an accredited continuing care retirement community. Certified in orthopaedic surgery and surgery for the hand, he serves as assistant professor with the UT-Campbell Clinic Department of Orthopaedic Surgery. Dr. Calandruccio is a member of the American Academy of Orthopaedic Surgeons, American Society for Surgery of the Hand, Kiro Research Society, Indianapolis Hand Society, Tennessee Orthopaedic Society, Tennessee Hand Society, and The Memphis Medical Society.

William J. Harb, MD, of Nashville, was recently honored with a legislative resolution marking his selection as a 2012 Compassionate Doctor, as well as his years of service to Tennesseans. He is a delegate from the Nashville Academy of Medicine, a member of the IMPACT Capitol Hill Club, and serves on the TMA’s Insurance Issues and Membership committees. Board certified in colon and rectal surgery and general surgery, Dr. Harb practices with Cumberland Surgical Associates, PC.

Danielle H. Hassel, MD, of Collierville, has been named one of the 2013 National Medical Association’s (NMA) Top Healthcare Professionals Under 40, and was honored during the NMA Annual Convention and Scientific Assembly in Toronto, Canada on July 27. Presented by the NMA Post-Graduate Section, the award program honors individuals under the age of 40 in the health professional community who are working to change the face, practice, and future of medicine for the better. Dr. Hassel is a 2012 graduate of the TMA Physician Leadership College, a member.
of the TMA Governance Work Group, a supporter of IMPACT and MEMPAC, and a member of The Memphis Medical Society. She practices with Baptist Medical Group-Germantown Physical Medicine and Rehabilitation in Germantown.

Linda M. Smiley, MD, FACS, FACOG, of Memphis, has been appointed to serve on the Quality Oncology Practice Initiative Steering Group for the American Society of Clinical Oncology. Currently, Dr. Smiley serves on the medical advisory board for the Ovarian Cancer Awareness Foundation and the board of directors for the Tennessee Chapter of the National Ovarian Cancer Coalition. Board certified in obstetrics and gynecology and gynecologic oncology, Dr. Smiley joined The West Clinic in 1995, specializing in the treatment of cervical, ovarian and uterine cancers. She received the Clinical Oncology Fellowship Award from the American Cancer Society, 1989-1990. She is a member of The Memphis Medical Society.

Thomas W. “Quin” Throckmorton, MD of Memphis, has been named Orthopaedic Residency Program director at the University of Tennessee-Campbell Clinic Department of Orthopaedic Surgery. Formerly associate director of the program, Dr. Throckmorton is a board-certified orthopaedic surgeon with Campbell Clinic, board member for The Campbell Foundation, and assistant program director for the Campbell Clinic Sports Medicine Fellowship. An expert in elbow reconstruction, he is a member of the American Academy of Orthopaedic Surgeons, American Shoulder and Elbow Surgeons, Association of Clinical Elbow and Shoulder Surgeons, Mid-America Orthopaedic Association, Mayo Elbow Club, Mayo Orthopaedic Alumni Association, Vanderbilt Orthopaedic Society, Willis C. Campbell Club, the Tennessee Orthopaedic Society and The Memphis Medical Society.

Ty T. Webb, MD, of Sparta, has been named a medical director for NHC Healthcare of Sparta. Board certified in family medicine, Dr. Webb currently serves as speaker of Congress for the Tennessee Academy of Family Physicians, and is a direct member of the Tennessee Medical Association. He practices with Cumberland Family Care, PC, and is an active medical staff member at Highlands Medical Center.

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.

ARE YOU A “TOP 50” PRESCRIBER?
(Continued from page 15)

mittee who represents that individual’s licensing board. The committee member will have access to all of the documents pertaining to the concerns of TDH and the expert reviewer. If this committee member also believes the explanations are not sufficient to justify the prescribing pattern of the prescriber, these concerns may be forwarded to the Office of Investigations.

Any data, reports and correspondence created under this law are confidential and not considered a public record but may be used in a disciplinary case against the prescriber and/or the supervising physician.

MORE QUESTIONS?
Contact the TMA Legal Department at 800-659-1862 or email legal@tnmed.org. +

OTHER PRESCRIBING LAW CHANGES
(Continued from page 15)

and could be inconvenient for a physician reporting a crime to testify in a location outside of their county of practice or residence.

This law also allows for the defendant to be charged with identity theft and prescription drug fraud for possessing, acquiring, obtaining or attempting to acquire or obtain a controlled substance by misrepresentation, fraud, forgery, deception or subterfuge.

Painkiller Limit
Effective October 1, 2013, no prescription for any Tennessee patient for any opioid or benzodiazepine may be dispensed in quantities greater than a 30-day supply. It will not matter what quantity is ordered by a prescriber, only a 30-day supply can be dispensed.

QUESTIONS?
For help with legal or prescribing issues, contact the TMA Legal Department at 800-659-1862 or email legal@tnmed.org. +
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Payment reform for providers is happening all over the healthcare industry, touting the widely accepted mantra of “lower cost and higher quality of care.” The current state of payment reform is fragmented across the industry, with some commercial payers working with specific specialties to develop new ways of payment and the federal government setting up pilot programs with groups of providers around the nation. While most healthcare professionals can agree that some type of payment reform needs to occur, we can also agree that it will certainly be a while before that happens. In the meantime, physicians should be aware of payment reform happening within Tennessee.
The majority of Medicare’s payment reform initiatives are in the form of pilot programs and demonstration projects that include a select number of participants for a specified period of time. The goal of these programs is to test various payment models to determine what will work best for the Medicare program as a whole in the future.

