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Keith Anderson, MD

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A Georgia-based group called Patients for Fair Compensation filed legislation in Tennessee in 2015 and 2016 in an attempt to move medical malpractice lawsuits against physicians from the civil court system to a government-run administrative patient compensation system. The legislation did not pass but is expected to be filed again in 2017.

TMA’s concerns about the proposal include verifying the actuarial numbers proponents claim will save the state money, and preserving medical liability insurance in the event a patient compensation system does not work. Doctors are also concerned about an almost certain increase in reports of claims to the National Practitioner Databank if the unproven concept were to be tested here, in what is already one of the most favorable liability climates in the country.

Proponents of the plan say, among other speculative claims, it would help reduce the incidence of defensive medicine and be similar to the current system in the United Kingdom. But defensive medicine is still prevalent in the UK, according to a 2013 survey:

- 78% of responding hospital doctors reported practicing defensive medicine.
- 59% said they ordered unnecessary tests.
- 55% said they made unnecessary referrals to other specialties.

Medical liability reforms which TMA helped put into place have already been effective in combating frivolous medical malpractice cases while preserving the rights of patients truly injured by medical negligence to be compensated.

National Practitioner Data Bank reports in Tennessee reached a 20-year low for MDs and DOs in 2015. They would be expected to skyrocket under the proposed system.

The National Practitioner Data Bank | Annual Reports of the Tennessee Judiciary
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“Surprise billing” occurs when a patient enters an in-network facility such as a hospital or ambulatory surgery center and receives medical services from an out-of-network provider such as an emergency room physician, anesthesiologist or pathologist. Because out-of-network fees are often inadequate and these providers are not contractually prohibited from balance billing, the patient receives a surprise bill. These bills can be pricey as they are based on charges rather than negotiated fee schedules. Expectedly, this process results in significant distress and anger among patients and their employers.

Legislators of the Tennessee General Assembly, weary from constituent complaints, debated this problem late in the 2016 session. Legislation was proposed that would have required out-of-network providers to give estimates of out-of-network charges to patients entering their facility. The Tennessee Medical Association opposed this legislation because of anticipated administrative hassles, difficulty identifying patient benefits and likely slowdowns in providing care, particularly in the acute or subacute setting. No legislation was passed, and a task force was created to study the issue with anticipation of legislation in the 2017 session.

TMA’s position is that any legislation must include meaningful and measurable assurance that health plans provide adequate panels. The more adequate in-network panels are within a facility, the less likely patients will receive surprise bills. Inadequate provider panels are the root cause of surprise billing. Also, the legislation must provide reasonable and workable avenues for patients to resolve disputes about balance billing.

To assure that network adequacy is addressed in any legislation regarding balance billing, the Tennessee Department of Commerce and Insurance intends to submit draft legislation to the Governor based on the National Association of Insurance Commissioners’ network adequacy model bill. Drafting of this bill and revisions are based on the recommendations of the task force with input from organizations including TMA. Should the governor favor the language of the proposed legislation, the Department will recommend to the balance billing task force that this legislation be adopted for the 2017 legislative session.

To TMA’s credit, favorable revisions of the NAIC model were made. TMA, in concert with other provider organizations, preserved the right of out-of-network providers to balance bill when the Department of Commerce and Insurance wanted to prohibit balance billing altogether. The department is also committed to constructing regulation for network adequacy. Regarding patient dispute resolution, payers, and the department wanted disputes to be examined based on a payment benchmark as a percentage of Medicare. TMA rejected this benchmark.

TMA agreed in concept to a two-step mediation process for dispute resolution similar to a process that has been successful in Texas. The first step would be a conversation facilitated by the department among the patient, the payer, and the out-of-network provider. In the Texas model, the vast majority of disputes are quickly resolved in this step. Should this step fail to resolve the dispute, a more formal mediation process would ensue.

Specific commitments regarding network adequacy have not been forthcoming, and further discussion will be required.

The proposed legislation includes language that would require a provider to disclose to patients that they could be treated by out-of-network providers at the time of scheduling elective procedures. However, failure to do so will not result in forfeiture of the right to balance bill.

Although the unrestricted right to collect 100 percent of disputed surprise balance bills will not be preserved, TMA in concert with the Tennessee Hospital Association, provider organizations and specialty societies has successfully engaged in the process to construct legislation that will be fair to out-of-network providers and hopefully resolve this complex problem facing all Tennesseans. +

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Another new year, and another new world.

Last January, we were pondering the effects of Ebola. Now, we are considering how the recent election will affect the world. Funny how things change in a matter of months.

Both issues could have dire consequences for the people of the world if not handled correctly. While the CDC and the World Health Organization continue to monitor and control Ebola outbreaks, the collective attention of our U.S. healthcare system now focuses on the latest outbreak of euphoria as many people relish the prospect of the repeal of the Affordable Care Act (ACA).

Now, before you start building your parade float to head down Pennsylvania Avenue, be reminded that it took almost three years for the ACA to become law. Then it was challenged a couple of times in the U.S. Supreme Court before moving toward widespread implementation.

While there are many politicians who ran on the promise to repeal “Obamacare,” the reality is going to be more of a slowdown and suffocation of certain regulatory features of the ACA. The simple fact is that Republicans do not have the required supermajority of votes in the Senate to repeal the law. Even if they did have the votes, any repeal without a replacement plan would be total chaos for American patients. Just as it took years to unpack and implement the ACA from its 2,000 pages, we will need to be very deliberate and cautious as we develop replacements for the portions of the act that we do not like. The goal should be to improve our system with replacement features designed to work better and be more palatable (and affordable) to all Americans.

Here in Tennessee, we find ourselves once again pondering some of the same questions as we gear up for another run at passage of Insure Tennessee, Governor Haslam’s rendition of Medicaid expansion for our state. This year, there’s still a desire to expand access to affordable and quality healthcare for our most desperate population, but eyes seem cast toward Washington looking for help to rain down in the form of block grants versus bloated regulatory mandates wrapped in red tape.

TMA has just completed its comprehensive analysis of what parts of the ACA made it to market, and what we want to see if we can revolutionize Tennessee healthcare in the coming years. We have studied the position papers of all the leading power brokers in Washington and Tennessee to glean some insight as to which way the wind will blow in the coming years as Washington begins to dismantle and reassemble the first major changes to our country’s healthcare system since the advent of Medicare and Medicaid in the 1960s.

There is widespread understanding that something needs to be done to control our country’s annual spend on healthcare, especially as the baby boom generation continues to flood into Medicare over the next 12 years. We’re not even at the halfway point of new recipients entering our largest government health program.

There has been some hesitance to abdicate reimbursement to value-based models. Physicians are not fearful of being paid based on the quality of the services they provide and the outcomes for their patients. What is most unnerving to them is who is designing the rules and deciding the final “grades.” TMA remains intricately involved in the episodes of care process in our state as the Tennessee Department of Finance and Administration continues to roll out its payment innovations program with TennCare and pushes to carry such measures to commercial plans.

TMA has another full slate of advocacy and activities on tap for 2017. You’ll read in depth elsewhere in this issue about our legislative agenda and grassroots plans to help our members voice their sentiments about the rules and laws by which they practice medicine.

