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The New President: Dr. Chris Young
Corporate Compliance in May
The Journal:
Isolated Pyocele of Anterior Clinoid Process
Heart Failure Presenting as Myxedema

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Chattanooga anesthesiologist Christopher E. Young, MD, has taken the helm of the Tennessee Medical Association as its 159th president, and says he hopes to help doctors navigate what he calls “the biggest change in health care since Medicare.”

Dr. Young said he wants physicians to realize they can still make a difference.

“There’s a lot of opportunity,” he said. “Physicians should feel empowered to make changes in health care. Focusing and working together through the TMA is the best way to effect those changes.”

He said the Affordable Care Act is now the law of the land and physicians must accept it. “Doctors don’t have to be discouraged; we need to make the best of what we have, and work to improve the law as we move forward. Our patients need us more than ever and our country needs leadership from physicians to address the many healthcare challenges in front of us.”

Coming from a family of physicians — his father was an orthopedic surgeon and his brother is a vascular surgeon – Dr. Young says he never really thought about doing anything else. He grew up in Knoxville watching his father practice, noting he was well respected and well liked by his patients. “I was proud to be his son.” For two summers he worked in the operating room after high school – “That’s when I was exposed to the OR for the first time and really liked that environment,” he said.

As an anesthesiologist, Dr. Young says he usually meets patients for the first time in the pre-op setting. “They’re frightened because they’re having surgery. You really only have a few minutes to talk to them but you need to be able to gain their confidence quickly and reassure them they’re going to be taken care of in the operating room.”

After moving to practice in Chattanooga in 1991, Dr. Young became aware of how much government impacted the practice of medicine. “I wanted to understand how regulations and laws were made and then have a part in trying to make it better.” He joined the American Society of Anesthesiologists (ASA) and began attending its legislative conference in Washington, DC, in 1999. “I came to understand that as a group, physicians are not involved in political activities to the extent we need to be.”

In 2006 he was elected president of the Tennessee Society of Anesthesiologists (TSA) and was able to help better organize and strengthen that society. It was Rae Bond, executive director of the Chattanooga-Hamilton County Medical Society, who encouraged his involvement in the CCHCM and subsequently the TMA Board of Trustees, leading to his run for TMA president in 2011.

As president Dr. Young will serve on the TMA Board of Trustees, which is responsible for the direction and implementation of Association activities between sessions of the House of Delegates, the Association’s governing body. He will also serve as the public spokesman and official representative for the TMA’s nearly 8,000 physician members.

Board certified in anesthesiology with specialized training in cardiovascular anesthesia and pain management, he received board certification in Pain Management in 1993. Dr. Young is a former assistant professor of anesthesiology at the SUNY Health Science Center in Syracuse, NY where he completed his residency. He was awarded the Robert D. Dripps, MD, Memorial Award for Outstanding Graduate Resident in Anesthesiology in 1989.

Dr. Young is a founding board member of the Signal Mountain based American Haitian Foundation, and is responsible for establishing the first solar/wind powered school in Haiti. Active in surgical mission work in Central and South America for two decades, he led a surgical team to Haiti immediately following the devastating earthquake in January 2010.

(Continued on page 10)
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Tennessee, like every other state in the nation, has a prescription drug abuse problem. No one knows that better than emergency physicians. No one is in a better position to see the systemic flaws and outright failures in American healthcare than EPs. We are the tip of the spear in medicine, the canary in the coal mine, the ... well, you get the idea.

Dealing with drug abusers, and sometimes even helping them, has always been a big part of emergency medicine. I never really minded that and looked at it as the price I paid for the chance to take care of the critically ill and acutely injured. Over the last couple of years my attitude has changed, however.

What’s different? First, the problem seems more severe than ever before. I have worked more than one shift in recent years in which every one of the first four patients I saw were, beyond any reasonable doubt, drug abusers. I could tell easily just from reviewing their medical records and ED visit histories on the computer – much less by consulting Tennessee’s Controlled Substance Monitoring Database (CSMD). Think what that kind of statistical sampling says about the ED’s patient population. Think what it means for the morale and longevity of emergency physicians. It feels like 20-25 percent of my patients don’t have any acute medical problem at all, and are in the ED only because they are addicted to prescription drugs – usually opioids or benzodiazepines – and want me to give them more.

Data confirm my subjective impression. According to an analysis of CDC data by The Los Angeles Times (Sept. 17, 2011), drug deaths now outnumber traffic fatalities in the United States. Most of these are from prescription drugs. How did we get to this point? The Times says, “The seeds of the problem were planted more than a decade ago by well-meaning efforts by doctors to mitigate suffering...” To put it politely, that’s a big, smelly, steaming load of crap. On the contrary, the seeds were probably planted when the Joint Commission made pain “the fifth vital sign” and saddled us with that ridiculous 1-10 pain scale – which brings me to the second and more important thing that has changed over the last few years: perverse incentives.

Wikipedia offers this definition: “A perverse incentive is an incentive that has an unintended and undesirable result which is contrary to the interests of the incentive makers. Perverse incentives are a type of unintended consequence.” It also provides this graphic and amusing example: “In Hanoi, under French colonial rule, a program paying people a bounty for each rat tail handed in was intended to exterminate rats. Instead, it led to the farming of rats.”

There was a time when most of us were physicians taking care of patients, rather than businessmen catering to customers, and when doctors were in charge of medical care rather than being another provider in the healthcare delivery system. Our first and most important goal was to do the right thing for our patients, not make the customers happy at all cost. Our motto was primum non nocere: “First, do no harm.”

Perverse incentives are eating away at that honorable tradition. I wonder what our motto would be if it were written now, especially by emergency physicians and the other hospital-based specialists who are employed at the pleasure of hospital administrators: “First, don’t piss off the Joint Commission,” or “First, I must keep my number of complaints in the bottom quartile”?

No matter how gently I explain to addicted patients that I fear they have developed a substance abuse disorder, or how sympathetically I offer referral to an appropriate treatment program, nearly all of these patients deny being addicts and leave angry. Almost all threaten, “I’ll have your job!” and some threaten my life. It is rare indeed for one to have a sudden epiphany, realize he is an addict and gratefully accept treatment for his real problem. This is a universal experience for emergency physicians and we can shrug it off when we have a wise and supportive hospital administrator (God bless ‘em!). However, when we have a hospital administrator who gives complaints
from drug abusers as much weight as those from the rare patient who caught the ED on a bad day and really should have been treated differently, it takes a heavy toll. Eventually we feel tremendous pressure to make the customer happy rather than adhere to our professional ethics. I have seen colleagues, excellent physicians whom I respect, become exhausted by the constant threat of losing their jobs and give in. On rare and particularly bad days when I couldn’t bear the thought of another email from my department chairman about the hospital administrator’s “concern,” even I have thought, “I should just give him a few Lortab and get him out of the ED.” And before someone casts the first stone, how many of you can say you never prescribe antibiotics for colds, acute bronchitis and acute sinusitis—even though the evidence is conclusive that antibiotics are all risk and no benefit for these diseases, and such misuse of antibiotics has serious public health consequences? Making the customer happy, aren’t you?

Think how much worse the pressure will be when most physicians are employees or have been gathered up into accountable care organizations, and can be fired or have a performance bonus withheld by a nonphysician boss who sees patients only as customers and has none of the ethical obligations of a physician. As Lisa Rosenbaum said in her recent editorial in the New England Journal of Medicine (“The Whole Ball Game – Overcoming the Blind Spots in Health Care Reform,” March 7, 2013): “We must admit that turning health care into a customer-service industry may to some extent undermine the delivery of evidence-based care.” It would have been more accurate to say quality care than evidence-based care.

The medical profession does bear some responsibility for the prescription drug problem and this has been addressed in our state. Tennessee now has strict laws regulating chronic pain clinics, making it harder for that tiny fraction of physicians who are really just licensed pushers to carry on. The CSMD makes it impossible for patients to hide their addiction to prescription drugs from us—unless they are going to other states to fill their prescriptions. Querying the database is now required before most prescriptions for opioids or benzodiazepines. Laws against doctor-shopping have also been toughened. All these measures had TMA support. In cooperation with several state agencies, the Tennessee Pharmacy Association (TPA) and others, the TMA also created the Tennessee Prescription Safety Program. Among other activities, it identifies and re-educates those overprescribers who are being duped by their addicted patients. Also in partnership with the TPA, the TMA has applied to the Blue Cross Blue Shield of Tennessee Health Foundation for a grant to fund a prescription drug safety program. This will include a public awareness campaign and professional education, among other things.

The measures above are important and should help over time, but the perverse incentives physicians are subjected to must be addressed. For patients to receive the best medical care possible, they must be patients first and customers second. Physicians must be in charge of medical care, free to exercise their best professional judgment on behalf of patients without being coerced by nonphysicians. Government bureaucrats, insurance companies, hospital administrators and maybe even tort lawyers have their place and their appropriate jobs to do. Making clinical decisions for physicians and their patients is not one of those appropriate jobs. Neither is putting pressure on physicians to harm the patient for the sake of making the customer happy. This hurts patients, damages the medical profession, and burns out physicians.

As Tennessee Medicine Editor Dr. David Gerkin said in his editorial in the March issue, “...many doctors are retiring early or leaving the direct patient-care setting to avoid the stress of trying to maintain quality in an environment of increasing mandates and regulations, which are creating barriers to the care they were trained to provide.” If addiction is a disease, then giving an addict more drugs prolongs the disease and actively harms the patient, in violation of our oath. If the prescription drug problem is to be solved, physicians must be free to do the right thing without penalty or outside pressure—and often that means making the patient very, very unhappy.

Dr. Walker is on the board of directors of the American Academy of Emergency Medicine, is editor of the AAEM newsletter “Common Sense,” and is vice-president of its Tennessee chapter. He is also a member of the Tennessee Medicine Editorial Board. The TMA welcomes but is not responsible for opinions expressed in this forum.
Internists see the evolution of medicine at ground level. As practice environments grow more complex, we find ourselves sometimes driving reform, sometimes along for the ride. The profession of internal medicine is changing, hospital rounds are diverging further from the clinic, and our identity as internists is evolving as we approach a crossroads.

Experts in the care of patients through their adult lives, general internists remain in great demand. In the clinic, we nurture relationships with our patients over a lifetime. With medical knowledge, communication skills, patience and compassion, internists aim to alter the devastating course of chronic disease. In the hospital, patients with complex, severe acute illness crowd emergency departments 24 hours a day and from admission to discharge, hospitalists conduct their care. As outpatient physicians shift the course of chronic illness, hospitalists manage the associated acute complications.

With growing needs in both clinic and hospital, internists are choosing sides. Recent graduates, in particular, are selecting hospital medicine, inflating the number of hospitalists from 1,000 to 30,000 over the past 15 years. Many factors have shifted internists to hospital medicine. From classroom instruction through clinical training, exposure to hospital and specialty medicine has traditionally overshadowed primary care. Students and residents also view contrasting realities as they plan their future. Outpatient physicians must change patients’ behavior while spending less time at the bedside. In contrast, acute interventions of the hospitalist align more easily with patients’ immediate goals. As administrative demands grow, employed hospitalists yield control in exchange for simplicity. Compensation is greater in the hospital and, in many systems, physicians can spend more time at home with their families. Reform efforts such as the Patient Centered Medical Home may ultimately strengthen the foundation of primary care but for now add to growing complexity and uncertainty. Thus while internists hope to fill an urgent need for primary care, the body of hospitalists continues to grow. As internists, we will shape medicine; first we must re-examine ourselves.