ACCOUNTABLE CARE ORGANIZATIONS

Unless you have been living under a rock for the past three years, it is likely you have heard all about Accountable Care Organizations (ACOs). An ACO, for Medicare’s purposes, is a group of providers and suppliers that work together to coordinate care for Medicare fee-for-service (FFS) beneficiaries and potentially share in any savings generated through efficient delivery of care.

Under the Medicare Shared Savings program, providers continue to receive FFS payments as they currently do. The ACO is then either awarded savings or held accountable for losses based on the performance benchmark developed by CMS for that ACO. The benchmark is an estimate of what the total Medicare FFS expenditures for ACO beneficiaries would otherwise have been in the absence of the ACO. If the ACO’s costs for a performance period are below the benchmark and it meets CMS’s quality measures, it will share in the savings generated. If its costs are above the benchmark, it may have to pay CMS the difference of the loss, depending on whether the ACO chose the one-sided model (no risk of loss but less savings possible) or the two-sided model (potential for risk but also higher savings). CMS has also established Minimum Savings Rates and Minimum Loss Rates to account for normal variations in healthcare spending within a performance period.

CMS is testing its Shared Savings Program through two different models: the Pioneer model and the Advance Payment model. The Pioneer model is designed for organizations that already have experience operating as an ACO, while the Advance Payment model is for smaller groups and rural providers with less capital to invest in forming an ACO.

Tennessee has providers participating in the Advance Payment model only, namely St. Thomas Medical Group and Cumberland Center for Healthcare Innovation in Nashville. Both programs started in July 2012. Participants in the Advance Payment ACO model receive upfront and monthly payments to help with infrastructure costs. CMS will then recoup these advance payments through offset of the ACO’s earned shared savings. If the ACO does not generate sufficient savings for CMS to recoup the advance payments, CMS will offset shared savings in subsequent performance years. Each performance period lasts for one calendar year, so the ACOs in Tennessee that started last July should have data soon, if they do not already, regarding their amount of shared savings for the year.

For more information on the Medicare ACOs, visit http://innovation.cms.gov/initiatives/ACO/.

BUNDLED PAYMENTS

Just behind the Medicare ACO programs is CMS’s Bundled Payments for Care Improvement initiative, participants of which were announced this January. The initiative has four different models of bundled payments with various participants in each. Bundled payments link payments for multiple services patients receive during a specific episode of care, and payments are received either retrospectively or prospectively, depending on the model. Model 1 covers retrospective acute care hospital stays; Model 2 deals with retrospective acute care hospital stays plus post-acute care; Model 3 includes retrospective post-acute care; and Model 4 covers acute care hospital stays with prospective payments. Providers in Tennessee have been selected to participate in Models 2 through 4.

CMS has developed 48 episodes of care with specific diagnosis-related groups (DRGs) in each, from which participants can choose to accept payment. The episodes range in conditions and procedures from amputations to urinary tract infections.

For Models 2 and 3, the bundled payment will include the physicians’ services, care by post-acute providers, related readmissions, and other related Medicare Part B services included in the episode definition. CMS will set a target price for each episode based on historical FFS rates and include a discount. Providers will then be reimbursed through usual FFS payments, after which CMS will compare the aggregate Medicare payment for the episode with the predetermined target price. The difference between the two will either result in a bonus to the participant to be shared among provider partners or a repayment to Medicare. The performance period for these two models should have begun in July if partic-
THAT PESKY SGR PROBLEM...

Looming over the future of healthcare payment for physicians is the nagging problem of Medicare’s Sustainable Growth Rate formula.

In Congress, the House Energy and Commerce Committee is marking up another “doc fix” bill that will repeal and replace the flawed payment system, hoping to have it passed out of committee before the August break.

The legislation proposes a move to a new hybrid fee-for-service system that includes the development of quality measures, with an eventual option for providers to leave the FFS system and instead, choose to be paid based on new models for delivering quality, efficient care.

There is still the problem of how to pay for it. The SGR system repeatedly mandates enormous cuts that Congress routinely votes to prevent. Calls to replace the system have grown as the cost to replace it mushrooms, and this year the Congressional Budget Office helped the cause by trimming more than $100 billion from its cost estimate for fixing the formula. But the pricetag still holds at about $140 billion over the next 10 years. Proponents of the new legislation have not said how their solution will be funded.


BACKGROUND*

Enacted in 1997 as part of the “Balanced Budget Act,” the Sustainable Growth Rate has been a source of continued concern for physicians who serve Medicare beneficiaries and for the beneficiaries themselves. Long recognized as an imperfect solution that rewards quantity of services rather than the quality of care, Congress has repeatedly implemented a temporary “doc fix” to prevent substantial Medicare reimbursement rate cuts, which could result in fewer physicians being able to serve Medicare patients.

2013 SGR Reform Milestones

February 7, 2013 - Energy and Commerce and Ways and Means Committee leaders outline a framework to reform the current Medicare system. Committees ask for feedback on the outline by February 25.

February 14, 2013 – Energy and Commerce Subcommittee on Health holds hearing on “SGR: Data, Measures and Models; Building a Future Medicaid Physician Payment System.”