TMA also remains focused on finding solutions to help reduce our state’s misuse and abuse of prescription drugs. While we have made great strides to reduce the use of opioids in our state, we have a long way to go.

This year seems to hold as much promise as potential peril for the future of healthcare, depending on who you ask. We are working to make sure that when questions about how healthcare should be designed and operationalized in Tennessee are asked, it’s the voice and opinions of the members of the Tennessee Medical Association that lawmakers listen to and trust regarding what is in the best interests for the health and wellbeing of Tennesseans.

Happy New Year!

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Once, there was a figure skater named Sonja Henie. Sonja was a doll. She made movies back in the 1950s and appeared in some TV specials, thereby introducing the larger public to figure skating. That was her second successful career. As an 11-year-old, in 1923 she won the Norwegian figure skating championship and did it again the next year. She ruled the ice as the female World Figure Skating Champion from 1927 to 1935, during which she gathered in three Olympic gold medals in the Winter Games of 1928, 1932 and 1936, after which she turned professional. After moving to the United States, she toured in ice shows until the 1950s, setting the tone of women’s figure skating as well as the design of the costumes. She died in 1969.

Though this is going to be mostly about women’s figure skating, I need to say a word here about the beginnings of men’s figure skating. It owes its beginnings largely to a well-known ABC commentator named Dick Button, who, having become delighted with ice skating while serving in Europe during and after the Second World War, formed a group of like-minded men that would make up the U.S. men’s contingent at the 1948 Olympic Winter Games, in which he won the gold medal. He won it again in 1952 and is widely credited with having introduced the modern style of figure skating.

Women’s figure skating had been the private domain of the Europeans, mostly Sonja Henie and a few Hungarians, until Tenley Albright, a young recovering victim of poliomyelitis skated into the world championship in 1953, winning it again in 1955. She climaxied her skating career by winning the Olympic Winter Games’ gold medal in 1956, retiring from skating immediately afterward to enter Harvard Medical School, rejecting a lucrative offer to turn professional. She is now a Boston surgeon.

The 1956 Olympics was the first to receive wide television coverage, though figure skating was eclipsed by skiing and speed skating. Its popularity has continued growing until nowadays you can find figure skating on the tube several times during almost any week in season, and not too infrequently out of it.

Though that popularity was slow in coming, it was helped along by a number of accomplished, attractive US skaters. Following Tenley Albright’s retirement, both Carol Heiss and Peggy Fleming, now also an ABC commentator, won Olympic Gold. For more than two decades Dorothy Hamill has been the U.S. dowager queen of the ice, having captured the Olympic Gold Medal in 1976.

Many marvelous U.S. ladies have distinguished themselves on the world’s ice rinks, and any enumeration of them will inevitably omit significant ones. But here goes, with the...
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Most of us think of feudalism as limited to the Middle Ages, but if the health insurance industry has its way the economic equivalent of feudalism is going to reappear in 21st century America — including Tennessee. And guess who insurers intend to be the serfs on their manor, toiling away to benefit the lords in the castle? Yep, you and me.

How do insurers plan to accomplish this? By making it difficult or even impossible for physicians to stay out of an insurer’s network and then balance bill that insurer’s customers. The insurance industry has mounted an effort in state legislatures across the country to restrict or eliminate out-of-network charges and balance billing and is trying to accomplish the same goal through federal regulators and Congress, too. Their first attempts at this in Tennessee occurred in our legislature in 2016 but were unsuccessful. The insurance industry is just getting started, however, and will be back in 2017. A task force of legislators and stakeholders, including insurers and the TMA, have been meeting to try and work out a compromise. Unfortunately, from the rumors I hear insurers are unyielding in their demands.

If physicians are to avoid being completely at the mercy of insurers — even more than now — we must educate our legislators quickly and thoroughly on this issue. Insurers are telling legislators that a ban on balance billing will protect patients. The truth, of course, is that restrictions on out-of-network charges and balance billing protect insurance companies, not patients. And based on the compensation packages of insurance company CEOs, insurers are doing just fine, thank you.

If you run your practice, are involved in the business end of a group practice or have negotiated a contract with a health insurance company, I don’t have to explain the importance of staying out of network and balance billing — the economic survival of your practice may depend on it. For those of us in hospital-based specialties, the ability to balance bill is even more critical. Unlike physicians in an office-based practice, we can’t screen our patients in advance and turn away those insured by companies that are not in our network. And even compared to other hospital-based specialties, emergency physicians and emergency departments (EDs) are uniquely vulnerable to restrictions on the right to stay out of network and balance bill. Any limitation of that right has the potential to both wipe out the private practice of emergency medicine,* and cause the closure of hospitals when EDs shift from profit to loss — or become even bigger money-losers than they are now. If that statement strikes you as hyperbole, let me explain with a real-world example.

I was once a partner in a physician-owned emergency medicine group in Nashville. Blue Cross/Blue Shield presented my group with a contract to be in-network, and rather than negotiating in good faith told us to “take it or leave it.” (I know none of you who are familiar with BC/BS are shocked by that.) We certainly wanted to be in-network with Tennessee’s biggest health insurance company. Being in-network meant getting paid faster and spending less on billing overhead, and our hospital had recently reached an agreement with BC/BS to become in-network, putting, even more, pressure on us to also be in-network. But the terms of the contract were horrible and would have led to the collapse and dissolution of our group. We had no choice. We stayed out-of-network. That had two practical results, one good and one bad:

1) Rather than billing BC/BS at an in-network discount rate, we billed at a significantly higher “reasonable and customary” rate. And since BC/BS had to pay that rate — one of the things the insurance industry wants to change — we made more money. (The good result.)

2) Our patients who were BC/BS customers had higher co-pays than if we had been in-network. (The bad result.)

Since we didn’t want our patients to suffer because we found their insurer monopolistic, greedy and unfair, whenever a patient called us or our billing company to report a hardship caused by their unexpected out-of-pocket bill, we waived all out-of-pocket charges entirely. From what I have heard from other emergency medicine groups in similar situations, this is typical. After all, the point of staying out of network isn’t to price-gouge patients (few ED patients pay any of their out-of-pocket charges anyway); it is to force insurers to offer reasonable terms instead of demanding discounts so severe we can’t survive. And eventually, that’s what happened. Our patients who were BC/BS customers complained to their employers about their insurer, and after about six months BC/BS came back to us, bargained in good faith and agreed to reasonable terms that were acceptable to both parties. And for the record, although BC/BS was the biggest and most aggressive of the insurers we went through this process with over the years, it wasn’t the only one. In my experience, this is common behavior for an insurance company.

As you can see, the only bargaining leverage hospital-based
specialists have when negotiating with insurance companies is the threat to stay out-of-network, bill the insurer at a higher rate and balance bill patients (which drives them to pressure their insurers). Unlike office-based specialists, we can’t tell insurers that “we won’t see your customers if you don’t give us a fair contract,” because we lack the opportunity to prescreen patients and turn them away – or even warn them that we are out of network and their out-of-pocket costs will thus be higher. Patients show up at the hospital, and we take care of them, no questions asked.