Ultimately, we can focus on our differences or hold on to our identity, unwilling to lose ourselves.

Whether practicing in a clinic-based setting or focused in the hospital, internists have always shared a common identity. As first depicted by Osler’s consultant generalist and more recently defined by the American College of Physicians, we focus on the prevention and treatment of all diseases which impact adults. We are equipped to deal with any problem a patient brings and we are specially trained to solve complex diagnostic dilemmas. We promise to care for the whole patient throughout every stage of life, and our adherence to this promise will define us.

As practice patterns diverge, consider the consequences of diverging identities. In the clinic, internists will focus on prevention, building models of more effective primary care. Outpatient internists will become less comfortable managing urgent situations, less familiar with the acute sequelae of chronic disease, and more distant at the end of life. Likewise by surrendering chronic care to others, hospitalists will become fighters of disease rather than promoters of health, and we will be valued differently. Instead of expert clinicians, hospitalists become maximizers of efficiency, focusing on brisk patient throughput and deferring medical decisions to specialists who will follow patients over time. With the emergence of hospitalists, it is clear that practice environments are changing. However if we lose our identity as internists and if we fail to keep our promise to our patients, then our profession will suffer immeasurably.

After all, our breadth of experience remains one of our greatest strengths. In the hospital, internists guide patients and families devastated by illness as we also tend to the unanticipated consequences of medical care. We observe families strengthened in times of struggle as others are torn apart. We witness firsthand the value of pushing forward, and the relief of letting go. In the outpatient setting, these hospital experiences prove essential as partner with our patients over a lifetime. Conversely, in clinic we learn to communicate clearly, to accept uncertainty, and to assume the responsibility of our patients’ care. Such vital skills, developed in clinic, provide a necessary foundation for care on the wards. And so even as our practice patterns diverge, another option remains. We can preserve our common identity, reinforcing our dedication to patients through all stages of their lives. We know that to keep our patients well, we must treat them at their sickest; to meet
their urgent needs, we must understand their chronic struggles; and to help our patients live, we must sit with them as they die. As we shape curricula, legislation and self-evaluation, we can ensure that all internists remain equipped to promote health and treat illness throughout our patients’ lives. For without our breadth and depth of understanding, we risk losing vital perspective. In clinic and on the wards, our shared experience and dedication to our patients unite us as internists, and we recognize that we stand stronger together than we can apart. Ultimately, we can focus on our differences or hold on to our identity, unwilling to lose ourselves.

References:

Dr. Hegedus is an internist with Baptist Medical Group Hospitals of Memphis. Contact him at hegedus123@yahoo.com.

Tennessee Medicine welcomes but is not responsible for views expressed in this forum.
PROFESSIONAL PRIVILEGE TAX; HIPAA UPDATES

Q: I found a notice for my professional privilege tax from 2012 the other day and seem to remember there was a notice from TMA about changes to the tax, but I can’t remember what it said. Are there some changes for 2013?

A: Yes. The Tennessee Department of Revenue will not be mailing professions any notice of their $400 Professional Privilege Tax assessment due on June 1, 2013. Noncompliance can result in monetary penalties.

All professional privilege tax returns filed on or after January 1, 2013, must be filed electronically. Professional privilege tax returns can be filed electronically either by individuals, or by companies who file and pay for multiple individuals. For a step-by-step guide to electronically file an individual professional privilege tax return, please visit https://apps.tn.gov/prittx/. If you have a company filing and paying your professional privilege tax, advise them to visit https://apps.tn.gov/privbatch/.

These new electronic filing requirements will permit the Taxpayer Services Division to process your return and payment more timely and efficiently at a cost savings to the State. Should you have additional questions, contact the state’s Electronic Commerce Unit at 866-368-6374 for in-state calls or 615-253-0704 for local or out-of-state calls.

Q: My practice administrator was telling me we have to update our HIPAA Notice of Privacy Practices and other HIPAA documents. What do we need to do? Will the TMA provide any assistance?

A: Yes, the TMA Legal Department is currently working on a comprehensive summary of the final rule that was promulgated at the end of January. Legal staff has reviewed the 500-page rule and created checklists, written articles and updated Law Guide topics to assist members in understanding what must be done by the compliance date. The HIPAA updates are announced through the TMA Weekly and through Twitter (@tnmed). The Rules were effective on March 26, 2013, and covered entities must be in compliance with them by September 23, 2013.

There is a grandfather-type provision for the business associate section of the rule. A Covered Entity (CE) and a Business Associate (BA) with a written BA agreement in effect prior to January 25, 2013, that is compliant with the old HIPAA BA requirements and is not renewed or modified from March 26 to September 23, 2013, may continue to operate under that agreement until the earlier of:

- The date the contract is renewed or modified after September 23, 2013; or
- September 24, 2014.

If you have any questions, please contact the TMA Legal Department at legal@tnmed.org or 800-659-1862. Law Guide topics are updated frequently and members may access the directory of topics at www.tnmed.org/lawguide (member login required).
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Physicians from across the state gathered in Franklin, TN, April 5-7 and considered a number of health policy positions for the Tennessee Medical Association, including support for expanding access to healthcare coverage, more funding of mental health screenings and treatment, transparency of patient charges for prescription drugs and hospital services, maternal mortality review and amending restrictive guidelines for care provided by physicians in training.

Following passionate debate, a resolution supporting expanded access to care for all Tennesseans was approved by a majority of delegates. The resolution supports expanded access under a three-year trial program using Medicaid expansion funds to cover uninsured residents through health exchange purchased plans, similar to Gov. Haslam’s proposal, or direct expansion.

“As physicians, our patients must come first – increased access leads to better health outcomes. Our policy is to support efforts to make affordable healthcare more accessible, which is part of the TMA’s core mission,” said Christopher Young, MD, of Chattanooga, who was installed as the TMA’s 159th president during the meeting.

(Continued on page 20)

TMA Delegates Vote to Support Expanded Access to Care

A statement from TMA President Dr. Chris Young

The TMA supports access to affordable, quality health care and believes that our state should take advantage of funding available to expand insurance coverage for our citizens. Our House of Delegates convened on April 7 and after lengthy debate and passionate testimony, there was a majority vote to change our position from neutral to supportive of expanding access to care for the uninsured using federal funds.

There was much concern expressed about what may happen in three years when the state has to come up with shared funds. There is worry that the federal government will not be able to hold up its financial promise to the state. We don’t know what will happen in three years with the program, but we do know what happens to our patients without access to care or insurance coverage: their health suffers and life expectancy is shorter.

At the end of all the debate, the lingering fact that patients with insurance have greater access to care, ultimately allowing them to live longer, healthier lives, seemed to resonate with the delegates assembled.

We encourage the State to accept the offer from the federal government to pay 100 percent of the cost for increased enrollment in TennCare as part of the Affordable Care Act for a three-year trial period. Whether the funding is used to subsidize the purchase of personal policies in the commercial market or to expand the current TennCare program is a choice for the Governor.

We request that the benefits offered to patients in any expanded program be at least equal to current TennCare benefits. And we pledge to make your Association available to the Governor and the General Assembly to advocate for healthcare coverage in Tennessee.

As physicians, our patients must come first. Our new policy supports making affordable healthcare more accessible, which is part of the TMA’s core mission. We cannot miss this chance to shape the future of health care in Tennessee.

Thank you for your continued support of the TMA as we represent you in the fight for a better medicine and a better practice environment.
Physicians who sign medical orders written by someone else could face penalties or open themselves up to possible fraud and abuse liability. That word of caution from TMA Legal officials who say one member has contacted them about a business practice by one home healthcare system in Tennessee that raises this concern.

Physicians who sign CMS-485 Plans of Treatment for patients are responsible for those orders even if they did not write them or read them. Physicians who sign an order saying they have had face-to-face encounters with patients when they have not could face penalties or false claim liability if claims for unwarranted services are filed with a government payer, such as Medicare or TennCare.

**BACKGROUND**

A Tennessee primary care practice reports multiple incidents of a home care entity faxing orders to the physician for his patients to receive home care upon discharge from the hospital. In the instances reported, both the hospital and the home healthcare business are owned by the same entity. The primary care physician was not the physician who ordered home care for the patient upon discharge, was not aware of the patient’s hospitalization, and could not make a clinical judgment regarding the clinical need for home care because he had not seen the patient face-to-face recently. The physician refused to sign the 485 Plan, citing the fact he did not issue those orders, and then contacted the TMA.

The TMA works to keep members apprised of legal and regulatory issues affecting the practice of medicine and patient care. For legal assistance, contact the TMA Legal Department at 800-659-1862.

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**Member Alert: Use Caution When Signing Medical Orders**

Physicians and practice staff can earn up to 4 CEU credits* for attending the TMA ICD-10 Roadshow, appearing at locations across Tennessee throughout May.

Sponsored by BlueCross Blue Shield of Tennessee and Emdeon, the program features THIMA experts talking about coding and documentation compliance issues; BCBST, United Healthcare and Emdeon discussing testing timelines, dual processing procedures and how to minimize payment delays now that they all have had time to develop their approach; and national expert, author and contributor to Talk Ten Tuesdays Denny Flint helping practices with a workable approach for implementation.

**DETAILS**

**Locations:**
- May 7 – Memphis, Longinotti Auditorium, Saint Francis Memphis
- May 8 – Nashville, Owen Continuing Education Center, Baptist Hospital
- May 21 – Kingsport, Meadowview Marriott
- May 22 – Knoxville, Knoxville Marriott (1st session SOLD OUT; 2nd session has been added)
- May 23 – Chattanooga, BCBST Headquarters

**Topics:**
- Roles & Responsibilities of Physicians & Staff
- How to Develop an Education & Transition Plan
- Understanding Documentation & Compliance Mandates
- Choosing Implementation Tools
- Payor Readiness

**Who should attend?**
- Physicians & Other Providers
- Practice Managers & Administrators
- Coding & Billing Specialists
- IT Consultants
- Clearinghouse & Revenue Cycle Managers
- Hospital Ambulatory Personnel

The half-day workshop costs $79 per person; register today at www.tnmed.org/icd-10/roadshow. For more information, contact TMA Practice Solutions at 800-659-1862.