April 3, 2013 – Leaders from the House Energy and Commerce and Ways and Means Committees outlined additional details of a proposal to repeal the SGR system. The leaders also sent a letter to the provider community requesting feedback. The leaders requested stakeholder feedback by April 15.

May 28, 2013 - the Energy and Commerce Committee unveiled a draft legislative framework, seeking further stakeholder input by June 10.

June 5, 2013 – Subcommittee on Health holds a hearing on “Reforming SGR: Prioritizing Quality in Modernized Physician Payment System”

TENNCARE PAYMENT REFORM INITIATIVE

On the home front, Tennessee has decided to take payment reform into its own hands. Earlier this year, the TennCare Bureau won a State Innovation Model (SIM) grant of up to $756,000 from CMS to design a comprehensive state plan for payment and care delivery. TennCare will use this money over the next six months to design episode-based payment models, which will then qualify the state to apply for a second round of federal grants to actually test their design. Provider stakeholders have been meeting with TennCare since May to offer input on the process, and the TMA has been actively monitoring its activities.

TennCare is basing its payment reform model after Arkansas’s recent payment overhaul in its Medicaid program, which incorporates episode-based payment as well as care coordination through patient-centered medical homes (PCMHs). An episode of care encompasses a selected condition or major procedure and includes any clinically-related services over a period of time following the condition or procedure, similar to the Medicare’s bundled payment model described earlier. Arkansas started its program in 2012 and so far has 13 episodes of care designed. The episodes that have already been implemented have a performance period through either September or December of 2013, so no data has yet been reported to evaluate the effectiveness of the program on cost-savings or quality.

The TennCare model, using elements of the Arkansas plan, will continue to reimburse physicians for services based on their current fee-for-service schedule. Incentive payments will then be calculated retrospectively after a performance period by identifying the primarily accountable provider (PAP) for each episode. The PAP will be identified by reviewing claims from the performance period to determine who was primarily in charge of that specific episode. Payers will calculate average cost per episode for each PAP and then compare average costs to predetermined “commendable” and “acceptable” levels, similar to the benchmark levels in Medicare’s ACO programs described earlier. These levels will be based on the average reimbursement across all relevant episodes completed in the performance time period. Providers will then share in savings if their average costs are below commendable levels, or pay part of the excess cost if their average costs are above the acceptable level. If their average costs are between the two, nothing will change for the providers’ reimbursement.

TennCare has already chosen the first three episodes of care to be designed by September: total hip and knee replacements, acute asthma exacerbations, and perinatal care. These three episodes will be designed by three Technical Advisory Groups (TAGs) that will be made up of clinicians from around the state, including TMA physicians in the necessary specialties. The designs are supposed to be evidence-based and include the services and procedures deemed necessary for each episode of care.

Thus far, the payment reform initiative is still in the earlier stages of planning, but TMA has been and will continue to be in the discussion every step of the way. Our focus is to ensure that the decisions being made incorporate Tennessee physicians’ concerns and suggestions.

Ms. Dageforde is assistant general counsel for the Tennessee Medical Association. Contact her at 800-659-1862 or katie.dageforde@tnmed.org.
IN A RECENT INTERVIEW WITH HEALTHLEADERS MEDIA, BLUECROSS BLUESHIELD OF TENNESSEE DIRECTOR OF PROVIDER RELATIONS AND COMMUNICATION CLAY PHILLIPS OUTLINED SOME OF THE CHALLENGES PRIVATE PAYERS ARE FACING. Declaring the nation’s current healthcare system “unsustainable in its current course,” he described the insurance industry as receptive but not quite prepared for the change that needs to happen.

Phillips was echoing industry officials who increasingly say fee-for-service (FFS) health care is on its way out and, as Phillips stated, hope to speed the piloting and implementation process for new quality care and payment models.
As with government payers, new models of care and payment break out in three areas, all of which aim to avoid duplication, error and unnecessary care, and improve efficiency and patient outcomes:

**BUNDLED PAYMENTS:** Providers receive a flat fee for episodes of care; for example, getting a single payment for treating a heart or hip replacement patient starting with the first visit, through surgery, and including follow-up care.

**ACCOUNTABLE CARE ORGANIZATIONS:** Providers come together in a collaborative relationship and are paid for the entire treatment and care of each patient, including their wellness and preventive care, chronic disease treatment, procedures, and follow-up.

**PATIENT-CENTERED MEDICAL HOMES:** A practice or provider is paid for being the main health caretaker for each patient, providing coordinated, preventive, evidence-based care.

These models are already being piloted and new variations may be coming, based on forthcoming data about which payment and treatment systems are proven to work best.

**COMING CHANGES**

As part of its role as a physician advocate, the Tennessee Medical Association is keeping an eye on insurance reform developments. The TMA Insurance Issues Committee is hearing from members who are worried not so much about reform itself, but about the additional work – and paperwork – health reform and payment reform will create.

TMA Insurance Recovery Program director Phyllis Franklin said the biggest concern voiced by doctors is about the lack of information, whether it’s payment reform, health reform, or other insurance system transformation.

For example, “I’ve heard comments from physicians who’ve been contacted by the health insurance exchange programs discussing signing contracts, but they don’t have any details and physicians feel like it’s going to come down to the wire and they’ll be asked to sign contracts not knowing how much they’re going to be paid and not understanding exactly how the exchange program works,” she said.