In fact, even discussing things like insurance networks and out-of-pocket charges in the ED before the patient has been cared for and any “emergency medical condition” has been found and “resolved” is a violation of federal law (EMTALA, the Emergency Medical Treatment and Active Labor Act of 1986). Patients can sue hospitals for EMTALA violations even when no malpractice is alleged, and for a single violation both doctors and hospitals can be fined up to $50,000 and excluded from participation in Medicare and Medicaid (TennCare).

Insurers know this. They know that emergency physicians and hospital EDs will take care of their patients no matter what, without even checking insurance status first, much less turning away out-of-network patients. If legislators or federal regulators make it difficult or impossible for out-of-network doctors and hospitals to charge insurers more than in-network doctors and hospitals, and to balance bill patients, it will be disastrous not just for doctors and hospitals but eventually for patients too. It will not only drive hospital-based specialty groups out of business; it will drive some hospitals to close – as we have seen in California, where the insurance industry has already won this battle.

Because of EMTALA, any restriction on the ability of hospitals and hospital-based specialists to stay out of network and balance bill will essentially 1) make all emergency physicians, all hospital-based specialists, all EDs and all specialists on call for EDs in-network with every insurer; and 2) make it possible for insurers to decide arbitrarily and completely on their own what to pay for medical care. Insurers would have no reason to negotiate with any hospital-based specialty group or ED. Emergency physicians and other hospital-based specialists, as well as EDs and the hospitals they are part of, would be left completely at the mercy of a notoriously greedy insurance industry whose goal is to pay next to nothing for healthcare.

One other aspect of a ban on balance billing is particularly destructive to EDs and emergency physicians because of the huge charity burden we bear. In most Tennessee EDs we lose money on the uninsured and TennCare patients who make up the majority of our patient population. We break even on Medicare patients. For emergency physician groups to stay in business, and for EDs to stay open, the minority of our patients with commercial insurance have to generate enough revenue to fund our charity mission. That will not happen if insurers are given the power to pay whatever they like to out-of-network doctors and hospitals, who are forbidden to balance bill. Emergency departments and those who work there make up our nation’s medical safety net. Maintaining that safety net takes funding.

Unless serfdom sounds attractive to you, get to work. Talk with your legislators, and let your hospital administration know about this, too. Not only should insurers shoulder the responsibility of educating their customers on which doctors and hospitals are in-network, rather than dumping that on physicians, restrictions on out-of-network charges and balance billing will:

1) Make it possible for insurers to pay as little as they want for medical care.
2) Drive hospital-based specialty groups, especially emergency medicine groups, out of business.
3) Cause EDs to run even bigger deficits than they do now, leading to hospital closures.
4) Destroy the medical safety net.

If insurance companies are allowed to pay next to nothing for medical care, then next to nothing is just what patients will get when they are most in need.

* Private practice of emergency medicine means an emergency medicine group in which the physicians own their practice, as opposed to when the physicians are employees of a staffing company.

Dr. Walker is a member of the Chattanooga/Hamilton County Medical Society and the TMA and is on the editorial board of Tennessee Medicine. He also serves on the board of directors of the American Academy of Emergency Medicine; is editor of its magazine, Common Sense; and is president of its Tennessee chapter, TNAAEM.
disclaimer that there is not space to include nearly all of them. In 1983 Rosalyn Sumners became the world ice queen and was the odds-on favorite to win the Olympic Gold the following year. She didn’t. She narrowly missed, taking the silver medal, deposed by a 16-year-old skater from East Germany by the name of Katerina Witt. Rosalyn suffered a decline afterward that was marked by growing pains, loss of desire, and minor injuries. She has re-emerged in the past few years as one of the loveliest and most talented of all the professional figure skaters.

Though Rosalyn’s loss was a severe disappointment, so far as I am concerned Katerina – who held the world title during 1984 and 1985, and again in ’87 and ’88 – more than made up for it. She missed the world title by a narrow margin in 1986, being unseated by the United States’ Debbie Thomas, the first black woman to compete at this level. In 1988, along with the world title, Katerina again captured the Olympic Gold. You hear remarks nowadays that figure skating has become the sport of young children. That is true for the women, but it does not apply to the men.

In addition, it has always been a sport of young children. Sonja Henie won the world title at 13 and won her first Olympic Gold Medal at 14. Michelle Kwan won the U.S. and world title at 15 and was knocked out of the U.S. title at age 16 by 14-year-old Tara Lipinski. Oksana Baiul, who hails from the Ukraine and is now living and training in Las Vegas, won the Olympic title in 1994 at age 15 and is currently recovering from her own disastrous time.

Those of you who have had teenage daughters are certain not to be surprised that even the most stable and consistent of them may have bad days, and one bad moment may lead to another, and the whole program come unraveled. That is what happened to Michelle, one of skating’s most consistent skaters, who in her long program fell not once, but three times. Oksana suddenly grew six inches and gained 20 pounds, predictably causing her problems, and it’s not surprising that she injured her back. Why any backs – not to mention knees, ankles and feet – survive the punishment is beyond me, anyway. When in her prime, the ever remarkable Katerina Witt once fell, leaving her admirers aghast. She said, “Well, what did you expect? So I fell. I’m only human. I’m not an automaton!” Which was news to her adoring public.

Which brings me to my logical conclusion. Notwithstanding the hard physical labor it involves, its consequent considerable rewards – prominent among which are the joys of the skating itself – make the lure of professional skating nigh onto irresistible. As Rosalyn Sumners observed, “I’m being paid to do what I love best.” After all her struggles with herself, her body and the ice, she is a lovely sight to behold. The professional skaters compete among themselves, but the competition is among comrades. There are many, many superb skaters in their ranks. Kristi Yamaguchi, who started out as a gangling child, won the world title in 1991 and 1992, when she also won the Olympic Gold. She was widely known and admired as one of the most consistent skaters ever. She fell and lost a competition. Of course. Though a seasoned amateur, now just turned professional, she is still very young. Denise Bielman, from Switzerland, was the first woman to do a triple Lutz. That was in 1978. She still charms her audiences and is the European favorite.

And then there is Katerina Witt, who for me is – for a variety of reasons – in a class by herself. Sometime after her second Olympic Gold Medal she defected to the United States, prompted to some extent by her friendship with that peerless male skater Brian Boitano. They share a passion for perfection in skating, as well as a taste for showmanship. Though it would be easy to view their careers as being in decline, I think that because of their artistry their stars continue rising. Along with Kristi Yamaguchi, Rosalyn Sumners, Karen Kadavy, and most of the earlier female skaters, Katerina’s art emphasized grace over spectacular athleticism. Those superb women, some at an advanced age for skaters (Katerina is 30), added a few triple jumps to their repertoire, and Kristi has for a long time been the best of all the skaters, both athletically and artistically.

Is it worthy all the pain and effort? The odds against reaching the pinnacle of success in any area of life are great, but figure skating and gymnastics, along with ballet (a kindred passion that is practiced to at least some extent by most if not all of the really successful skaters) present problems beside which those of other pursuits pale in comparison. Each day literally thousands of children, inspired by those few who made it to the top, put on skates religiously and struggle upwards by falling downwards. Lots. Some get hurt, sometimes badly. Children are supple, and they don’t weigh much, and they haven’t to fall. On the other hand, their joints are immature, with still open epiphyses. Damage can be long in healing, creating a bonanza for those in the growing field of sports medicine. Perhaps worst of all is the loss of their childhood, often sacrificed to a doting parent’s dreams of glory that proffer scant promise of ever being even partially fulfilled.