*This program meets AAPC guidelines for 4.0 Core B continuing education credits.
MEET

Membership Committee Chairman
Dr. Jerome “Jerry” Thompson

PERSONAL
Official Title/Position: Chair of ENT at the University of Tennessee-Memphis and chief of Surgery at Methodist Lebonheur Healthcare
Company/Years: University of Tennessee/University Methodist Lebonheur Pediatric Specialists, 20 years
Practice Interests/Specialties: Pediatric airways, healthcare economics
Most Important Accomplishment: Past associate dean of UT Memphis, founding member and past president of the American Society of Pediatric Otolaryngology (ASPO)
Family: Married for 24 years, I have seven children, and my two middle daughters just got into UT medical school
Something Not Widely Known About You: I love to hunt anything, and have a grizzly in my office that I shot
Currently Reading: Theodore Rex about Teddy Roosevelt

COMMITTEE
Years as Chair: Three years as Insurance Committee chair, one as Membership chair
Why Agreed to Step into Leadership Role: (President-elect) Dr. Doug Springer asked me to be the chair of membership and I believe major changes are going to happen in the structure of TMA membership in the coming years
Goals/Philosophy as Chair: Our goal is to expand membership to represent more physicians in Tennessee
Most Important Accomplishments of Your Committee: Kept membership up for this year
Importance of the TMA: Fully employed physicians are going to be a major force in future medicine in this country and I want the TMA to be one of the first to take advantage of this sea-change moment

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

Professional Privilege Tax: No Notice Given But Penalties Will Be Levied

The Tennessee Department of Revenue will not be mailing physicians any notice of their $400 Professional Privilege Tax due on June 1, 2013. Noncompliance can result in monetary penalties.

All professional privilege tax returns filed on or after January 1, 2013, must be filed electronically. Professional privilege tax returns can be filed electronically either by individuals, or by companies who file and pay for multiple individuals. Read more on those requirements and access a step-by-step guide to filing electronically at www.tnmed.org/electronic-filing-pro-priv-tax.

These new electronic filing requirements will permit the Taxpayer Services Division to process your return and payment more timely and efficiently at a cost savings to the State. Should you have additional questions, feel free to contact the state’s Electronic Commerce Unit at 866-368-6374 for in-state calls or 615-253-0704 for local or out-of-state calls. See our related "Ask TMA" article on page 11.

Rx Database Query Only Required on Opioids and Benzos

The Board of Pharmacy/Controlled Substance Monitoring Database (CSMD) has confirmed that the TMA and the Tennessee Chapter of the American Academy of Pediatrics (TNAAP) are correct in our interpretations of the new state prescription safety law – that only prescriptions for opioids and benzodiazepines require a query of the database.

As part of its mission to be a physician advocate on legal and regulatory issues and particularly prescribing laws, the TMA continues to work behind the scenes to seek adjustments and give feedback to state officials on issues that arise with the CSMD.

LAW REQUIREMENTS

Physicians are required to begin checking the controlled substance database effective April 1 before prescribing opiates or benzodiazepines, with some exceptions.

The law was effective April 1. At least one physician had been told that prescriptions for schedules II-IV required a CSMD query. While the law language states, "...but are not limited to," officials have confirmed that currently, opioids and benzodiazepines are the only classes of drugs that trigger a CSMD query. That will not change without further action, which could take a couple of years.

To learn more about the new law, read the TMA’s online Law Guide topic on the “Controlled Substance Database” at www.tnmed.org/lawguide (member login required) or call the TMA Legal Department at 800-659-1862.
The Tennessee Medical Association is proud to announce the 2013 graduates of the TMA Physician Leadership College. The class represents physicians from multiple specialties across the state of Tennessee. The graduates were honored during a ceremony on Saturday, April 6, at MedTenn 2013, the TMA’s 178th annual meeting in Nashville.

Over the past year, these physicians have completed coursework in collaboration, decision making, advocacy, media relations and conflict resolution. In addition to learning new leadership skills, each participant has completed a leadership project focused on improving patient care and/or organized medicine.

We are proud of the following physicians who completed their training and are now graduates of the TMA PLC:

- Ralph Atkinson, MD
  Nashville
  Nephrology

- James Batson, MD
  Cookeville
  Pediatrics

- Steve Bengelsdorf, MD, FACS
  Nashville
  General Surgery

- Jennifer Dooley, MD
  Chattanooga
  Internal Medicine

- Norma Edwards, MD
  Memphis
  General Surgery

- Tim Gardner, MD
  Johnson City
  Dermatology
The TMA Physician Leadership College was created in 2007 to offer opportunities for physicians to gain invaluable experience and training in the core aptitudes to excel in leadership positions within organized medicine, medical practice and business. To date, 70 physicians have graduated from the program.
Robert C. Lee, MD, of Kingsport, has received board certification in hospice and palliative medicine. Currently the medical director of Holston Medical Group, Dr. Lee is also certified by the American Board of Family Practice with special interest in geriatrics. He is a member of the Tennessee Geriatrics Society and the Tennessee Association of Long-Term Care Physicians, as well as the Sullivan County Medical Society.

Russell B. Leftwich, MD, of Nashville, has been appointed to the FAC A Consumer Technology Workgroup of the Office of the National Coordinator for HIT Standards Committee. The charge of the workgroup is to facilitate patient engagement and data exchange between physicians and other care team members and patients and their family members and caregivers. He is a member of the National Quality Forum’s Health Information Technology Advisory Committee and was the 2011 Physician IT Leadership Award Recipient for the Healthcare Information and Management Systems (HIMSS). Serving as chief medical informatics officer with the Tennessee Office of eHealth Initiatives, Dr. Leftwich is a member of the American Medical Informatics Association, HIMSS, and the Nashville Academy of Medicine.

Michael C. Levin, MD, of Memphis, has been awarded a grant by the Department of Veterans Affairs’ office of Research and Development for a multiple sclerosis study. Building on his previous research, the study will focus on how MS causes a patient’s own antibodies to attach nerve cells in the brain and spinal cord. Dr. Levin is an associate professor and director of the Multiple Sclerosis Program and Laboratory of Viral and Demyelinating Diseases at the University of Tennessee Health Science Center and Semmes-Murphey Clinic. He has over ten years of clinical trial experience at the National Institutes of Health and the university level with over 1.5 million in grants received from the NIH, Veterans Administration, and the National Multiple Sclerosis Society. Dr. Levin’s articles have appeared in over 50 peer-reviewed scientific presentations and publications. Previous awards include the Alpha Omega Alpha Student Research Fellowship Award in 1987. He is a member of The Memphis Medical Society.

Robert A. Mericle, MD, and Timothy P. Schoettle, MD, both of Nashville, have been named 2012 Compassionate Doctors, ranked among the top physicians in the nation based on patient reviews by Patients’ Choice. Of the nation’s 870,000 active physicians, only three percent were accorded this honor in 2012. A former president of the Tennessee Neurological Society, Dr. Mericle practices with HW Neurological Institute of Nashville. Dr. Schoettle has practiced neurosurgery in Nashville since 1985, currently with Howell Allen Clinic, specializing in disorders of the neck and back, peripheral nerve surgery, brain tumor treatment, brain trauma, and cerebrovascular disease of the nervous system both are members of the Nashville Academy of Medicine.

William Schaffner, MD, of Nashville, has been awarded the John P. Utz Leadership Award by the National Foundation for Infectious Diseases. Dr. Schaffner is chair of the Department of Preventive Medicine and a professor of Medicine and Preventive Medicine at Vanderbilt University School of Medicine. A pioneer of hospital infection control programs, he has been a 40-year partner with the Tennessee Department of Health investigating communicable disease outbreaks and environmental hazards. Past honors include a quarterly TMA Public Health Champion award and the Walter E. Stamm Mentor Award by the Infectious Diseases Society of America. Dr. Schaffner is president of the National Foundation for Infectious Diseases, a member of the Executive Council of the Infectious Diseases Society of America and has worked with the CDC’s Advisory Committee on Immunization Practices for nearly three decades. He is a member of the Nashville Academy of Medicine.

Linda M. Smiley, MD, FACS, FACOG, of Memphis, has been appointed to the medical advisory board for the Ovarian Cancer Awareness Foundation. Board certified in obstetrics and gynecology and gynecologic oncology, Dr. Smiley serves on the board of directors for the Tennessee Chapter of the National Ovarian Cancer Coalition. She 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 a number of medical associations including The Memphis Medical Society.
MEMBER NOTES

Thomas W. “Quin” Throckmorton, MD, of Memphis, has been elected to the board of trustees for the Campbell Foundation, established to support the advancement of musculoskeletal research, physician education and community health. Dr. Throckmorton is a board-certified orthopaedic surgeon with Campbell Clinic, associate professor and associate residency program director of orthopaedic surgery at the University of Tennessee/Campbell Clinic, 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.

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.

The IMPACT Board of Trustees recognizes the following IMPACT donors who have become Capitol Hill or Platinum 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 or the Capitol Hill Club, please contact Debra Maggart at 615-207-5424 or debramaggart@gmail.com, or log on to www.tnimpact.com.
The resolution calls for the TMA to continue to support access to affordable healthcare for all Tennesseans as put forth in its previous statement on health reform; to support a three-year trial to expand access to care using Medicaid expansion funds to either subsidize plans purchased by the uninsured through the federal health insurance exchange or through direct Medicaid expansion; and to insist that the benefits purchased through the exchange remain comparable to Medicaid/TennCare benefits.

The TMA House of Delegates held its session as part of the association’s 178th annual meeting, MedTenn 2013. The event also offered CME and informational sessions on prescription drug abuse and neonatal abstinence syndrome, the mental health crisis in Tennessee, the state’s Controlled Substance Monitoring Database, which became mandatory for prescriber checks for certain pain medicine prescriptions on April 1, health reform, electronic health information exchange and quality incentive programs, ICD-10 coding changes, and more.

RESOLUTIONS OF INTEREST

Increasing Access to Care – The TMA House of Delegates (HOD) voted to support access to affordable healthcare for all Tennesseans; support a trial for three years to expand access to care by using Medicaid expansion funds either to subsidize uninsured residents to purchase health insurance through the federal insurance exchanges or through direct Medicaid expansion; and instructed the Association to make itself fully available to the governor and the state legislature to advocate for healthcare coverage in Tennessee.

Indigent Care – Delegates reaffirmed the importance of physicians providing free and reduced-cost care to indigent patients and directed the Association to support and promote such activities.

Mental Health Screening – Delegates voted to support efforts for more state and federal money for mental health screenings and treatment in Tennessee.

Maternal Mortality Review – The HOD voted to support the establishment of a peer review-protected and HIPAA-compliant maternal mortality review process under the auspices of the Tennessee Department of Health to review maternal deaths in Tennessee and make recommendations for system changes to improve healthcare services for women in Tennessee.

Cosmetic Surgery – Delegates passed two resolutions to pursue expansion of the definition of the practice of medicine to include any surgical procedure for cosmetic or aesthetic purposes; and to support efforts to prevent unlicensed and unsupervised cosmetic surgical procedures through legislative action and enforcement by the Board of Medical Examiners.

Health Cost Transparency – Delegates passed separate resolutions supporting the required posting of patient out-of-pocket costs for prescription drugs and hospital charges.

Medical Education & Physician Involvement – The HOD voted to petition the American Medical Association to work with CMS and other federal authorities to remove onerous language from its guidelines on care by physicians in training; and petition the AMA for requirements that recognize more accurate documentation of care while allowing the profession to resume educating its future colleagues in a more cost-effective and efficient manner.