Uncertainty prevails with traditional insurance contracts, as well. Franklin said payers are reviewing current contacts with physicians and trying to change fee schedules – lowering fees in most cases to meet the additional cost demands of health reform coverage. They are shrinking physician network panels to save money, depending on the location and specialty coverage, using rating and tiering criteria to measure them by cost and performance against their peers. Insurance premiums are expected to rise and in some cases, possibly double, to help pay for the additional coverage required under health reform. That may cause a shift in employer coverage and migration to health insurance exchanges. For physicians and their billing staff, that means big changes in covered care, payment contracts, procedures, rules and regulations. With the implementation of the ICD-10 coding system in October 2014, physician billing and payment systems are in for additional change.

**TMA CAN HELP**

Through it all, the TMA is working to keep members up to date on what’s required and when, as well as provide tools to help them more easily adjust their workflow and processes to meet those requirements.

The TMA has launched a three-phase educational program on ICD-10 to help members and their practice billers and coders get ready for the system shift. Members can take online CME classes on both staff preparation and physician documentation, and late this year will be able to catch Phase II in the renewed ICD-10 Roadshow, with Phase III scheduled to travel the state in early 2014. This is one of the most critical changes for medical practice, Franklin said. If they are not ready for it, they will not be paid.

“We’re seeing a reluctance on the part of physicians to get ready, thinking it’s going to be delayed;” she said. “We’ve received word from CMS and insurance companies that it will not be delayed. Time’s running out to get this started. It’s a long process to get your office ready for ICD-10, and the sooner they start, the better. And of course, we can help them with that.” Members can find out more about ICD-10 preparation and available transition tools and software at www.tnmed.org/icd-10.

The TMA’s annual Insurance Workshops, scheduled statewide from October 8-30, will include elements of ICD-10 as well as payer updates from all the major players, both government and private. For more information and to register, visit www.tnmed.org/workshop.

For personal assistance with insurance payment recovery, questions or issues, contact Ms. Franklin at 800-659-1862 or phyllis.franklin@tnmed.org.
It has been estimated that patients are 90 percent more likely to pay for services before they see the physician. Proper front desk training is a crucial part of patient satisfaction and payment since patients are more likely to pay when asked for payment face-to-face. After a visit, payment rates drop as low as 40 percent.

The front desk is the first contact with patients, the first opportunity for getting correct patient demographic and insurance information, two vital pieces for submitting a “clean” claim. Yes, the front-desk’s role is critical to the success of your medical practice, but frequently overlooked with staff lacking resources and proper training.

Physicians, you must train your employees. A formal orientation and training session for front desk employees is critical because that way, you can teach them your system and they don’t just invent their own.
FRONT DESK RESPONSIBILITIES

PATIENT EDUCATION
Starting from the time the appointment is scheduled the patient should be informed that payment is expected at the time of service. Your front desk person should educate patients on your financial policy.

CHECKING INSURANCE ELIGIBILITY
As soon as a patient is scheduled the insurance verification process begins. The patient’s eligibility should be verified prior to the patient’s appointment. When verifying a patient’s insurance it is important to obtain the following:
• The effective date of the patient’s coverage.
• Is the coverage currently active?
• Is the diagnosis, procedure, treat, or visit covered?
• Are there any limitations or policy exclusions
• Does the procedure/visit require prior authorization or predetermination?

VERIFYING DEMOGRAPHIC INFORMATION
Medicare requires that the patient’s name, birth date, the spelling of the patient’s name and the ID number should be verified against the patient’s Medicare card to ensure that this information matches the information in your computer system. Medicare will deny the claim if any of the information is incorrect. This protocol should be in place when verifying the demographic and insurance information for all of your patients, regardless of the type of insurance. Additionally, contact information should be verified prior to every visit.

Avoid:
“Has anything changed since your last visit?”

Better:
“Do you still live at 123 Patient Home Address, Somewhere, TN?”
“Is your current phone number XXX-XXXX?”
“Do you still have ABC Health Insurance?”

COLLECTING AT THE POINT OF SERVICE
Have your front desk person remind patients of outstanding balances, copays and deductibles. It is best to collect the copay at every visit before the patient sees the physician. Remember, not collecting copay amounts is a violation of your contract with payers who require it. The front desk should also collect outstanding balances.

Avoid:
“Do you want to pay today?”

Better:
“Both your payment (or copayment) for this visit and your prior balance of $XX will be due today.”

Additionally, there may be patients who do not have insurance or who require some kind of financial assistance. Your front desk staff should be prepared to counsel these patients. This can include working out payment plans or informing them of financial programs available to them.

Your front desk staff is the first impression of your practice. They should greet each patient upon arrival, present a professional attitude and appearance. They must feel comfortable explaining the patient’s financial responsibility and indicating that payment is expected at the time of service. They should be friendly, yet firm.

Most important, physicians in the practice need to be supportive of the collection policy and refer any questions regarding financial matters to the appropriate personnel.

And finally, your office should have a clear, written financial policy stating when you expect payment.

Ms. Franklin is director of the TMA Insurance Recovery Program. For questions or help with insurance recovery issues, contact her at 800-659-1862 or phyllis.franklin@tnmed.org.