For this reason, I never begrudge the stars their income, no matter how outrageous it may seem. Rather, I question the wisdom of the public and marvel more at their profligacy than at the cupidity of the stars and especially of their managers and agents. Taken in the context of the meager reward the public is willing to allot to those who care for and teach their children and risk their lives for the public safety, the public’s infatuation with sports and entertainment successes and their ”just” rewards becomes a travesty.

That travesty is equaled only by the outrageous differentials between those at the top of the upper echelons and those in the lower echelons. But I suppose the two are of a pattern. +
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Must an in-person encounter take place before a physician can lawfully issue a controlled substance prescription via telemedicine to a patient located in Tennessee?

It depends. An in-person encounter is not absolutely required as a prerequisite to a prescriber issuing a controlled substance prescription via telemedicine to a patient located in Tennessee. However, there may be many instances in which an in-person physical examination of the patient should be performed prior to a physician issuing a controlled drug prescription using telemedicine. Certain medical conditions may necessitate in-person encounters between a physician and patient.

As background, the Tennessee Board of Medical Examiners (BME) has a new telemedicine FAQ page on its website.* Physicians who are considering prescribing a controlled substance using telemedicine should review this page, along with the applicable laws and rules.

One of the FAQs answers the question, “Can a physician prescribe controlled substances via telemedicine?” The BME answers, in part:

“Federal regulation may limit a physician’s ability to prescribe controlled substances electronically without first performing at least one in-person assessment of the patient. Prescribers are encouraged to consult with personal (legal) counsel to determine whether their intended prescribing practices violate federal laws or regulation.” [emphasis and paren added]

The statement appears to be in reference to 21 USC 829(e)(2)(A)(i) of the Federal Controlled Substance Act. Subsection (e) (1) of the Act requires that no controlled substance may be issued via the internet without a valid prescription. The law further defines the term “valid prescription” to mean a prescription that is issued for a legitimate medical purpose in the usual course of professional practice by a practitioner who has conducted at least one in-person medical evaluation of the patient, or a covering practitioner.

The law defines “in-person medical evaluation” as “a medical evaluation that is conducted with the patient in the physical presence of the practitioner, without regard to whether portions of the evaluation are conducted by other health professionals.” However, subsection (e)(3) clearly states that “Nothing in this subsection shall apply to the delivery, distribution, or dispensing of a controlled substance by a practitioner engaged in the practice of telemedicine.”

TMA believes that the law carves telemedicine out of the broader usage of the term “electronically” as it is used in the Act. Therefore, if a prescriber intends to prescribe controlled substances to a patient based on a set of questions answered on the internet, an in-person encounter would be a prerequisite to the issuance of the prescription. However, if telemedicine is utilized, no previous in-person encounter is necessarily required.

Telemedicine Prescribing is different than internet prescribing. Under Tennessee law, a telemedicine encounter does not take place unless electronic media is used to “enable interaction between the healthcare provider and the patient” and is in “real time.” An internet exchange does not meet these criteria. Thus, there is a difference between prescriptions issued as a result of a telemedicine encounter and a more general online exchange.

BME rules require, among other things, that a physician, before prescribing or dispensing any drug to an individual by any means, perform an appropriate history and physical examination.** A physician may perform an appropriate history and physical exam via telemedicine and lawfully prescribe a controlled substance without a prior in-person encounter with the patient. The treating physician is the one who makes the determination of whether a telemedicine exam allows him/her to adequately diagnose and treat a patient. It boils down to standard of care.

*Find the BME Telemedicine FAQ at: http://tn.gov/assets/entities/health/attachments/Telemedicine_FAQs.pdf

**Rule Tenn. Comp. R. & Regs. 0880-02-.14(6)(e)(3) and 0880-02-.14(7)(a) +

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Sample Pricing!

<table>
<thead>
<tr>
<th>Prescription</th>
<th>RETAIL PRICE</th>
<th>DISCOUNTED PRICE</th>
<th>% OFF</th>
</tr>
</thead>
<tbody>
<tr>
<td>Xopenex 0.2mg/1ml</td>
<td>$261.99</td>
<td>$15.81</td>
<td>94%</td>
</tr>
<tr>
<td>Fluoxetine 20mg TAB (Prozac generic)</td>
<td>$21.39</td>
<td>$9.69</td>
<td>55%</td>
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<tr>
<td>Lipitor 40mg TAB</td>
<td>$400.00</td>
<td>$322.46</td>
<td>19%</td>
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<tr>
<td>Captopril 25mg TAB</td>
<td>$29.09</td>
<td>$24.65</td>
<td>15%</td>
</tr>
</tbody>
</table>

*Discounted prices were obtained from Walgreens pharmacy in January 2016. Prices vary by pharmacy and region and are subject to change.

For more information or to order free hard cards, please contact:

Natalie Meyer
1-888-987-0668• natalie@tennesseedrugcard.com
TMA, AMA SUPPORT PHYSICIANS CHALLENGING CMS AUDIT

TMA and The Litigation Center of the American Medical Association and State Medical Societies are jointly providing financial assistance to help fund a legal action by Tennessee primary care physicians. The lawsuit challenges a federal rule that has led to what the organizations deem unfair payment recoupments.

A TennCare audit conducted in 2015 based on criteria set by the Centers for Medicare and Medicaid Services in 2012 led to the attempt to collect millions of dollars from Tennessee physicians, mostly in rural, underserved areas, who received enhanced Medicaid payments under the Affordable Care Act.

This fall, TMA collaborated with attorneys at Nashville-based Bass, Berry & Sims law firm to jointly represent some of the providers appealing the recoupment.

TMA’s Board of Trustees has pledged funds to the legal fees of the plaintiffs. Last month, the AMA Litigation Center pledged to match and double the monetary contribution from TMA at TMA’s request.

More information is available at tnmed.org/pcpratebump. +

DR. AZAR ELECTED DIRECTOR-ELECT OF ABOS

Frederick Azar, MD, of Memphis has been elected as director-elect of the American Board of Orthopaedic Surgery.

Azar is chief of staff of Campbell Clinic Orthopaedics and a professor at the University of Tennessee-Campbell Clinic Department of Orthopaedic Surgery and Biomedical Engineering. He has served as president and treasurer of the American Academy of Orthopaedic Surgeons. +

TMA HIRES NEW STAFF MEMBER

TMA recently hired Ben Simpson, JD as Associate Director of Government Affairs. Simpson will work strategically with TMA’s lead lobbyist to promote better healthcare policies in the Tennessee General Assembly.