NEW OFFICERS

In addition to Dr. Young’s inauguration as president, the following leaders were installed for 2013-2014:

• Dr. Douglas J. Springer, a Kingsport gastroenterologist, will serve as president-elect and on the TMA Board of Trustees.
• Dr. Keith G. Anderson, a Germantown cardiologist, was reappointed as chairman of the TMA Board of Trustees.
• Dr. Bob Vegors, a Jackson internal and geriatric medicine specialist, is the new vice-chairman of the TMA Board.
• Dr. James “Pete” Powell, internal medicine and pediatric physician from Franklin, was reappointed as secretary/treasurer for the TMA.

AWARDS

The TMA presented its 2013 annual awards to the following honorees:

• Outstanding Physician: Winston P. Caine, MD, Chattanooga; Bobby Clark Higgs, MD, Jackson; John Lamb, Sr., MD, Nashville
• Distinguished Service: Marion Dugdale, MD, Memphis; B W. Ruffner, Jr., MD, Signal Mountain
• Community Service: Greater Memphis Greenline, Inc., Memphis; Hamilton County Project Access, Chattanooga; Cathy Self, PhD, Baptist Healing Trust, Nashville

For a full recap of the meeting including approved policy, news releases, photos and more, visit www.tnmed.org/medtenn-wrap.
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Doctors are frequently besieged by advice that they should do something or avoid something for their patients.

Television, print media, internet searches and advertising of products all can provide unsolicited advice. We frequently ignore the chatter with good reason; now comes an admonition worthy of our careful consideration. New advice is coming from our professional organizations that we can provide better, less wasteful and less expensive services by avoiding some common testing or treatments that provide little benefit. Inherent in this advice is the perspective that we must do more than “test and treat.” We must provide value for our services, not only to the patient, but also to those other entities than are paying most of the bills.

We now know through regional variation studies that about one third of what physicians do and where they have patient care money spent does not contribute to helping our patients. We could save one third of healthcare costs without depriving any patient of beneficial care. Underlying our need to do something is our professional oath (and the American College of Physicians (ACP) Professional Charter) which reminds us of two things: 1) to place the interests of our patients above our own interests—including our financial interests; and 2) that we are committed to a just distribution of finite resources, which means we appropriately allocate resources and scrupulously avoid superfluous tests and procedures.

Top Five Lists

The National Physician Alliance conceived and piloted a project for physicians to practice their professional ethics and save costly dollars. They challenged physician specialties to develop a “Top Five” list that physicians and patients should question. The American Board of Internal Medicine (ABIM) had stimulated this work through its grant program for Putting the Charter (Professionalism) into Practice. As a result physicians in internal medicine, family medicine and pediatrics each developed a list of five specific steps they could take to promote the more effective use of healthcare resources. These three lists were published in the Archives of Internal Medicine in 2011 in an article titled, “The ‘Top Five’ Lists in Primary Care.”

Internal medicine and family medicine independently selected three activities that were the same:

1) Don’t do imaging for low back pain within the first six weeks unless red flags are present.
2) Don’t order annual ECGs or any other cardiac screening for asymptomatic, low-risk patients.
3) Don’t use DEXA screening for osteoporosis in women under age 65 or men under 70 years with no risk factors.

With leadership from ABIM Foundation (ABIMF) the national “Choosing Wisely” Campaign has now been launched. Twenty-six (26) United States specialty societies representing 420,400 physicians developed lists of Five Things Physicians and Patients Should Question in recognition of the importance of physician and patient conversations to improve care and eliminate unnecessary tests and procedures. Sixteen additional medical specialties will release their top five lists in late 2013 (for a total of 42). Examples of recommendations from the 26 active specialties include:

1) Don’t schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks 0 days gestational age.
2) Don’t diagnose or manage asthma without spirometry.
3) Don’t do repeat colorectal cancer screening (by any method) for 10 years after a high-quality colonoscopy is negative in average-risk individuals.
4) Don’t perform PET, CT, and radionuclide bone scans in the staging of early breast cancer at low risk for metastasis.
5) Don’t perform cardiac imaging for patients who are at low risk.
Of the 135 recommendations a proportionally high number are directly related to diagnostic imagining. Possible reasons for the inappropriate use might include worry about malpractice, generating revenue through office equipment, an over-dependence on technology, patient demand, other potential conflicts of interest, etc. The article reminds us that “inappropriate imaging exposes patients to excessive radiation, inconvenience, and actual harms that come from the cascade of diagnostic and therapeutic interventions that often follow identification of a lesion that proves only to be an incidentaloma.”

Consumer Reports, the world’s largest independent product-testing organization, is working with the ABIMF to lead the effort. Several consumer-oriented organizations have joined Choosing Wisely to help disseminate information and educate patients on making wise decisions.

On April 6, 2013, I had the pleasure of discussing the Choosing Wisely Campaign with about 100 Tennessee physicians who were attending the 2013 Tennessee Medical Association (TMA) meeting. The TMA has received a grant from ABIMF to promote the Campaign. My impression was that most of these physicians were interested and supportive. However, our discussion focused primarily on malpractice issues and how many physicians order tests their patients may not need to protect themselves from a malpractice lawsuit. They also mentioned patients who demanded tests that were not indicated. Several of us felt that if national specialty organizations were recommending against certain tests and procedures and if we endorsed that standard locally, we would be setting our own community standard of care. Also, the superb work of the TMA has greatly improved the malpractice climate in Tennessee. As the Campaign moves forward we will engage malpractice defense lawyers to give us their opinions on the strength of this defense. In terms of dealing with patients who demand tests and procedures that are not indicated, we will find and provide learning tools on how to address that situation.

The Memphis Medical Society (MMS) put this grant together and will take a lead in its implementation. As we have successes or even failures in Memphis, we will pass these lessons on to our colleagues throughout the state. Our plan is to regularly communicate with Tennessee doctors through both the TMA and MMS. We will get the recommendations out based on specialty. The hospitals and clinics for the underserved in Memphis seem interested in the Campaign so we will partner with them. We will also work with the many medical residency programs in Memphis and hopefully expand our efforts here across the state to other programs. In Memphis we have several community-wide

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**AMERICAN ACADEMY OF FAMILY PHYSICIANS**

**TEN THINGS PHYSICIANS AND PATIENTS SHOULD QUESTION**

1. Don’t do imaging for low back pain within the first six weeks, unless red flags are present.
2. Don’t routinely prescribe antibiotics for acute mild-to-moderate sinusitis unless symptoms last for seven or more days, or symptoms worsen after initial clinical improvement.
3. Don’t use dual-energy x-ray absorptiometry (DEXA) screening for osteoporosis in women younger than 65 or men younger than 70 with no risk factors.
4. Don’t order annual electrocardiograms (EKGs) or any other cardiac screening for low-risk patients without symptoms.
5. Don’t perform Pap smears on women younger than 21 or who have had a hysterectomy for non-cancer disease.
6. Don’t schedule elective, non-medically indicated inductions of labor or Cesarean deliveries before 39 weeks, 0 days gestational age.
7. Avoid elective, non-medically indicated inductions of labor between 39 weeks, 0 days and 41 weeks, 0 days unless the cervix is deemed favorable.
8. Don’t screen for carotid artery stenosis (CAS) in asymptomatic adult patients.
9. Don’t screen women older than 65 years of age for cervical cancer who have had adequate prior screening and are not otherwise at high risk for cervical cancer.
10. Don’t screen women younger than 30 years of age for cervical cancer with HPV testing, alone or in combination with cytology.

See the other specialty society lists of “Things Physicians and Patients Should Question” at www.choosingwisely.org/doctor-patient-lists/.

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**SHARING THE KNOWLEDGE**

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projects to improve the health of our population; Choosing Wisely will become part of those long-term projects. The area the MMS is most interested in is working with physicians to reduce over-use of tests and procedures. We hope to find several areas that generate great interest. Our plan is to find funding to determine if we can systematically reduce over-use by convincing our colleagues to lead the charge.

Doctors working individually with their patients to help them address their health issues is the way medicine should be practiced. However, if doctors do not work individually and collectively to address the over-use of tests and procedures, we are likely to see health insurance companies, malpractice companies, lawyers and politicians tell us how to practice medicine. The choice is ours.

If you have not already done so you might want to look at your specialty’s “Top Five” list to see if you concur. Go to www.ChoosingWisely.org to learn more. Depending on the level of interest, the MMS and the TMA may want to do more in this area. We hope it does, because effective stewardship of resources and dedication to patients is the responsibility of all physicians.

LEARN MORE
www.choosingwisely.org
http://consumerhealthchoices.org/campaigns/choosing-wisely/

REFERENCES

Board certified in internal medicine, general preventive medicine and public health and clinical lipidology, Dr. Dismuke is chair of The Memphis Medical Society committee that developed the TMA Choosing Wisely grant. He is currently a professor/director in the Division of Health Systems Management and Policy at the University of Memphis School of Public Health; professor emeritus and dean emeritus of the University of Kansas School of Medicine in Wichita, KS. Since his fellowship as a Robert Wood Johnson Foundation Clinical Scholar at the University of North Carolina, he has been interested in evidence-based medicine and overuse in health care.

Dr. Miller was a member of the MMS Committee that wrote the TMA Choosing Wisely Grant. A highly regarded general internist in Memphis, Dr. Miller is an endowed professor and associate chair of the Department of Medicine at the University of Tennessee College of Medicine, associate chief medical officer at the UT Medical Group, and a past ACP Governor for Tennessee, currently serving as medical director, medical education and research with Methodist LeBonheur Healthcare. Dr. Miller hired Dr. Dismuke in 1978 to help him build a new Division of General Internal Medicine at the UT Memphis campus.

For more information, contact Dr. Dismuke at sdismuke@memphis.edu.
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I have learned . . .

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

- R.B., M.D.
Corporate Compliance & Ethics Week is a national week-long event held each year – this year it is May 5-11 – highlighting the importance of ethics and compliance in the workplace.

Many companies use the week as an opportunity to raise awareness about compliance and ethics and engage employees about these difficult yet vital topics. Other companies use the week to roll out a new compliance training program or hold annual compliance training activities.

Does your practice have a written compliance program? If so, would it be viewed as “effective” if your practice were to be audited? Below is an excerpt from the federal register from the U.S. Health and Human Services Office of Inspector General (HHS/OIG) on the elements of an effective compliance program for individual and small group physician practices.

Components of an Effective Compliance Program
This compliance program guidance for individual and small group physician practices contains seven components that provide a solid basis upon which a physician practice can create a voluntary compliance program:

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;
- Designating a compliance officer or contact;
- Conducting appropriate training and education;
- Responding appropriately to detected offenses and developing corrective action;
- Developing open lines of communication; and
- Enforcing disciplinary standards through well-publicized guidelines.

Voluntary vs. Mandatory
Similar components have been contained in previous guidances issued by the OIG. However, unlike those, this guidance for physicians does not suggest that physician practices implement all seven components of a full-scale compliance program. Instead, this guidance emphasizes a step-by-step approach to follow in developing and implementing a voluntary compliance program. This change is in recognition of the financial and staffing resource constraints faced by physician practices. The guidance should not be viewed as mandatory or as an all-inclusive discussion of the advisable components of a compliance program. Rather, the document is intended to present guidance to assist physician practices that voluntarily choose to develop a compliance program.