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• New Compliance Requirements You Need to Know
• Upcoming "Hot" Issues
• 2013 Legislative Highlights, which include:
  + Passed a law that seeks to encourage treatment, not punishment, of pregnant drug abusers
  + Won return to play concussion protections for youth athletic programs
  + Established common-sense restrictions on the prescribing of certain controlled substances
  + With ophthalmologists, defeated an optometrists’ bill that would have allowed them to perform dangerous procedures around the eye
  + Worked to separate legitimate pain clinics from “pill mills”
  + Helped block another attempt to weaken Tennessee’s motorcycle helmet law
  + Advocated for physicians on wholesale changes to the state’s workers’ compensation laws

Dates and Locations:

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• MEMPHIS  Aug 19 – Longinotti Auditorium at St. Francis Hospital
• NASHVILLE Aug 20 – Mob Auditorium at Centennial
• CHATTANOOGA Sept 10 – Probasco Auditorium at Erlanger
• KNOXVILLE Sept 11 – Bearden Banquet Hall
• JOHNSON CITY Sept 12 – Johnson City Public Library

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www.tnmed.org/2013-legislative-update

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What Will ACA Insurance Mandates Mean to My Practice as An Employer?

By Jeff Smith, CPA

n recent conversations I have had with small business owners, I have discovered most are struggling to understand their duties as employers regarding new health insurance mandates set to take effect in 2014.

CONFUSION ABUNDANT
A recent poll by the Kaiser Foundation indicates that most people are either unaware or confused by the mandate. In an April 2013 poll, 12 percent of respondents indicated they believe the law had been repealed by Congress, seven percent believed the Supreme Court had overturned the law, and 23 percent just did not know if the ACA remained as law. Another article I read indicated that most employees are looking for their employer to help them understand the ramifications of the law.

TWO SIGNIFICANT PROVISIONS TO KNOW
Let’s consider two major provisions in the law for businesses that, until the Obama administration’s recent delay, were scheduled to begin in January 2014. These are just two of the approximately 17 provisions scheduled to go into effect next year.

Employer Penalty
First of all, large employers (defined as 50 or more employees) will face penalties for not providing a minimum level of health insurance benefit at an affordable rate to the employee. The law defines the minimum level of benefit as coverage that provides an actuarial value of at least 60 percent — meaning that on average the insurance plan covers at least 60 percent of the cost of covered services for a typical population. The law defines affordable coverage as a charge for the employee coverage of a premium that does not exceed 9.5 percent of the worker’s income.

So if you have an employee who makes $40,000 per year, the cost for their health insurance cannot exceed $3,800 per year ($316.66 per month).

As mentioned above, on July 2 the Treasury Department announced it would delay its enforcement of these penalties until January 1, 2015, so employers and employees have a temporary reprieve.

Individual Penalty
The second part of the law imposes penalties on people for not having a minimum level of health insurance. This provision, known as the individual mandate, is scheduled to go into effect on January 1, 2014. Individuals will face penalties in 2014 of up to $285 for a family, or one percent of family income, whichever is greater.

WHAT ABOUT SMALL EMPLOYERS?
Where does that leave smaller employers — those with fewer than 50 employees? While they will not be penalized for failure to provide health insurance benefits, the costs of providing these benefits will probably be on the rise. In addition, these benefits have long been used to attract and retain quality employees. Many small business owners will still want to continue to provide health insurance benefits to key employees, as well as themselves.

Higher Benefit Costs to Your Practice
Even though the penalties do not apply to smaller employers, the financial impact of the ACA can be significant. It is possible that you, as an employer, now offer a health insurance benefit to your employees and pay some of the cost for this coverage. However, some of your employees elect not to participate. In the coming months, they will begin to hear more and more about the individual mandate and the penalty for not having health insurance. This may increase the enrollment in your plan and could therefore increase your costs significantly.

Higher Cost to Your Employees
As I mentioned, many of your employees will be counting on you to provide guidance on the effect the ACA has on them. Without some form of guidance, they could pay more than they have to for their insurance benefit. For example, a 32-year-old single parent with two children, making $35,000 per year, could be eligible for premium subsidies of approximately $5,500. If you, as the employer, offer that employee “affordable coverage” (as defined earlier), the employee would no longer be eligible for the subsidized government premium from the federal exchange or Health Insurance Marketplace, as it is now called. Your employer-sponsored health insurance plan could end up costing this employee thousands of dollars in subsidies. Now, what once was a key “benefit” to your employee is now a financial impediment to retaining that employee.

TMA WORKING ON A SOLUTION
As you can see, there are many reasons for practices of all sizes to analyze the effect of the Affordable Care Act on their business. The problem is the rules and regulations are still being issued and changes are happening quickly.

The TMA Insurance Agency is working on a new program to help members easily analyze their personal situations, and create a plan to guide you and your employees to
the proper solution to the challenges regarding health insurance mandates. We will continue to monitor changes as they materialize and provide more information on how the TMA stands ready to help its members and their employees make the right decisions.

Mr. Smith is a CPA and Certified Financial Planner. He is the CFO/treasurer of The TMA Association Insurance Agency and has worked in the insurance industry for 24 years. Any questions or comments can be emailed to him at jeffs@tmainsurance.com.

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To the Editor:
I am writing in praise of our late colleague, Burgin E. Dossett, Jr., MD, colonel, U.S. Army Medical Corps, CO of 912th Combat Support Hospital, Operation Desert Storm, Iraq, who died on March 14, 2013. He was a natural leader! A commanding officer! A dedicated physician!