Simpson previously spent three years as legislative liaison and attorney for the Tennessee Department of Health and also worked as a claims examiner for the Tennessee Department of Treasury. He earned a degree in political science from the University of Tennessee and a JD from the Nashville School of Law. +

Don’t give up the fight. We need your support to continue making a difference and ensuring friends of medicine are in the Tennessee General Assembly.
MEMBER NEWS

Richard J. DePersio, MD, FACS
Steven Reid Dickerson, MD
Robert Marshall Dimick, MD
Brian R. Dulin, MD, FACC
James E. Ensor Jr., MD, FACP
Tamara P. Folz, MD
David Gerkin, MD
John W. Hale Jr., MD
Charles Russell Handorf, MD
William Joseph Harb, MD
Kenneth L. Holbert, MD, FACEP
Ronald H. Kirkland, MD, MBA
George R. Lee III, MD, MS
Adele Maurer Lewis, MD
James C Loden, MD
Shauna Lorenzo-Rivero, MD
Gary Keith Lovelady, MD
Michael McAdoo, MD
John David McCarley, MD
Robert Wallace McClure, MD
Michel Alice McDonald, MD
Fredric Ronald Mishkin, MD
Brent Robert Moody, MD, FACP, FAAD
Lee Richard Morisy, MD
William J.L. Newton, DO
Jeffrey Patton, MD
Julie Maria Penas, MD
James Powell, MD
F. Bronn Rayne, MD
Michael Wayne Bookout, MD
Glenn H. Booth Jr., MD, FACP
Michael Wayne Brueggeman, MD
Gary A. Brunvoll, DO
Jeffrey William Bunning, MD
Jeffrey Byers, MD
Jorge I. Calzada, MD
Marian L. Chamberlin, MD
Steve Charles, MD
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Mary A. Churchwell MD
Elijah Grady Cline Jr., MD
F. Hammond Cole Jr., MD
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Gregory Corradino, MD
Alan Lee Cox, MD
Donna R. Dillard, MD
Dennis H. Duvall, MD, FACP
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Walter Frizzell Fletcher, MD
Charles S. Fulk, MD
Paige Clifton Furrow, MD
Jeffrey W Gefter MD PC
Larry Gibson, MD
Paulino E. Goco, MD
Mark S. Goldfarb, MD
Charles E. Goodman Jr., MD
Timothy Edward Gordon, MD
Paul W. Gorman, MD
Roland William Gray, MD
Richard S. Greene, MD
David Nelson Gwaltney, MD
David Raymond Hall, MD
Richard S. Hall, MD
Joe Mark Harris, MD
Danielle Hinton Hassel, MD
James William Haynes, MD
Robert G. Hewgley, Jr., MD
Joshua A. Hicks, MD
George Alan Hill, MD
Anna Kristine Hopla, MD, FACP
Pushpendra K. Jain, MD
Kimberly Marshelle Johnson, MD
John C. Johnson, MD
James E. Jolley II, MD

2016 SUSTAINING MEMBERS

Mark D. Anderson, MD, FACP
Joseph R. Armstrong, MD
Stanley L. Bise, MD
Mark William Bookout, MD
Glenn H. Booth Jr., MD, FACP
Michael Wayne Brueggeman, MD
Gary A. Brunvoll, DO
Jeffrey William Bunning, MD
Jeffrey Byers, MD
Jorge I. Calzada, MD
Marian L. Chamberlin, MD
Steve Charles, MD
Luella Grigg Churchwell, MD
Mary A. Churchwell MD
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George Alan Hill, MD
Anna Kristine Hopla, MD, FACP
Pushpendra K. Jain, MD
Kimberly Marshelle Johnson, MD
John C. Johnson, MD
James E. Jolley II, MD

To join IMPACT or to make a corporate donation contact Kelley Hess at 615.460.1672, or kelley.hess@tnmed.org. Please make your check out to IMPACT and send to 2301 21st Avenue S. Nashville, TN 37212.
MAINTAINING FAIRNESS

TMA FIGHTS FOR PHYSICIANS AGAINST UNNECESSARY AND COSTLY MOC BURDENS

Getting recertification through the American Board of Orthopaedic Surgery took nearly three years and meant a revenue loss of close to $100,000 because of time spent away from patients for Paul Gorman, MD of Johnson City.

He was recertified through the ABOS in 2012 but says he will not seek recertification when it comes time for renewal in 2022.

“I’ve written the ABOS and said ‘You guys are crazy if you think I’m ever doing this again,’” he said, adding that board certification isn’t correlated with quality of care.

Dr. Gorman was among dozens of doctors who reached out to the Tennessee Medical Association with their MOC frustrations this fall when TMA asked for stories from members.

Concern about MOC is a nationwide trend. A national cross-specialty survey published by the Mayo Clinic in 2016 showed that only 15 percent of responding doctors believe that MOC activities are worth the time and effort they take, and just 24 percent believe they are relevant to patients. A total of 81 percent viewed them as a burden.

In Tennessee, TMA is addressing MOC concerns this year with legislation to be sponsored by Sen. Richard Briggs, MD (R-Knoxville) and Rep. Ryan Williams (R-Cookeville).

Other legislative priorities include passing the Healthcare Provider Stability Act to bring more predictability to reimbursement for healthcare providers, fighting against balance billing legislation that doesn’t address the narrowing networks that make it necessary and combating negative changes to the state’s medical malpractice system, among others.

Read more about all of TMA’s legislative priorities at tnmed.org/legislative.

The goal of TMA’s MOC bill will be to prevent hospitals from denying admitting privileges, insurance companies from denying reimbursement or participation in a network, or the Tennessee Board of Medical Examiners from denying licensure based solely on whether a physician participates in MOC.

The Tennessee General Assembly will not be alone if it chooses to take on this issue. Two other states — Kentucky and Oklahoma — passed MOC laws in 2016.

The Oklahoma law clarifies that state statute does not require a physician to secure MOC as a condition of licensure, reimbursement or employment and admitting privileges at a hospital. The Kentucky law states that maintaining state licensure won’t be tied to maintenance of certification.

Dr. Gorman said that addressing concerns about MOC could help Tennessee become a haven for doctors as the state faces a physician shortage.

“This would not be promoting the public good if the Tennessee General Assembly ignores this issue,” he said.

Wayne Kelly, MD, of Cleveland took the MOC test for his certification through the American Board of Pediatrics in November, but preparing was time-consuming while the test itself was full of esoteric questions, he said.

“In my opinion it has become basically an extortion ring, charging us lots of money to participate in these MOC exercises,” he said.

Many of the specialty certification boards require exams for which there are significant fees, but they also receive substantial revenue by offering courses that physicians can take to prepare for the certification exams.

He said the CME section of his recertification was redundant because he already needs CME hours to maintain his state license, and a quality improvement section required extensive chart reviews over a four-week period and didn’t result in any helpful knowledge.

“My partners and I are certainly opposed to MOC,” Dr. Kelly said of himself and his colleagues at Peerless Pediatrics. “I really felt very strongly that it was overly burdensome and very time-consuming.”

The system is also unfair, in Dr. Kelly’s estimation. Many doctors are grandfathered in and don’t have to go through the MOC process. There also isn’t an equivalent to MOC for midlevel practitioners.

Dr. Kelly and his partners plan on meeting with legislators to discuss an MOC fix, and it is important for physicians of all specialties to be active with medical societies, write letters and meet with their legislators to encourage action on the issue.

“We need to very clearly communicate with the Tennessee legislators and let them understand what a big problem this truly is,” he said.

Gregory Hines, MD of Lawrenceburg is certified through the National Board of Physicians and Surgeons rather than maintaining certification through the American Board of Family Medicine.