For a compliance plan to be effective, it will need to be tailored to fit the individual or organization and its operation will have to become an element of every step in the process from initial patient encounter to the submission of a resulting claim for payment.

You have likely read about physician practices receiving audits and financial settlements where in the past, small to medium size practices were practically exempt from any real ramifications around enforcement. You may remember this particular headline from April 17, 2012: $100,000 HIPAA fine designed to send message to small physician practices. The story concerned Phoenix Cardiac Surgery, a five-physician practice that became the first small practice to enter into a resolution agreement which included a civil money penalty over charges it violated the HIPAA privacy and security regulation. This shows the federal government is getting serious about HIPAA compliance — and so should you.

We Can Help
You are not alone in meeting these regulations – the TMA is here to help. We can answer your compliance questions and have wonderful resources from our Legal Department, including a practice checklist and summary document on the new Omnibus HIPAA rules changes. Have you considered educating your office staff with our TMA’s HIPAA employee online training? What coding and documentation education are you performing in regard to the ICD-10 transition? Come grow your compliance plan with us. Host a Compliance Awareness Week event in your practice. Go over the new Omnibus rules and how they apply to your practice. Review and revise your policies to include the changes. Update your employee education. Attend our ICD-10 Roadshow to
hear from industry experts about documentation compliance and education approaches for the transition.

Finally, make plans to attend next year’s TMA compliance month “Lunch and Learn” awareness series. We will highlight an area of practice compliance each week in May 2014 and provide resources to support your compliance efforts. We will be expanding our resources to our membership and their practices to help point you in the right direction.

For more information on compliance, regulatory and other rubber-meets-the-road issues for your practice, please contact our Practice Solutions or Legal departments at 800-659-1862.

Ms. Madden is director of Practice Solutions for the TMA. Formerly with the state Office of eHealth Initiatives, she has a background in medical practice administration, EHR consulting and implementation. Contact her at 800-659-1862 or angie.madden@tnmed.org.
Doctors, Lawyers, and Disability Benefit Claims

By Peter T. Skeie, JD, LLM

Doctors hate disability claims, I know. Many of you have told me so, and sometimes not too politely. Nevertheless, your patients need you to understand the legal issues and procedures underlying their claims because you are vital to their claims’ success.

DISABILITY IS NOT A MEDICAL QUESTION
Doctors frequently presume that all they need to do is announce that a patient is disabled to establish this fact. This is never the case, however. Disability is not a medical issue. It is a vocational question. Whether someone is disabled in regard to a claim for disability benefits depends on the source of the benefit, the individual’s age, education, work history, salary, medical conditions, symptoms, impairments and, most importantly, the definition of disability that applies to the claim.

THREE RATIONALES
1. The claimant is disabled due to work restrictions. A work restriction is something someone can do but should not do because of a medical condition. The essential question is one of public safety or risk of individual injury.
2. The claimant is disabled due to lack of capacity. This category concerns claims based on objectively measureable physical or mental impairments. The essential question is whether the claimant has the physical or mental capacity required for a job.
3. The claimant is disabled due to lack of tolerance. These almost always concern allegations of chronic pain, fatigue, or mental illness. The essential question is whether the claimant can sustain and consistently meet the physical or mental demands of a job.

LACK OF TOLERANCE CLAIMS NEED DR. SUPPORT
Disability claims based on chronic pain, fatigue, or mental problems are exceptionally hard to win without a treating physician’s support. There are at least four reasons why this is the case:

1. The merits of a lack of tolerance claim are not immediately apparent from the medical records. Pain is entirely subjective, chronic fatigue is exceptionally hard to measure, and the severity and frequency of most mental problems are self-reported.
2. These claims are medical outliers. They concern allegations of pain, fatigue, or mental problems that are more severe than would normally be medically expected. If the alleged symptoms and impairments were medically expected the claim would be approved without contest.
3. The prospect of money for nothing invites malingering and even outright fraud. Unfortunately for legitimate claimants, the specter of illicit claims tends to predispose adjudicators to suspect the merits of all chronic pain, fatigue and mental health claims.
4. Many doctors refuse to get involved with a patient’s disability benefit claim. Refusing to support a claim will often doom it for denial. It creates the impression that the doctor does not believe the patient and it leaves the claim open to attack for being “inconsistent with objective medical evidence.”

ADJUDICATION OF LACK OF TOLERANCE CLAIMS
Disability claims based on chronic pain, fatigue, or mental problems usually cannot be proved by objective medical evidence. If the claimant’s alleged impairments could be objectively proven the claim would be approved due to the claimant’s lack of capacity. Consequently, when considering a lack of tolerance claim adjudicators have to infer the merits of the claim from the record as a whole. In almost all cases adjudicators will hire a medical professional, usually a physician, to assess the claimant’s residual functional capacity (“RFC”) based on a review of the claimant’s medical records. In addition, adjudicators will often hire a physician or physical therapist to conduct a functional capacity examination (“FCE”).

The problem with medical record reviews and functional capacity examinations is that they are inherently biased against a lack of tolerance claim. Medical record reviews can only confirm what is already known: The claimant’s allegations are disproportionate to average medical expectations. FCEs are equally problematic because they are presented with the façade of scientific accuracy even thought they are not validated to determine an individual’s ability to sustain the physical demands of a job.

Unfortunately, many claimants suffering from chronic pain, fatigue or mental problems do not realize that the medical evidence collected in the course of their claim is biased against them. They often mistakenly think that the fact that they are disabled is self-apparent. This is the reason why these claimants in particular need a lawyer. A disability benefits lawyer knows that a lack of capacity claim is a medical outlier and that the claim determination process is biased against these claims. He also knows that it is
his job to overcome this bias and to demonstrate the merits of the claim. To do this well, the lawyer needs the treating physician’s help.

THE TREATING PHYSICIAN & THE LAWYER

As an advocate, the lawyer’s job is to prove the merits of a claim. He presumes that his client’s allegations are true and he lacks the medical training to identify exaggerated allegations easily (although after a while we get a pretty good nose for this concern). Accordingly, the lawyer needs the treating doctor to signal if he thinks the claim is without merit.

If the claim is based on chronic pain, fatigue or mental problems, the lawyer needs the treating doctor to explain why the claimant’s alleged impairments are real and consistent with the medical record — even though the alleged impairments might be more severe than would be expected in most cases.

The amount and kind of help a lawyer needs varies depending on the nature of the underlying medical condition and whether the claim is for Social Security or privately insured benefits. Accordingly, most disability lawyers have a range of tools to minimize the hassle to a doctor. We have short checkbox questionnaires that can be completed in several minutes. We draft letters for the doctor to edit that explain in “lay” terms the reasons the claimant’s allegations are true and valid, and that address any unfavorable evidence. When a doctor is willing, we will even videotape and transcribe an interview in which the doctor walks through the medical records and explains their significance. Regardless of the extent of involvement, however, whatever help a doctor is willing to give always improves the chance of a successful result.

Unfortunately, many doctors refuse to provide this support. Some doctors are concerned (ill-founded in my opinion) about liability. Some think that an FCE is required. Some doctors refuse because disability claims are yet another time consuming distraction from the practice of medicine. From a claimant’s perspective, however, these rationales are contrary to the purpose of the doctor/patient relationship. Individuals seeking disability benefits are under severe medical, personal and financial distress. Although disability benefits will not eliminate this distress, they can make a material difference to a patient’s wellbeing. That said, the issue of money must be addressed. After all, the patient is seeking a monetary benefit. Without any income, few claimants can afford their medical care much less pay for an assessment of their impairments. Initially, the solution to this quandary would appear to be to charge the patient’s lawyer. The lawyer should be able to afford a nominal fee. The problem with this solution, at least in regard to Social Security claims, is that these claims are adjudicated in a non-adversarial administrative proceeding. This means the attorney has an ethical duty to present any adverse evidence he obtains because no one is actively opposing the claim. No attorney wants to pay for help that could kill a client’s claim.

DISABILITY & WORKERS’ COMP CLAIMS

Some doctors refuse to get involved in disability claims because they perceive disability claims to be akin to workers’ compensation claims. This perception is a misperception; these two are entirely different.

The public policy behind workers’ compensation is to assure that individuals who are injured on the job are compensated for their injury while capping an employer’s financial exposure for such injuries. In contrast, the purpose of disability benefits is to secure a minimum income for individuals who are no longer able to work or who have lost much of their earnings capacity due to a medical condition. In addition, workers’ comp claims are subject to state law, whereas most disability claims are subject to federal laws governing Social Security claims or employee benefit plans. There is even a branch of the Tennessee Court of Appeals dedicated solely to hearing workers’ compensation claims. Although this separate system might be the best solution to an impossible problem, it is nevertheless problematic. At least in my opinion, workers’ compensation laws both encourage de minimis claims and grossly and unjustly undercompensate serious injuries. I suspect the doctors who refuse to get involved in workers’ compensation claims share some of these opinions.

CONCLUSION

Disability claims based on medically-documented work restrictions or validated medical impairments are relatively straightforward. The primary challenge is to document the validity of the claimant’s restrictions or impairments.

Disability claims based on chronic pain, fatigue or mental problems are much more problematic. These claims are medical outliers. The claimant’s allegations are usually more severe than would be expected in most cases, and there are no validated methods to confirm the claimant’s allegations. This is the reason these claimants need strong support from a treating physician. No one is in a better position to explain why the claimant’s alleged impairments are real, valid, and consistent with the patient’s clinical presentation. Accordingly, if you think your patient is severely impaired, please help him by working with his disability lawyer.

References:
1. The definition of disability can vary widely depending upon the nature of and basis for a claim. For example, the Social Security Administration defines disability as “the inability to do any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death or which has lasted or can be expected to last for a continuous period of not less than 12 months.” (20 C.F.R. § 404.1505(a)). Many employee benefit plans define disability as the “inability to perform one or more of the essential functions of your own occupation.” After two years this definition frequently changes to the “inability to perform ‘any occupation’ for which the individual is qualified.” Individual purchased insurance policies often incorporate the policyholder’s profession into the definition of disability.
3. Claims adjudicators will protest this accusation. Nevertheless, anyone remotely familiar with disability claims knows it to be true.

(Continued on page 35)
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Almost 30 years ago, a group of enterprising physicians took their demands to Chattanooga area hospital administrators: Settle on one application for medical staff credentialing and use a county medical society-sponsored credentials verification service to do the checking on these applications. Their efforts were successful and soon physicians were undergoing reappointment at the same time across the area, and four or five separate processes became one process.

Since that time, this medical society-based program expanded its client base across the healthcare spectrum and across the country. The Chattanooga-Hamilton County Medical Society’s Central Verification Service is now TPQVO, a NCQA-certified CVO with clients from California to New York. Although TPQVO’s services include credentials verification for IPAs, PPOs, surgery centers and hospitals and reaches nationwide, its core focus continues to be Tennessee physicians. Celebrating 15 years of service in June, TPQVO continues toward its motto of being “your credentialing partner.”