Now, when membership in our Tennessee Medical Association is vital to our future, Dr. Dossett told me personally as founder and managing partner of his practice, Internal Medicine Group, that he paid the TMA membership of all of his medical partners “out of the till.” Dare we wonder how many of our medical groups follow his lead in support of our TMA?

Dr. Dossett welcomed me into our TMA, always calling me “Colonel.” I am privileged to have known him! Truly, humbly, privileged!

Josh Grossman, MD, FACP
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—J.S., M.D.

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Case Report and Review of Literature: Coronary Artery Fistulae

By Wissam Mechleb, MD; Lucien Abboud, MD; Costy Mattar, MD; and Tariq Haddadin, MD

ABSTRACT
Coronary artery fistula (CAF) is a rare disease. In more than 90 percent of cases, a single fistula drains into the right heart chambers or into the pulmonary artery. Fistulae draining into the left ventricle are uncommon; further, multiple CAF involving the three major coronary artery vessels are very rare.

This report will describe two rare cases of CAF, one of multiple CAF, and the other of single CAF, all of which drained into the left ventricular chamber.

INTRODUCTION
A coronary artery fistula (CAF) is an abnormal communication between a coronary artery and a cardiac chamber, great vessel or other vascular structure.

CAF is considered a rare disease, which accounts for only 0.4 percent of congenital heart defect and almost 50 percent of pediatric coronary vasculature anomalies.1 It is found in 0.3 to 0.8 percent of diagnostic cardiac catheterization.2 The majority of CAF are congenital, also many acquired rare cases have been reported, including traumatic and iatrogenic causes (endomyocardial biopsy, PCI, CABG, pacemaker implantation, MVR).3 CAF often arise from the right coronary system and usually drain into the right heart chambers or into the pulmonary artery. Fistulae to the left ventricle are uncommon; further, multiple CAF are rare, with only approximately 20 cases reported as generalized arteriosystemic fistulae originating from all three major coronary vessels.4

In this report, we will describe two rare cases—single and multiple CAF—draining to the left ventricle chamber, and we will review the manifestations, diagnosis and treatment of CAF.

CASE PRESENTATIONS
Case 1
A 73-year-old woman, known to have a past medical history of mild dementia, hypertension, hyperlipidemia and gastroesophageal reflux disease, was admitted to our institution for an acute respiratory failure.

Her physical exam showed an elderly patient in severe distress; her vitals showed a stable BP of 120/76, pulse of 110 and SaO2 85% despite FIO2 100% per-non-rebreather mask. Her lung examination showed diffuse bilateral crackles. Cardiovascular examination showed S1S2 without any additional sounds. The rest of the physical examination was unremarkable.

Her ECG showed a sinus tachycardia of 112 bpm and a left bundle branch block (LBBB) with ST-T changes related to LBBB, but there were no significant changes when compared to previous EKG except for a higher heart rate. A CXR showed bilateral interstitial infiltrate with mild cardiomegaly indicative of an acute pulmonary edema. Her initial BNP was 3940 pg/dL.

The patient required intubation and mechanical ventilation; she ruled out for ACS with three sets of CIE. Patient was diuresed with IV lasix with very good urine output. Patient improved clinically so a LHC was done to rule out coronary artery disease as a potential cause of her initial presentation.

An echocardiogram showed global mild hypokinesis with mildly reduced EF of 40-45%. LHC showed normal coronary luminography but the patient was accidentally found to have large multiple coronary fistulae from LCX to LV (Figures 1, 2), and left ventriculogram again showed a mildly reduced EF of 40–45%.

The patient was treated medically with beta-blockers, ACEI and oral diuretics and was offered surgical treatment of her coronary artery fistulae but she refused due to her age and general clinical condition.

Case 2
A 64-year-old female known to have a past medical history of HTN, HLP and ongoing tobacco use, was admitted to our institution with a four-month history of typical angina occurring both at rest and stress.

Her physical examination showed a normal first and second heart sounds without a murmur. Her BP was 132/78 mmHg and her HR was 68 bpm. No signs of heart failure were observed.

ABBREVIATION KEY:

ACS: Acute Coronary Syndrome
BNP: Brain Natriuretic Peptide
CABG: Coronary Artery Bypass Graft
CAF: Coronary Artery Fistulae
CIE: Cardiac Iso-Enzymes
EF: Ejection Fraction
LAD: Left Anterior Descending artery
LCX: Left Circumflex Artery
LHC: Left Heart Catheterization
LV: Left Ventricle
LVH: Left Ventricular Hypertrophy
MVR: Mitral valve replacement
PCI: Percutaneous Coronary Intervention
RCA: Right Coronary Artery
Her ECG showed a normal sinus rhythm and positive voltage criteria for L VH with ST-T changes related to repolarization abnormalities of LV.

Her 2D echocardiogram confirmed the presence of mild concentric L VH with grade I diastolic function but with preserved LV systolic function. Both RA and RV were enlarged but with preserved RV free wall contractility. Her PASP was mildly elevated at 52 mmHg. Her CXR showed mild cardiomegaly but with clear lung fields.