NBPAS was created as an alternative to the ABMS and requires previous ABMS or American Osteopathic Association certification and 50 hours of CME over a 24-month period.

“I’ve been in practice for 14 years, and I got tired of having to go sit and take exams for the rest of your career,” Dr. Hines said.

The scope of the test required for ABFM recertification is too large to practically test people over in the way it is done now, he said.

“I’m a family practitioner, which means that my scope of practice is from one day old to 102,” Dr. Hines said.

However, he needed to maintain some form of certification because without it he would not be allowed in the insurance networks of some of his patients, he said.

“I try to treat all of my patients the exact same way,” he said. “It shouldn’t matter to me what insurance you have.”

Dr. Hines said he would welcome a change in the ABFM’s process for recertification to make it more reasonable for physicians to continue certification with the group.

“The whole point of this is to be treating patients, not trying to pass some arbitrary exam,” he said.
It’s election season! Use this voter guide to review nominees before casting your ballot online. All election materials are available at tnmed.org/elections.

• Voting will be open Feb. 1 – Feb. 28, 2017.
• All active dues-paying members and veteran members as of Dec. 31, 2016, will be eligible to vote in the election.
• All votes must be cast online.
• Every member with an email address in the TMA system will receive an electronic notice with his or her TMA member number, verification of voting region and a link to the election ballot.
• Members without active email addresses on file with TMA can access the ballot at tnmed.org/elections.
• No login will be required to vote, but a TMA member number and region number will be required.
• All ballots will include space for write-in votes.
• All ballots must be cast by 5 p.m. CST on Tuesday, Feb. 28, 2017, in order to be counted.
• If a runoff election is needed, it will take place March 21-28.

All ballots must be cast online by 5 p.m. CST on Tuesday, Feb. 28, or they will not be counted.

For more information, contact Amy Campoli at amy.campoli@tnmed.org or 615.460.1650.
ELECTIONS

2016 TMA ELECTION NOMINEES

PRESIDENT-ELECT:
Matthew Mancini, MD, Knoxville
Jane Siegel, MD, Nashville

BOARD OF TRUSTEES:
Region 1: James Ensor Jr., MD, FACP, Germantown
Region 3: Peter Swarr, MD, FAAP, Brentwood
Region 6: John McCarley, MD, Hixon
Region 8: Tedford S. Taylor, MD, Johnson City

JUDICIAL COUNCIL:
Region 2: Pamela D. Murray, MD, Jackson
Region 4: Richard Soper, JD, MD, Nashville
Region 6: Shauna Lorenzo-Rivero, MD, Chattanooga
Region 8: Charles Leonard, MD, Talbott

MEET THE CANDIDATES

PRESIDENT-ELECT: Serves as head of the Tennessee Medical Association for the year following the election. Responsibilities include serving as official spokesperson with media, government officials, and other entities. The president-elect will serve one year as president-elect, one year as president and one year as immediate past president.

Nominee: Matthew Mancini, MD
City: Knoxville
CMS: Knoxville Academy of Medicine
Specialty: General Surgery
Medical School: Mercer University School of Medicine
Email: mmancini@mc.utmck.edu

I have been a proud member of TMA since 1999. Of all the associations to which I belong, I believe TMA to be the most important to my career as a physician. Practicing general surgery for 20 years, I have seen the progress on tort reform and how it has made Tennessee a great place to practice medicine. Of course, we always can make it better! The Tennessee Medical Association is the vehicle where we as physicians can affect the most change. I have served on the TMA Board of Trustees, including serving as chairman. Currently, I am on the TMA Membership Committee as well as the CME Advisory Committee, which provides quality educational programs for the membership. Additionally, I am a graduate of the John Ingram Institute for Physician Leadership. On a local level, I am a past president of the Knoxville Academy of Medicine and presently serve as a governor of the KAM Foundation. TMA must continue to be at the forefront of medicine, helping physicians deliver high-quality healthcare to Tennesseans. Healthcare will need to evolve, and we need to be part of the solution. It would be an honor and a privilege to serve as TMA President. I appreciate your vote!

Nominee: Jane Siegel, MD
City: Nashville
CMS: Nashville Academy of Medicine
Specialty: Hand Surgery
Medical School: Vanderbilt University
Email: siegeljm@toa.com

I graduated from Vanderbilt University medical school and practice hand surgery in Nashville and in Hendersonville with Tennessee Orthopaedic Alliance. I have participated with TMA as a delegate for many years, as vice speaker and as speaker of the house. I have served on the insurance issues committee and have participated in the physician leadership college.

My concerns for our house of medicine primarily involve the dilution of ‘medicine’ into ‘medical providers’ and our fragmentation into smaller specialty-focused societies which dilute our strength and cloud our voice. My goals are lofty, but I hope to go after them tenaciously, with a sense of urgency and focus. I want to define the practice of medicine. What is it exactly? What is it that we do, uniquely, that can’t be substituted for by a midlevel, a podiatrist, optometrist, aesthetician or administrator? I want to define it so that we can defend it. Proudly. I want to work to unite our specialty societies, our hospitalists, our whole state to defend our unique role in patient care, or we will continue to slowly lose ground – become diluted and devalued.

I hope to be able to work with physicians across the state – to come together with one voice to assert what medicine is and what it is not. I ask for your support in this year’s election and in strengthening our house.
ELECTIONS

REGION 1
Nominee: James K. Ensor Jr., MD, FACP
City: Germantown
CMS: The Memphis Medical Society
Specialty: Internal Medicine
Medical School: University of Tennessee College of Medicine – Memphis
Email: jensor6729@aol.com

Dr. Ensor received his medical degree from the University of Tennessee College of Medicine – Memphis in 1975. He has held various leadership positions with the Memphis Medical Society. He was a member of the Grievance Committee (1997-2004), Ethics Committee (1991, 1993 and from 1997-2001), Board member (2004-2011) and MMS president in 2010. He is a past president of the Memphis Academy of Internal Medicine. Dr. Ensor has served as a TMA delegate from 2005 to the present, a member of the TMA Legislative Committee from 2013 to the present and has served on the TMA Board of Trustees since 2015 representing Region 1.

“I have been a member of various Medical Society committees, as well as former president of the MMS,” Dr. Ensor said. “Having made numerous trips to Nashville advocating for medicine, I am a member of the TMA Legislative Committee where I have seen firsthand the mechanics of protecting our association and our members. I would hope that you would support me in this great honor of nomination.”

REGION 6
Nominee: John McCarley, MD
City: Hixson
CMS: Chattanooga-Hamilton County Medical Society
Specialty: Nephrology
Medical School: University of Wisconsin Medical School
Email: Dr.McCarley@nephassociates.com

Medicine is going through rapid and unprecedented change, and physicians must be dynamically and actively engaged in health policy if we are to protect the best interests of patients and preserve our profession. Those are my goals. I joined the board in 2016 to complete Dr. Shumaker’s term, and I want to continue this work. I am on the TMA Finance Committee and also serve as liaison to the TN Delegation to the AMA. I am a past president of the Chattanooga-Hamilton County Medical Society, in which I also served as a board member. I also serve on the board of the Medical Foundation of Chattanooga. Earlier I served on the Board of Directors of Nephrology Associates, where I practice. I am a 2014 graduate of the John Ingram Institute for Physician Leadership.