THE BEGINNING – SUCCESSFUL PHYSICIAN ADVOCACY

Wrestling away the traditional medical staff office role of processing medical staff applications has not been easy. The “Doctor Power” asserted by Chattanooga and then-physician leadership in Knoxville was necessary to get those first hospital contracts. Doctor Power is still a power we can wield when working with our hospital, surgery center, and network administrators.

Proving to hospital administrators that TPQVO is both economical and high quality has been a struggle and not always successful. The hardest thing to prove is that TPQVO will save money over an internal process. The quality proof is not as difficult. Within the first year of operation, TPQVO obtained NCQA certification, and has undergone re-certification every two years since that first certification in 1999. NCQA is all about quality and our continued designation attests to our commitment to our clients that quality is our mission in the credentialing arena. Achieving and maintaining this certification for the past 14 years gives value and comfort to our clients and potential clients—they know our service product meets the industry gold standard.

RENEWED EMPHASIS ON CREDENTIALING

In 1999, the national media seized on the astonishing case of a physician serial killer who managed to escape implication in unusual patient deaths at a number of training and hospital facilities. The Michael Swango case highlighted the danger posed to the public by inadequate background checking, and gave healthcare accreditation organizations and credentialing committees renewed purpose. It wasn’t just hospitals that needed to tighten up their verification processes—surgery centers were no longer allowed by accreditation organizations to rely solely on hospital credentialing as proof that physicians and other healthcare providers were competent to provide services. No longer could physicians gain medical staff privileges based on self-presented documents attesting to their competence and ethical conduct. Many consultants suggested further tightening the noose around fraudulent applicants by recommending criminal background checks as part of the credentialing process. In fact, the Tennessee Board of Medical Examiners began requiring new license applicants to submit to a criminal background check in 2010. Some might consider the credentials verification process “low-hanging fruit” and a way to avoid tougher decisions concerning a physician’s clinical competence. Rather than distract from the difficult task of performance evaluation, TPQVO has always offered hospital credentialing staff a way to focus less on matching up an applicant’s self-reported education, training and experience and more on collecting internal and external quality data. In this way, medical staff and credentialing committees can spend more time and resources scrutinizing quality of care members deliver in their facility and in the healthcare community.

The Joint Commission has tightened its medical staff credentialing and privileging...
SPECIAL FEATURES

10 REASONS TO USE TPQVO

1. We know what we’re doing. TPQVO is a NCQA certified CVO since 1999. We are members of the National Association of Medical Staff Services as well as the Tennessee chapter.

2. We can perform credentials application processing and recredentialing for less than it costs for most in-house credentialing operations (apples-to-apples comparison).

3. We are there to help with Joint Commission, AAAHC and NCQA reviews especially during the survey process.

4. We are here to help, not to replace staff. We free administrative staff to focus on the organization’s programs and activities like QI, etc.

5. Clients have a built-in file backup system—if you can’t find the credentialing information or file, we will have the original record or a certified copy. Also, clients can access needed information 24/7 through our website.

6. We assume legal liability for the accuracy and completeness of the credentials information we verify. We carry $1 million/$3 million errors & omissions and general liability insurance.

7. TPQVO helps keep track of expiring licenses, insurance policies, DEA registrations as well as monitors adverse licensing and Medicare and Medicaid sanction information.

8. We work with physicians and their staff directly to obtain and verify their professional information.

9. We are physician friendly and are owned by state and county medical societies. One of our goals is to reduce paperwork for physicians through standardized credentials applications and recredentialing schedules.

10. Our clients are satisfied with us! For the past 14 years we have measured client satisfaction, our clients have rated their satisfaction with our services as “satisfied” and “highly satisfied.”

DOCTORS, LAWYERS, AND DISABILITY BENEFIT CLAIMS

(Continued from page 32)

6. Some doctors refuse to support a claim because the prospect of disability benefits can impede recovery, which is a rationale I cannot protest.

7. For your market intelligence, most doctors do not charge to complete basic functional capacity assessment forms. Some doctors charge an “administrative fee” that typically ranges from $20- $50. On rare occasions the demanded fee is substantially higher. The most I have ever paid for a treating source functional assessment is $250, although I did so only because I already knew what the doctor was going to say.

8. The Employee Retirement Income Security Act of 1974 (“ERISA”) governs almost all claims related to employee benefits, including disability benefits and medical insurance claims.

Mr. Skeie is the principal of the law firm of Peter T. Skeie & Associates, dedicated to representing individuals in regard disability and employee benefit claims. Contact him at 615-313-9111 or peterskeie@mac.com.

KEEPING UP WITH TECHNOLOGY

Today, TPQVO is not the same operation it was in 1998 — we have embraced information technology and its promise of cost efficient and effective data management. In 2009, we launched client access to credentialing records and reports and in 2011 initiated the online application module. While credentialing continues to be a paper-driven, TPQVO has been “paperless” in its records management since 2006. This means we serve as an archive for physician records for clients as well as physicians themselves.

A quarter of a century ago, physicians took up the mantle of leadership and advocacy and created what became TPQVO. And TPQVO continues to look for ways to help physicians keep up with the ever-changing mix of credentialing requirements.

Dr. Ryan, an internist and pediatric urologist from Chattanooga, is chairman of the Board of Governors of the Tennessee Physicians Quality Verification Organization (TPQVO). Visit tpqvo@tpqvo.com or call 423-495-1191, toll-free 888-779-0300.
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Isolated Pyocele of Anterior Clinoid Process Presenting as a Cavernous Sinus Syndrome

By Thomas J. O'Donnell, MD; L. Madison Michael, II, MD; Robert Laster, MD; and James C. Fleming, MD

**SUMMARY**

A 37-year-old man presented with fever, decreased vision in the left eye, a partial left cranial nerve III paresis, and a left cranial nerve VI paresis. Neuro-imaging showed an opacification of a left pneumatized anterior clinoid process. After failing a course of intravenous antibiotics, a craniotomy was performed with exenteration of the cavity and resolution of symptoms. Although rare, a pyocele of a pneumatized anterior clinoid process may cause ocular morbidity and require surgical intervention.

**CASE REPORT**

A 37-year-old man presented to the emergency room with a seven-day history of left-sided eye and face pain with nausea and vomiting. Four days before admission, the patient developed diplopia, ptosis of the left upper lid, and periorbital pain. On ophthalmic examination, he presented with both a left partial cranial nerve III paresis and a cranial nerve VI paresis. The remainder of the neurological examination was otherwise unremarkable. Computed Tomography (CT) imaging showed pneumatization of the right anterior clinoid. There was opacification of the left anterior clinoid with thinning of the entire circumference and deficient bone along the inferior margin with an adjacent expansile soft-tissue mass. There was also thinning of the adjacent lateral wall of the optic canal (Figures 1a and b). There was no evidence of infection or inflammation of other sinuses. Magnetic Resonance Imaging (MRI) of the orbits and brain were obtained. The MRI confirmed a dehiscent floor of the opacified anterior clinoid with a soft-tissue mass extending into this cavernous sinus. Post-contrast imaging revealed significant enhancement of the left anterior clinoid and adjacent cavernous sinus (Figures 2a and b). Infectious disease and neurosurgical consultations were obtained, and the patient was started on intravenous cefepime and metronidazole for a presumed anterior clinoid pyocele. After about 10 days with slow improvement of symptoms, he was discharged home with a peripheral indwelling catheter for additional intravenous ceftriaxone and continued metronidazole.

Over the next few weeks, the patient’s pain decreased and fever subsided; he was then switched to oral trimethoprim-sul-

**FIGURE 1.** Computed tomography (CT) imaging was performed using a GE Light Speed 16 detector scanner before and after contrast.

One hundred ccs of Optiray 30 were injected intravenously, and scans were obtained with transverse acquisition and coronal reconstruction. Transverse parameters included a 16 FOV, thickness 2.5 mm, and pitch 1.375:1. The scan showed pneumatization of the right anterior clinoid but opacification of the left anterior clinoid. There is thinning of the anterior clinoid and an adjacent expansile soft-tissue mass. Figure 1a axial view, Figure 1b coronal view.

**ABBREVIATION KEY:**

CT = computed tomography  
MRI = magnetic resonance imaging  
FOV = field of view  
T = Tesla  
TE = echo time  
TR = repetition time  
NEX = number of signals averaged
famethoxazole with continued improvement of his symptoms. After two months, attempts to withdraw antibiotics failed with recurrence of pain and persistence of sinus opacification. The case was reviewed with otolaryngology and neurosurgery. It was felt that the lesion could not be approached endoscopically due to its lateral position in relation to the optic nerve. A left frontotemporal craniotomy was performed, and extradural exposure of the anterior clinoid was achieved. The aerated clinoid process was removed in entirety.

Intraoperatively, the mucosa was found to be thickened and pathology confirmed the presence of a mucocele. Cultures taken during the operative procedure did not grow a responsible pathogen. Post-operatively, the patient did well with normalization of his neurological examination. His visual acuity without correction was 20/15 bilaterally. A paracentral depression was present on Goldmann visual field testing, although both Humphrey 24-2 and 10-2 visual field programs were normal. An MRI scan performed five months later showed no abnormal enhancement; clinically, he has continued to do well without return of symptoms (Figure 3).

DISCUSSION
Mucoceles originating in the anterior clinoid are rare. Because of their location near the cavernous sinus and orbital apex, they may cause substantial ocular morbidity. Obstruction of mucus drainage from a sinus may lead to formation of a mucocele that may slowly expand and cause erosion of bone with compression of nearby structures, and a ptosis may occur with secondary infection.\(^1\) Compression, inflammation, or infection of the cavernous sinus may cause: 1) pain or sensation loss in the first trigeminal distribution; 2) paresis of cranial nerves III, IV, or VI; or 3) sympathetic paresis.\(^2\) The close approximation of the orbital apex may also result in an optic neuropathy with vision loss.

Neuro-imaging is critical to making the diagnosis. CT is excellent for bone detail. MRI with and without contrast is useful to look for other lesions involving the cavernous sinus, such as meningiomas or nonacoustic schwannomas. Orbital views may be helpful when evaluating the optic foramen. Deshmukh and Demonter\(^3\) reported a case of optic neuropathy related to an anterior clinoid mucocele that resolved with antibiotic therapy alone. Other authors who described cases with acute monocular vision loss, and diplopia stressed the need for early diagnosis and surgery.\(^4\) Our patient, who presented without vision loss, required extended antibiotic treatment to improve his symptoms; with the recurrence of pain, he eventually required neurosurgical intervention.

CONCLUSION
Although rare, a pyocele of an anterior clinoid process may be considered in the differential diagnosis of a patient presenting with symptoms referable to the cavernous sinus, orbital apex, or with an atypical optic neuritis. Early neuro-imaging is invaluable to making the diagnosis. As in our patient, this may present as an isolated process without evidence of sinusitis elsewhere. Antibiotic therapy may resolve the problem in a minority of cases, but surgical intervention will likely be required.