An adenosine myocardial nuclear scan was normal and showed no evidence of reversible ischemia; gated images showed an EF 64%. But due to the persistence of her symptoms, a LHC was done and showed normal coronary luminoigraphy but multiple fistulae were revealed connecting the LAD and LCX to LV and RCA to LV (Figures 3, 4, 5).

Since the patient had multiple fistulae, neither surgery nor transcatheter coil occlusion were considered in her case and she was treated medically with ASA, Metoprolol, ni- trates and amlodipine to control her anginal symptoms. The patient did well on medical management and when seen in our office as an outpatient, she was chest pain-free.

**DISCUSSION**

The clinical presentation of CAF varies widely, but it mainly depends on the size of the fistula, the age of the patient and the presence of myocardial ischemia. Abdelmoneim, et al., reported 30 patients with CAF, all of them symptomatic, mainly because of their age at the time of presentation and the fact that their center is a tertiary referral institution. Luo, et al., have reviewed six case series and found that about half of the patients with CAF are asymptomatic at the time of diagnosis.

Chest pain was reported to be the most common presentation in one single center experience, but it seems dyspnea and congestive heart failure symptoms were the most common symptoms in the majority of the other case series. Other symptoms include palpitations, arrhythmias, fatigue, rupture or thrombosis of the fistula, infective endocarditis and rarely sudden cardiac death. Dyspnea and congestive heart failure symptoms were mainly attributed to volume overload secondary to multiple CAF and large shunt, which is the case of our first patient. Though pulmonary hypertension has been reported to be the cause of dyspnea in some patients, exertional angina without angiographic evidence of coronary atherosclerosis has been attributed to a coronary steal phenomenon. This decreases the myocardial perfusion on exertion due to the inability of the coronary flow reserve to be augmented, that was the case of Patient 2.

Coronary angiogram is still the gold standard for the diagnosis; however, Ortega, et al., used transthoracic 2D echocardiogram and Doppler as initial diagnostic tools. Other emergent technologies, such as cardiac CT, MRI, and MRA, may have an added diagnostic value.

Some authors recommended the Doppler echocardiogram as a noninvasive technique for monitoring of spontaneous CAF closure. Also, transesophageal echocardiography is used intraoperatively to localize the fistula, which is sometime missed by the preoperative coronary angiogram. In our cases, the fistulae were diagnosed only by coronary angiogram and the echocardiogram did not reveal any suspicious fistulae.

Elective closure of coronary artery fistula in children has been recommended since it may prevent future complications. Elective closure of symptomatic CAF is accepted, however, treatment of asymptomatic adult patients is a matter of debate. Further, the choice between transcatheter embolization and surgical intervention is also still debated.

Armsby, et al., have reported the findings in 39 patients who underwent transcatheter closure of coronary artery fistulae. TCC was feasible in 33 patients; a total of 35 procedures were performed (two patients had second catheterization due to residual fistulae); complete occlusion was noted in 19 (54.2 percent); barely perceptible flow was noted in 11 (31.4 percent); and tiny flow was noted in five (14.2 percent). There were no deaths or long-term morbidity. The authors concluded that transcatheter closure is an acceptable alternative to surgery; with similar effectiveness, morbidity and mortality.

Recently, Collins, et al., reported TCC as a safe and effective method of therapy in 14 symptomatic adult patients with CAF. The procedure was successful in 11 patients, two patients had coil embolization that was retrieved and one patient had dissection within the fistula without successful coil placement.

In the case series reported by Abdelmoneim, et al., all patients were asymptomatic. Conservative management was opted in 17 patients who had minimal symptoms and small shunt. There was significant improvement in chest pain in both groups (conservative and intervention) but only the intervention subgroup had some significant improvement in their CHF symptoms.

However, all series did not recommend TCC or surgery in case of multiple CAF. Medical management after complete occlusion of CAF remains controversial. Most studies do not recommend anticoagulation; however, some authors recommend aspirin and even warfarin in case of severe coronary artery dilation (> 10 mm).
Recently, Kharouf, et al.,15 reported a TCC of a CAF (LCX---->CS) complicated by an acute myocardial infarction caused by complete occlusion of the LCX, most likely caused by thrombosis. They recommended warfarin for several months and aspirin indefinitely, in the presence of significantly dilated coronary artery (double the size of the normal coronary artery).

Also, prophylaxis for bacterial endocarditis is recommended after complete fistula occlusion for at least one year.

Otherwise, management of congestive heart failure and angina due to CAF is similar to that without CAF; the only difference is that nitrate should be used with caution, as they may dilate the fistula and increase the coronary steal phenomenon.

Patient 1, who presented with CHF and multiple CAF was treated conservatively, as she is not a candidate for elective fistulae closure. The patient has evolved uneventfully and she was discharged on aspirin, beta blocker and diuretics, to be followed in our clinic.

Patient 2 presented with typical angina and had a single CAF with no atherosclerotic coronary disease. She refused an elective transcatheter embolization and preferred to stay on medical management. We discharged her on aspirin and beta blocker. At six month follow-up, she was doing well with no recurrence of her chest pain.

CAF is still a rare disease; even so, all physicians should be aware of this entity in the differential diagnosis of patients with dyspnea, angina or congestive heart failure. +

References:

From the Cardiology Departments at James H. Quillen Veterans Affairs Medical Center, Mountain Home, and James H. Quillen College of Medicine, East Tennessee State University, Johnson City, TN.