REGION 3
Nominee: Peter J. Swarr, MD, FAAP
City: Brentwood
CMS: Williamson County Medical Society
Specialty: Internal Medicine and Pediatrics
Medical School: University of Vermont School of Medicine
Email: pswarr@gmail.com

I am a practicing general internist and pediatrician in Brentwood. Additionally, I am an Alive Hospice Home Team Medical Director for both adult and pediatric patients. While serving on the TennCare Drug Utilization Review Board since 2005, I have enjoyed the challenges of reviewing pharmacy benefit and drug utilization for Tennessee’s Medicaid program as we work to improve the quality of member care, prevent fraud and abuse and control costs for the State. I enjoy the camaraderie of my fellow physicians as a member of the TMA Board of Trustees as my understanding of the current realities of regulatory reform has improved. I look forward to the continued opportunity and honor to represent our profession during this challenging period of change in our profession.

REGION 8
Nominee: Tedford S. Taylor, MD
City: Johnson City
CMS: Carter County Medical Society
Specialty: Pediatrics
Medical School: University of Tennessee Center for Health Science
Email: tedtaylor@sotha.net

I would be pleased to serve on the Board of Trustees representing Region 8. I have served as trustee and secretary-treasurer for the past two years. I have been involved with TMA since early in my 37-year career in pediatrics. This includes being president of our local medical association, a representative to the House of Delegates and on various committees. I have also served in numerous positions on the medical staff of the hospitals that I have attended. I and my wife, Ramona, of 46 years have one son, Blake, with his wife, Rachel, and their three children. My motto for daily living comes from Ephesians 2:10, “We were created to do good.” I am now working part time and have more time for other efforts. Thanks for your consideration.
### ELECTIONS

**TMA JUDICIAL COUNCIL:** The Judicial Council meets annually, or more often if necessary, to investigate alleged improper conduct and oversee formal disciplinary action against members or component medical societies. Councilors also assist component medical societies in maintaining viability in the region. Each region has one councilor serving on the Judicial Council. Councilors serve two-year terms.

**REGION 2**

**Nominee: Pamela D. Murray, MD**

**City:** Jackson  
**CMS:** Consolidated Medical Assembly of West Tennessee  
**Specialty:** Internal Medicine  
**Medical School:** University of Tennessee College of Medicine  
**Email:** pamela.murray@wth.org

My first term as councilor has been enjoyable and productive, as we have addressed questions regarding regionalization. We have also assisted in the consolidation of several component societies into the newly-named Upper Cumberland Medical Society. I would be pleased and honored to continue the work of the Council into a second term.

**REGION 4**

**Nominee: Richard Soper JD, MD**

**City:** Nashville  
**CMS:** Nashville Academy of Medicine  
**Specialty:** Addiction Medicine  
**Medical School:** University of Tennessee  
**Email:** rsopermd@tennesseemedical.com

I maintain an active private practice in Nashville and my current positions within organized medicine include:

- Judicial Council – Tennessee Medical Association
- Board of Directors – Nashville Academy of Medicine
- Task Force for Opioid Abuse – American Medical Association
- Board of Directors – National Association of Drug Court Professionals

I am a past president of Tennessee Society of Addiction Medicine and actively participate in and assist in numerous TMA-sponsored legislative actions. It would be a privilege to continue representing fellow TMA members on the Judicial Council. I would appreciate your vote.

**REGION 6**

**Nominee: Shauna Lorenzo-Rivero, MD**

**City:** Chattanooga  
**CMS:** Chattanooga-Hamilton County Medical Society  
**Specialty:** Colorectal Surgery  
**Medical School:** Washington University St. Louis College of Medicine  
**Email:** shauna.lorenzo-rivero@universitysurgical.com

I have been a member and active participant of TMA for ten years. I have been privileged to practice medicine in this state and have served on the Judicial Council for the prior two years, learning how the system works. I believe physicians do a better job governing themselves than any outside institution. I am committed to the practice of medicine clinically, professionally and politically, serving locally as society president-elect last year. I feel my experience and commitment make me a worthy candidate. I request your support as I run for this office.

**REGION 8**

**Nominee: Charles Leonard, MD**

**City:** Talbott  
**CMS:** Lakeway Medical Society  
**Specialty:** Family Medicine  
**Medical School:** University of Tennessee Medical School  
**Email:** beamup@charter.net

I am the current chairman of Judicial Council and past secretary/treasurer and board member. I am also the current chairman of the Insurance Issues Committee. I would like to continue on the Judicial Council to try to pull together medical societies into a more cohesive working network. Plans are underway to get those counties with little or no activity to become active again. I will work to make this happen. Thank you for your vote.
NEW MEMBERS

BLOUNT COUNTY MEDICAL SOCIETY
Daniel Kim, MD, Maryville

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY
Matthew C. Aboudara, MD, Chattanooga
Edwin J. Abraham, MD, Chattanooga
John W. Allred III, MD, Chattanooga
Syamal D. Bhattacharya, MD, Chattanooga
Ladd M. Campbell, DO, Chattanooga
Larry C. Cary, MD, Lexington
William M. Cooney, MD, Chattanooga
Susan G. Fisher, MD, Cleveland
Devon H. Ghodasra, MD, Dalton
Daniel B. Herz, MD, Chattanooga
Christopher R. Horton, MD, Dayton
Froilan B. Joves, MD, Chattanooga
Iwayemi O. Olayeye, MD, Chattanooga
Maren G. Shaw, MD, Chattanooga
Larry L. Shears II, MD, Chattanooga
Christopher M. Snyder, DO, Ooltewah
Alexander D. Sokohl, MD, Hixson
Ellen H. Valadez, MD, Lookout Mountain
Harsha G. Vardhana, MD, Jonesborough

CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE
Wood M. Deming, MD, Jackson
Candice J. Jones, DO, Henderson
Gregory E. Mitchell, MD, Jackson

KNOXVILLE ACADEMY OF MEDICINE
Katherine Bellmore, MD, Knoxville
Ronald S. Hamrick, Jr., MD, Knoxville
Micah A. Hatch, MD, Knoxville
Matthew W. Ison, MD, Knoxville
Carrie M. Polin, MD, Knoxville
Martha J. Smith, MD, Knoxville
John D. Towle, MD, Knoxville
Stephanie G. Vanterpool, MD, Knoxville