References:

(Continued on page 43)
ABSTRACT
Hypothyroidism is a common medical problem easily treated when diagnosed but requiring regular follow-up and patient medication compliance. At times, this diagnosis can go untreated resulting in the development of severe consequences such as Myxedema Coma. Of all the clinical symptoms, cardiovascular manifestations tend to be especially severe and often life threatening.

CASE
A 55-year-old female presented to the ER with sudden onset of shortness of breath. Her past medical history included hypothyroidism. Vital signs showed mild hypothermia (95.2 degrees F), tachycardia, respiratory rate of 10/min, confusion, and bilateral decreased breath sounds, cyanotic cold clammy bilateral lower extremity with +2 pitting edema and decreased deep tendon reflexes. Initial testing revealed sinus tachycardia with a prolonged QT interval on EKG (Figure 1), CXR showed signs of pulmonary edema and cardiomegaly (Figure 2) and an ABG showed respiratory acidosis. Routine labs done in the ER showed WBC 17.8, sodium 132, BUN 30, Creatinine 1.83, BNP of 1534 and a negative first troponin/cardiac isoenzymes. For further evaluation, TSH, ESR, blood culture, and urine culture were drawn. Bedside ECHO (Figure 3) was done which showed global hypokinesia with Ejection fraction of 30 percent. Further questioning of her family members revealed the patient had been previously diagnosed with hypothyroidism which had gone untreated over the past two years due to financial constraints. The patient appeared to be in overt heart failure likely secondary to her untreated hypothyroidism and was subsequently started on aggressive treatment with IV diuretics and respiratory therapy.

Combining the patient’s acute presentation of decompensated heart failure with confusion and decreased tendon reflexes, a probable diagnosis of Myxedema coma was made. Random cortisol level and free T4 and free T3 were ordered before beginning treatment with IV thyroxine and IV hydrocortisone; further labs were ordered to search for precipitating factors. The patient recovered successfully after a lengthy course with plans for close physician follow-up.

DISCUSSION
Myxedema coma is an endocrine emergency presenting as a life-threatening form of decompensated hypothyroidism with underlying precipitating factors. Scattered cases have been reported in medicine literature with an incidence of 0.22 million per year with an 80-percent prevalence of cases in females, mostly in winter.

Cardiovascular changes associated with hypothyroidism include decreased heart rate, decreased cardiac output, decreased contractility and increased peripheral vascular resistance leading to diastolic hypertension. Low T3 in hypothyroid state leads to decreased expression of enzymes involved in regulating calcium influx in cardiac muscle, leading to a decrease in inotropic and chronotropic function of the heart and eventually impaired systolic contractions and diastolic relaxation. Thyroid hormone relaxes vascular smooth muscle cell by releasing...
Although there is an increasing concern regarding precipitation of myocardial infarction and arrhythmia after the administration of intravenous levothyroxine, studies have shown improvement in a patient’s condition and a decrease in mortality by the life-saving effects of levothyroxine. Medicine experts also demonstrate controversy regarding a thyroid regimen being used, whether to use levothyroxine (T4) or liothyronine (T3), or a combination. Other supportive measures in the treatment of myxedema include endotracheal intubation and mechanical ventilation for airway protection and respiratory failure. Hypovolemia and Electrolyte disturbances should be corrected. Hypothermia can be managed with external warming and treatment of underlying precipitating factor (Table) with antibiotics for infection, hemodialysis for renal failure, avoidance of responsible drugs, and management of organ dysfunction in case of cerebro-vascular accidents and Gl bleeds if present.

PROGNOSIS

Significant predictors of mortality are advanced age, bradycardia, hypotension and the need for mechanical ventilation. Different studies are reported regarding the predictors of prognosis. Sequential organ failure assessment (SOFA) is more effective. A SOFA score on the day of admission and day three or more of more than 6 is highly predictive of a poor prognosis. Our patient had a SOFA score of 9 at the time of admission, which signifies a less than 33-percent mortality, and on day three her score was 1.

CONCLUSION

Our case represents a good example of clinical awareness for physicians to be mindful of myxedema coma/severe hypothyroidism as a differential for underlying cause for heart failure, considering higher mortality rate if left untreated, and also for patients to understand the importance of follow-up and treatment of hypothyroidism.

References:


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Treatment of Cerebral Malaria and Acute Respiratory Distress Syndrome (ARDS) with Parenteral Artesunate

By Harshida Chaudhari, MBBS; Jay B Mehta, MD, FCCP; Ketan Chaudhari, MD; and Jeff Farrow, MD, FCCP

ABSTRACT
Infection with Plasmodium Falciparum can cause a severe form of malaria with multi-organ involvement. Cerebrum is one of the organs involved in the P. Falciparum malaria, which can lead to coma, convulsions, and other neurological sequel. The sequestration of cerebral vasculature with parasitized red blood cells is one of the proposed mechanisms for the development of cerebral malaria. We present a case of malaria with multi organ involvement. Cerebral malaria should be suspected in any febrile patient from a malaria-endemic region with loss of consciousness. Compared with quinine, intravenous artemisinin compounds (artesunate, arteether, artemether) are well tolerated by patients and have fewer side effects. Due to multi-organ involvement in P. Falciparum malaria, supportive therapy is crucial along with parenteral anti-malarial to improve survival.

INTRODUCTION
Cerebral malaria is one of the major causes of morbidity and mortality in people infected with plasmodium falciparum malaria. A high index of suspicion is required in patients with impaired consciousness from malaria-endemic areas as delayed or missed diagnoses can be life threatening. Prompt treatment of the patient with adequate anti-malarial in an intensive care unit is crucial for a positive outcome. Approximately half of the world’s population is at risk for malaria. The most vulnerable groups are children, pregnant women, immune-compromised individuals and international travelers from non-endemic areas who are visiting an endemic area. Most deaths due to malaria occur in sub-Saharan Africa. Multi-organ involvement is frequent in adults with malaria. According to 2010 malaria surveillance, the majority of malaria infections in United States were imported due to travelers visiting friends and relatives in the regions with ongoing malaria transmission. There were 216 imported cases of malaria from India; out of these 14 were P. Falciparum.

We present a case of cerebral malaria with acute respiratory distress syndrome (ARDS) from Surat, a large city located in the western province of India. The patient survived from this deadly disease due to early diagnosis and treatment with parenteral anti-malarial and mechanical ventilation. The Surat region is most industrialized and the eighth-largest metropolitan area of India. People from the Surat region comprise one of the highest immigrant population of India located in the U.S., African countries, the United Kingdom, and Canada. A majority of hotel and motel owners in the U.S. are from the Surat region. Surat is one of the malaria endemic areas. Non-resident Indians visiting this region are at risk of getting malaria.

CASE REPORT
A 36-year-old female from the malaria-endemic region of Surat, India, went to a local doctor with complaints of high-grade fever and headache and was treated for viral fever. After three days she developed yellowish discoloration in her urine and vomiting, along with high-grade fever, chills, rigor, headache, and body ache. On physical examination she had a temperature of 102 F, BP 110/70, pulse 100/min. and RR 22/min. She had mild icterus, hepato-splenomegaly on abdominal examination and bilateral basal crackles on chest auscultation. She was admitted to the hospital. Her blood sample was sent to a laboratory for complete blood count, comprehensive metabolic panel and peripheral smear for malarial parasites. She was started on IV fluids, antibiotics, antipyretics and antiemetic while waiting for reports.

Laboratory investigation showed Hb 12.2 gm total, WBC count 17700/mm3, and platelet count 26000. Peripheral smear was

FIGURE 1. Peripheral blood smear shows ring form trophozoites of Plasmodium Falciparum (arrow) in the periphery of infected red blood cells.
positive for *P. Falciparum* malarial parasites (Figure 1). On blood chemistry, she had elevated serum bilirubin (5.5mg/dL), mildly elevated liver enzymes (S. SGPT 88, S. SGOT 147), and elevated blood urea and serum creatinine (blood urea 68, S. creatinine 2.2). Her chest x-ray and EKG were normal. The patient was started on Inj. Artisunate 120 mg IV bid, Tab Mefloquine 300 mg 1 bid, and higher antibiotics and IV fluids.

Despite being treated with parenteral anti-malarial, she became drowsy, and developed abnormal rapid breathing with confusion. On examination she had rigrors with drenching sweat and absence of neck stiffness. Her blood sugar and serum electrolytes were normal. Urgent CT scan of the brain and cerebrospinal fluid examination were normal. After exclusion of the other causes of encephalopathy, the clinical diagnosis of cerebral malaria was made. She also had mild metabolic acidosis on arterial blood gas analysis. Repeat chest x-ray showed diffuse infiltrates of both lung fields, suggestive of ARDS (Figure 2).

The patient was transferred to an intensive care unit and was kept on mechanical ventilation. After three days of aggressive management of patient with parenteral anti-malarial, antibiotics and supportive therapy, she regained consciousness. We gradually weaned her off the ventilator. After seven days of intravenous artesunate treatment, the patient’s clinical condition and laboratory abnormalities improved gradually and her parasitemia cleared completely on peripheral smear. She was discharged after complete recovery on tab clindamycin 300 mg 1 bid for seven days to prevent recrudescence. On follow-up she had a normal peripheral smear examination and normal blood chemistry.

**DISCUSSION**

Malaria is a parasitic infection caused by various species of plasmodium (*P. Falciparum*, *p. vivex*, *p. malariae*, *p. ovale* and occasionally *p. knowlesi*). It is transmitted via bites of infected anopheles mosquitoes. *P. vivex* and *P. Falciparum* are the most common species found to cause human infection. *P. Falciparum* is known for its severe complications such as anemia, bleeding disorders, coma, convulsions, hypoglycemia, metabolic acidosis, fluid and electrolyte disturbances and renal failure. According to a World Health Organization (WHO) 2011 report, an estimated 216 million cases and 655,000 deaths were reported worldwide due to malaria in 2010. Most deaths occurred among children living in Africa. The majority of cases reported in United States were imported through international travel. Nine fatal cases of malaria were reported in U.S. malaria surveillance in 2010 due to *Plasmodium Falciparum* malaria. All the fatalities resulted either from delay in seeking treatment or delayed diagnosis. The majority of these cases were imported from West Africa. Clinicians should include malaria in the differential diagnosis of any febrile patient with a history of travel to malaria-endemic areas.

![FIGURE 2. Chest X-ray shows bilateral diffuse infiltrates of lungs suggestive of acute respiratory distress syndrome.](image)

Two percent of patients with *P. Falciparum* infection develop cerebral malaria. Vascular sequestration of parasitized red blood cells and blockage of microcirculation affecting cerebral vasculature is the main underlying mechanism. Other mechanisms such as nonspecific immune inflammatory response and release of cytokines are also proposed. The latter is responsible for increased alveolar permeability leading to ARDS. According to WHO guidelines, suspect cerebral malaria in any patient presenting with impaired level of consciousness who is from a malaria-endemic region or has traveled to such region recently and who has a positive peripheral smear for *P. Falciparum* malarial parasite, after exclusion of other causes of encephalopathy. Imaging modalities like CT scans can underestimate the extent of cerebral involvement as there have been many cases reported with normal CT brain in patients with cerebral malaria. The clinician should be vigilant and should start prompt treatment based on suspicion, as a major reason for the development of severe disease is delayed or missed diagnoses.