For reprints, contact Dr. Mechleb at ETSU HEART, 329 N. State of Franklin Rd, Johnson City, TN, 37604; phone: 423-439-7280; email: wissam_mechleb@me.com.
Rhombencephalosynapsis (Abstract Only)

By Greg Nieckula, DO; Daniel Zapko, MD; Lisa Staton, MD, FACP; Abdelazim Sirelkhatim, MD; and Pradeep Jacob, MD

LEARNING OBJECTIVES:
• Identify the clinical features of rhombencephalosynapsis, a rare disorder
• Recognize congenital causes of neuropsychiatric disease.

CASE
A 28-year-old male with history of seizure disorder, schizophrenia, developmental delay with intellectual impairment and gait ataxia presented to the hospital with a breakthrough tonic-clonic seizure. Further medical history included craniosynostosis with calvarial vault remodeling at the age of two and exotropia with surgical correction at the age of 16. The patient had recently been released from prison after serving a five-year sentence for motor vehicle theft. He admits that he stopped taking anti-psychotic medication prior to committing the crime. He also admitted to IV drug abuse during the distant past. Pertinent findings on exam included a high forehead and constant head rocking throughout the exam. The patient was awake, alert, and oriented. He displayed a poor attention span. Basic spelling and math skills were impaired. Cranial nerves were grossly intact. No nystagmus was noted. There were no focal motor or sensory deficits. Reflexes were intact and symmetric. Assessment of coordination revealed dysmetria and dysdiadochokinesia. Gait was wide-based and ataxic. Laboratory data was unremarkable aside from a positive rapid HIV screen that was later confirmed by Western Blot. Brain MRI revealed incomplete development of the cerebellar vermis and fusion of the cerebellar hemispheres. The patient was diagnosed with rhombencephalosynapsis.

DISCUSSION
Rhombencephalosynapsis (RES) is a rare congenital cerebellar malformation characterized by partial or complete absence of the cerebellar vermis and apparent fusion of the cerebellar hemispheres with an unknown etiology. RES can be seen in isolation, or in combination with other brain malformations and malformations outside the nervous system. The clinical manifestations of this malformation are variable. Possibilities include craniofacial dysmorphology, alopecia, developmental delay, intellectual impairment, trigeminal anesthesia, additional brain malformations, strabismus, nystagmus, head rolling or rocking, seizures, sleep apnea, small size, and behavioral disorders. Our patient exhibited many of the clinical manifestations of RES. Unfortunately, due to the rarity of this malformation, it may go undiagnosed. In the case of our patient, RES likely contributed to negative social consequences leading to incarceration.

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Leadership and the Alliance

By Heidi Dulebohn, TMAA President

Along with a strong delegation from Tennessee, I was fortunate enough to attend the American Medical Association Alliance (AMAA) Leadership Development Conference and Annual Meeting in Chicago in June. We had special cause for celebration as one of our own, Jo Terry of Knoxville, was installed as AMAA president.

During the conference I found myself looking around the room, full of dedicated Alliance members from across the country, eager to listen and learn so they could go home and lead their Alliances to new heights. Each of them was accomplished in their own right. When it came time for Jo to be installed as the new leader of this prestigious group, I reflected on what it really means to be a great leader. What does it take to be singled out of so many capable people?

“Before you are a leader, success is all about growing yourself. When you become a leader, success is all about growing others.”
— Jack Welch

Jo comes to her AMAA leadership role with a wealth of experience. She has spent her lifetime helping others in one way or another, working tirelessly to abate domestic violence, is a lay leader in her church, has a beautiful, loving family and has held many offices in the TMAA, including president (2005-2006). Jo has deservedly received many honors and accolades for her successful work on the behalf of others.

Jo has inspired many to follow in her footsteps. Personally, she has been a sage and supportive ally to me. When I looked around the room at LDC, I saw the faces of many others who, too, had a supportive ally in Jo.

On the eve of her inauguration, Tennessee served as host to a wonderful reception. Our Reception Committee worked hard to produce a fun evening with Tennessee flair. A personal highlight was when the TMA delegation to the AMA meeting arrived en masse, each donning a “Tennessee” tie. We are grateful for the TMA’s generous support and it was a goosebumps moment to stand together with the TMA as we saluted Jo. I especially thank TMA President Dr. Chris Young for his kind words for Jo and the Alliance.

“Never doubt that a small group of thoughtful, concerned citizens can change the world. Indeed it is the only thing that ever has.”
— Margaret Mead

The Alliance has produced many great leaders, each making their community, state and country a healthier place. We strongly believe we can be agents for change. I strongly believe that by working in concert with the TMA, and with Jo at the national “helm,” we will accomplish great things. We are BETTER TOGETHER!

“A leader is a dealer in hope.”
— Napoleon Bonaparte

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For membership information, contact Jan Headrick at 423-344-6206 or GoloMama@aol.com; or TMAA Executive Assistant Judy Ginsberg at 615-460-1651, 800-659-1862 (toll free) or tmaa@tnmed.org.
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IN MEMORIAM

WILLIAM C. SMITH, MD, age 58. Died December 14, 2012. Graduate of University of Tennessee Health Science Center. Member of Chattanooga-Hamilton County Medical Society.

DAVID FRANKLIN KLINAR, MD, age 53. Died June 6, 2013. Graduate of Medical College of South Carolina. Member of Sullivan County Medical Society.
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