THE MEMPHIS MEDICAL SOCIETY
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Robert N. Aguillard, MD, Memphis
Dereen E. Akins, MD, Germantown
Raza Askari, MD, Memphis
Shari L. Brown, MD, Memphis
Kayla G. Bryan, MD, Memphis
Meghan V. Burkley, MD, Germantown
Robert Burns, MD, Memphis
Ray S. Daugherty Jr., MD, Memphis
Christi L. Č. Earnest, MD, Memphis
Adam C. Elnaggar, MD, Memphis
Laura L. Engbresen, MD, Memphis
Tasha J. Ford, MD, Memphis
E. Arthur Franklin, MD, Memphis
Joel F. Gradowski, MD, Memphis
Humani Gupta, MD, Germantown
Malini Gupta-Ganguli, MD, Memphis
Ara J. Hanissian, MD, Memphis
Gina R. Hanissian, MD, Collierville
David H. S. Iansmith, MD, Memphis
Stephen M. Johnston, MD, Germantown
Katherine O. Kopinski, Cordova
Kashif A. Latif, MD, Memphis
Benedict J. Malakkal, MD, Memphis
David Martineau, DO, Germantown
Sonal M. Mehr, MD, Memphis
Edward S. Muir, MD, Germantown
Phillip R. Northcross, MD, Memphis
Shweta Patel, MD, Memphis
Vikram P. Patel, MD, Arlington
Evan S. Glazer, MD, PhD, Memphis
Stephen Gregory Porter, MD, Memphis
M. Nauman Qureshi, MD, Arlington
Nidal Rahal, MD, Memphis
Terence P. Rhone, DO, Memphis
Shannon E. Riedley Malone, MD, Memphis
Ceylon M. Rowland, MD, Memphis
George Van Rushing, MD, Germantown
David L. Schwarz, MD, Germantown
Tzeeko G. Stoerz, MD, Germantown
Joseph C. Sullivan, MD, Germantown
Ralph Taylor, MD, Memphis
Daniel A. Vaena, MD, Germantown
Christopher C. Vanison, MD, Memphis
Randy J. L. Villanueva, MD, Germantown
Sarah M. Wallett, MD, Memphis
Angela Denise Watson, DO, Memphis
Eric Wiedower, DO, Memphis
Norman F. Woodlief, MD, Memphis
Neeraja Yedlapati, MD, Memphis

STONES RIVER ACADEMY OF MEDICINE
Rodney P. Benson, MD, Murfreesboro
Justin A. Taylor, MD, Murfreesboro
Tim E. Thomas, MD, Brentwood

SULLIVAN COUNTY MEDICAL SOCIETY
Joseph A. DeStefano Jr., MD, Johnson City
Stephen K. Evans, MD, Bristol

TMA DIRECT MEMBER
Joseph H. Wandass III, MD, Nolensville

WASHINGTON-UNICOI-JOHNSON COUNTY MEDICAL ASSOCIATION
Kent S. Hjerpe, MD, Johnson City
James J. Hollandsworth, MD, Johnson City
Unnati M. Kiran, MD, Johnson City
Carolyn K. Moody, DO, Blountville

*Does not include student or resident members.
IN MEMORIAM

Laurie M. Baker, MD, age 56. Died October 22, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

Frederick F. Boling, MD, age 81. Died May 12, 2016. Graduate of Indiana University School of Medicine. Member of the Sullivan County Medical Society.

William R. Campbell, MD, age 74. Died October 1, 2016. Graduate of the University of Tennessee Center for Health Science. TMA direct member.

James H. Creel Jr., MD, FACEP, age 77. Died November 29, 2016. Graduate of Facultad de Medica de Universidad Autonoma Guadalajara. Member of the Chattanooga-Hamilton County Medical Society.

Kathleen Gage, MD, age 66. Died September 1, 2016. Graduate of University of Florida College of Medicine. Member of the Washington-Unicoi-Johnson County Medical Association.

Roy F. Harmon Jr., MD, age 87. Died September 22, 2016. Graduate of University of Mississippi School of Medicine. Member of the Maury County Medical Society.

Adil I. Mohyuddin, MD, age 55. Died August 23, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Coffee County Medical Society.

John P. Nash, MD, age 88. Died November 9, 2016. Graduate of the University of Tennessee Center for Health Science. Member of The Memphis Medical Society.

Lloyd H. Ramsey, MD, FACP, age 95. Died October 29, 2016. Graduate of Washington University School of Medicine. Member of the Nashville Academy of Medicine.

Howard W. Thomas, MD, age 89. Died July 20, 2016. Graduate of the University of Tennessee Center for Health Science. TMA direct member.

Minnie R. Vance, MD, age 94. Died October 7, 2016. Graduate of the University of Tennessee Center for Health Science. Member of the Chattanooga-Hamilton County Medical Society.
The constant pressure to perform at high levels can lead physicians to problems with chemical dependencies or other addictions and behavioral changes. The consequences of their intensely personal conflicts can extend outward, affecting their patients and communities in ways they never intended.

As I reflect on this...

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

— J.S., M.D.
**INSTRUCTIONS FOR AUTHORS**

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

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

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**References** – References should be limited to 15 for all papers. All references must be cited in the text in numerically consecutive order, not alphabetically. Personal communications and unpublished data should be included only within the text. The following data should be typed on a separate sheet at the end of the paper: names of first three authors (last name first initial[s] with no commas or periods) followed by et al.; complete title of article cited, name of journal abbreviated according to Index Medicus, volume number, first and last pages, and year of publication. Example: Olten JL, Buice JE, Heeschen N, et al.: Cancer in parents of children with cancer. N Engl J Med 333:1594-1599, 1995.

**Illustrated Material** – Illustrations should accompany the emailed article in a JPG, TIF, JPG or PDF format; files must be high resolution, at least 300 dpi. Photos must be accompanied by descriptive legends typed at the end of the paper. Tables should be typed on separate sheets, be numbered, and have adequately descriptive titles. Each illustration and table must be cited in numerically consecutive order in the text. Materials taken from other sources must be accompanied by a written statement from both the author and publisher giving Tennessee Medicine permission to reproduce them. Photos of identifiable patients should be accompanied by a signed release.

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**Publication** – Publication of accepted submissions could take up to a year or more; TMA Members enjoy an expedited publication benefit that could reduce the wait time by up to several months. All articles and abstracts will be published in an online forum and open for peer review on our website, and online database for journals, articles, and resources available to TMA members only.

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**COMPARE THE BENEFITS...**

<table>
<thead>
<tr>
<th>IF YOU...</th>
<th>HYBRID LTC PLANS</th>
<th>TRADITIONAL LTC PLANS</th>
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</thead>
<tbody>
<tr>
<td><strong>LIVE</strong></td>
<td>✓</td>
<td>✓</td>
</tr>
<tr>
<td>If you need LTC benefits</td>
<td></td>
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<tr>
<td><strong>DIE</strong></td>
<td>✓</td>
<td>✗</td>
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<tr>
<td>If you pass away without the need for LTC benefits</td>
<td></td>
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<tr>
<td><strong>QUIT</strong></td>
<td>✓</td>
<td>✗</td>
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<tr>
<td>If you want your money back</td>
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**FOR MORE INFORMATION...**

**DID YOU KNOW...**

7 in 10 Americans will need some type of long-term care in retirement (age 65 or older).¹

The average U.S. nursing home cost is $85,000 per year.²

In 30 years, the projected average U.S. nursing home cost will be $271,740 per year.²

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¹ U.S. Administration on Aging, Department of Health and Human Services, April 2014, (202) 619-0724.

² Average annual U.S. nursing home costs in 2011 and in 30 years (assuming costs increase each year by 3.95%, the average annualized increase of U.S. nursing home costs from 1994 to 2011). Source: 2013 Sourcebook for Long-Term Care Insurance, American Association for Long-Term Care Insurance.
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