The mainstay of treatment of cerebral malaria or any form of complicated malaria is parenteral anti-malarial treatment. Intravenous chloroquine has become outdated in many parts of world, including Asia, due to widespread resistance. Quinine, once widely used, is now replaced by Artmisinins due to the serious side effects such as cardio toxicity, cinchonism, and hypoglycemia. Artemisunates, the group of Artemisinins, are currently the most popular in the treatment of malaria. The Artemisinin class of compounds has many advantages over quinine including activity against multidrug resistant *P. Falciparum*, rapid therapeutic response and reduction in gametocyte carriage. The drug is well tolerated by patients. However, when given alone, recrudescence rates are high. It should be given in combination with other drugs. In the case described, we combined it with mefloquine.

Apart from parenteral anti-malarial, supportive care of the patient is very important. Comatose patients should be treated in a critical care unit with meticulous nursing care. Urethral catheter, naso-gastric tube, input-output chart, level of coma (GC scale), antipyretics, anticonvulsant (if the patient has had seizures), manitol (for raised ICP), and correction of hypoglycemia are essential parts of supportive care. Exchange transfusion, desferrioxamine (an iron chelator) and pentoxifylline can be used in severe cases, however not widely used. Steroids are not recommended in the treatment of ARDS or cerebral malaria. In two well-conducted studies, steroids failed to improve morbidity and mortality in cerebral malaria and increased the risk of infection and gastrointestinal bleeding. A malaria vaccine is still under trial. Preventive measures (vector control, insect nets), chemoprophylaxis and early treatment of infected individuals are important to prevent morbidity and mortality from malaria.
CONCLUSION
The number of cases reported in United States in 2010 by the Malaria Surveillance team was the largest number of cases reported since 1980. The majority of the malaria infections in the U.S. occur among people who have travelled to malaria endemic areas. Clinicians should inform travelers about the risk of malaria and encourage them to use chemoprophylaxis along with other protective measures (mosquito nets, repellents). Clinicians should include malaria in the differential diagnosis of any febrile patient with a history of travel to malaria-endemic areas.

References:

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ISOLATED PYOCELE OF ANTERIOR CLINOID PROCESS PRESENTING AS A CAVERNOUS SINUS SYNDROME
(Continued from page 38)

Drs. O’Donnell and Fleming are with the Hamilton Eye Institute, University of Tennessee, Health Sciences Center, Memphis, TN. Drs. Michael and Laster are with Semmes-Murphey Neurologic and Spine Institute, Memphis, TN.

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No portion of this paper has been previously presented or published. Medical editor Jeannie D. Haman, PhD (Houston, TX, USA), provided professional editing of this article.

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Alliance Year in Review

By Beth Kasper, TMAA President

Your TMA Alliance has worked during the past year promoting the good health of Tennessee and supporting the family of medicine. Whether or not you are a member, we are your Alliance because we are at the service of all Tennesseans. We want all Tennesseans to enjoy good health and all physicians and their families to find fulfillment in their association with the medical profession. Through health promotion projects, legislative advocacy and community-building efforts, we have moved the needle toward greater wellbeing for many in our state.

Part of my activity as president was visiting component Alliances. What struck me were the differences between the groups. Programs vary. Leadership structures vary. Numbers vary. While most, like typical civic groups in America, struggle to keep membership numbers up, at least one Alliance, Washington-Unicoi-Johnson, has accomplished membership increases. Attracting members can be done. I also learned from our smallest Alliance’s big accomplishments that membership numbers are not the only factor for success. The tiny Bedford County group makes me think of the term “cell” as used to describe units in underground movements. Of course BCMAA members are not troublemakers, but the results they get with their little band are outsized.

TMAA has four focus areas. In the Health Promotion focus, we took guidance from the TMA’s Public Health Committee and made the proper use of antibiotics our goal. Vice President Nora Lee and Assistant Vice President Lorrie Villeneuve crafted a flyer for members to distribute in their spheres of influence. Based on information found at www.cdc.gov/getsmart/, Lorrie and Nora’s publication helps parents and others understand when antibiotics are useful, when they are not, and why it is harmful to take them when not needed.

The biggest part of our legislation focus was encouraging members to attend the TMA’s PITCH (Physicians Involved at Tennessee’s Capitol Hill) Day at Legislative Plaza on March 6. Alliance members were among the 132 advocates who showed up to push for medicine’s agenda. The PITCH lunch gave us a chance to do some Alliance networking as well as learn about legislative concerns. Vice President Gail Brabson and I thank the Alliance members who participated.

Our third focus area is fundraising for AMA Foundation. We do this primarily with our “sharing card.” This year, Vice President Debbie Hilgenhurst arranged for the use of a delightful winter scene on the cards, a painting by artist Marabeth J. Quin. Most of the thousands of dollars raised with the sharing card will come back to Tennessee’s medical schools’ scholarship funds.

Our fourth focus area is membership development. The big change we made this year was defining our membership cycle for state dues. In the past, we were clear about when moneys were due but not about what period they were paying for. To prepare for an earlier than usual convention, to make budgeting easier, and to go along with a “pay-for-it-today, get-it-tomorrow” expectation in modern culture, we said that membership is for a calendar year, is due on the last day of the previous calendar year, and has a grace period until March 1 for voting rights at convention. We’ve taken this system for a test drive. It sputters and coughs but should be fine with a tune-up. Many thanks to Vice President Emily Shore for her work, especially in mailing notices and acknowledgements to members-at-large.

Finally, we have had the pleasure of planning a reception for Jo Terry’s June installation as AMA Alliance’s next president. Congrats to Jo, a past TMAA president! I’ve asked myself many times this year, “How would Jo handle that?” She is one of the many good leaders and speakers from whom I have learned during my years in the Alliance. Our theme for the year, “Training Tennessee’s Health Promotion Leaders,” highlights the Alliance as a place for us to learn skills to benefit our communities. Serving the Tennessee community this past year has been an honor and a privilege. Now I pass the presidency into the capable hands of Heidi Dulebohn so that she may enjoy a year of service to medical families and the people of Tennessee.

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

BLOUNT COUNTY MEDICAL SOCIETY
Neal W. Atchley, MD, Alcoa
Nancy G. Bartley, MD, Alcoa
Jennifer L. Best, MD, Alcoa
Andrew C. Dirmeyer, MD, Maryville
Rodney R. Ferguson, MD, Alcoa
Nils P. Gaddis, DO, Alcoa
Richard M. Gaddis, DO, Louisville
Stanley S. Kelsey, MD, Maryville
Roy E. Kuhl, Jr., MD, Alcoa
Alma K. Leaird, MD, Maryville
Joe T. Mandrell, MD, Alcoa
William R. Moore, MD, Maryville
Walter M. Novikoff, DO, Alcoa
C. Larry Rahn, MD, Walland
John R. Reisser, MD, Alcoa
Darryl L. Riegel, MD, Alcoa
Richard A. Savell, MD, Alcoa
Jeffrey S. Scheib, MD, Alcoa
William D. Vines, MD, Alcoa

CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE
Lolly H. Eldridge, MD, Jackson
Spirinoula D. Vasilopoulos, MD, Jackson

KNOXVILLE ACADEMY OF MEDICINE
Todd B. Abel, MD, Knoxville
Jason E. Cox, MD, Knoxville
J. Caroline Haney-Weaver, MD, Knoxville
Oliver E. Hoig, MD, Knoxville
Julie W. Jeter, MD, Knoxville
Mariana C.M. Koonce, MD, Knoxville

LAKENWY MEDICAL SOCIETY
Conrad L. Brimhall, MD, Morristown
Regina N. Coleman, MD, Talbot
Rebecca A. Moul, DO, Morristown
Hong I. Tjoa, MD, Jefferson City

THE MEMPHIS MEDICAL SOCIETY
David J. Daniels, MD, Rochester

NASHVILLE ACADEMY OF MEDICINE
Ms. Solita R. Jones, Nashville
Matthew R. McDonald, MD, Nashville
William R.C. Stewart, III, MD, Brentwood
Wesley P. Thayer, MD, Brentwood

NORTHWEST TENNESSEE ACADEMY OF MEDICINE
Sam W. Bradberry, MD, Union City
Johnny B. Joyner, MD, Dyersburg
Joseph W. Wolfe, MD, Dyersburg

STONES RIVER ACADEMY OF MEDICINE
Bhabendra N. Putatunda, MD, Lebanon

SULLIVAN COUNTY MEDICAL SOCIETY
Marcus C. Grimes, MD, Kingsport
William A. McCormick, MD, Bristol
Lisa A. McKinney-Smith, MD, Bristol
Kristin A. Pierce, MD, Kingsport

WASHINGTON-UNICOI-JOHNSON COUNTY MEDICAL SOCIETY
Heather B. Breen, MD, Johnson City
Ms. Katie Johnson, Johnson City

WILLIAMSON COUNTY MEDICAL SOCIETY
William D. Halford, MD, Franklin

IN MEMORIAM

RICHARD M. PENNY, MD, age 66. Died February 26, 2013. Graduate of University of Kentucky School of Medicine. Member of Sullivan County Medical Society.

WILLIAM SNODGRASS TAYLOR, MD, age 89. Died March 19, 2013. Graduate of University of Tennessee Health Science Center. Member of Putnam County Medical Society.

MALCOLM EMORY ROGERS, MD, age 89. Died March 24, 2013. Graduate of University of Tennessee Health Science Center. Member of Sullivan County Medical Society.

WALTER MICHAEL BOEHM, MD, age 62. Died March 25, 2013. Graduate of New York University School of Medicine. Member of Chattanooga-Hamilton County Medical Society.

WILLIAM GORDON JENNINGS, MD, age 83. Died April 3, 2013. Graduate of University of Tennessee Health Science Center. Direct member.

MAURICE MASON ACREE, JR., MD, age 84. Died April 7, 2013. Graduate of University of Tennessee Health Science Center. Member of Nashville Academy of Medicine.

WARREN BARCLAY HENRY, MD, age 89. Died April 12, 2013. Graduate of Tulane University School of Medicine. Member of Chattanooga-Hamilton County Medical Association.
CORRECTION

An incorrect abstract was published as part of “Case Report and Review of the Literature: Spontaneous Aortobronchial Fistula” in the April issue of Tennessee Medicine (Vol. 106, No. 4, p. 39). The correct abstract is published below:

ABSTRACT

We present a fatal case of aortobronchial fistula due to ruptured atherosclerotic aneurysm of the aorta into the left lower lobe, bronchus. Also, review of the pertinent literature is presented. Fistulas between the aorta and tracheobronchial tree are rare but usually lethal if not treated promptly and timely, as they can cause fatal hemoptysis. Aortobronchial fistulas occur most often in patients who have a history of thoracic vascular surgery. Nevertheless, few cases without previous thoracic surgery, trauma or infectious process of the aorta have been described in the literature.

Tennessee Medicine regrets the error.
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