WE SHOP. YOU SAVE.

TMA members have access to discounted products and services that you need, want and use to run your practice through the TMA Marketplace.

You no longer have to research and negotiate deals with multiple vendors. Just contact us and use the TMA network.

Insurance and Financial Services  Technology Solutions

Professional/Business Services  Human Resources/Personnel

Medical Office Consumables  Miscellaneous Physician Services

TMA
Tennessee Medical Association

FIND OUT MORE tnmed.org/marketplace or Michael Hurst 615.460.1646 | michael.hurst@tnmed.org
Cover Story
17 Future Physicians: TMA Fights to Expand Graduate Medical Education — Katie Brandenburg

President’s Comments
5 I Swear … — John W. Hale Jr., MD

Editorials
7 CEO’s Note: Take the Lead by Becoming Involved in Organized Medicine — Russ Miller
8 Guest Editorial: Little Green Men — John B. Thomison, MD

Ask TMA
11 When Must Continuing Medical Education Hours be Completed for License Renewal?

Member News
13 Physician Spotlight: Dr. George Woodbury Jr. Promotes Healthcare Advocacy
13 Tennessee Physician Publishes Essay Collection
14 Member Photo Gallery
15 Members in the News
16 IMPACT Capitol Hill Club

Special Features
19 TAG, You’re It — Jackie Woeppel
21 CMS’ Star Ratings Presents Challenges and Opportunities — Karen Cassidy, MD
23 Reform Act Impacts Care of Injured Workers — James B. Talmage, MD, and Robert B. Snyder, MD

For The Record
29 New Members; In Memoriam
30 Advertisers in This Issue; Instructions for Authors; Statement of Ownership
6:30 A.M.
already behind schedule

LUNCH SKIPPED.
Your patients are priority.

AND A LATE-NIGHT URGENT CALL
about the
one thing your practice cannot heal –
A DOWNED COMPUTER SERVER.

It's time for professional IT help.

Healthcare professionals need technology professionals. Jackson Thornton Technologies is on call 24/7, keeping your IT networks up and running. Helping ensure HIPAA compliance with secure systems. Converting paper to Electronic Medical Records. Now you can concentrate on patient care—while JTT Takes care of IT.

877.226.9091  |  jtteconnect.com
When was the last time you thought about the Hippocratic Oath?

I know we all practice by the ideals espoused in the oath, but when was the last time you actually thought about it? I admit that until recently I probably had not considered it since I recited it. Even then, it took me about five minutes to get distracted.

Crossing that finish line of medical school and starting residency to make some money instead of constantly paying tuition were the overwhelming thoughts in my mind. During residency, my paramount concerns were learning, moonlighting and trying to get some sleep.

After residency, I became focused on passing the boards and finding a place to practice where my family would be happy and I could be successful. Starting a practice while finding family time was all very important; only those of us who have been down that road can truly understand the constant attention and energy needed to maintain your practice in order to make it flourish.

During these past few months as TMA president, my concerns have been about payment reform, the ICD-10 gorilla and our physician-led, team-based approach to healthcare. I’ve given media interviews and traveled the state to hear the concerns of our members.

One of my presidential visits took me to Johnson City, where I went to medical school. I passed by the auditorium where we gathered before our graduation for awards and to recite the oath. The day seems like a blur, but I do remember the arguments in our class about which oath to recite (disagreements between doctors appear to start early).

Later that day, I was privileged to be able to talk to medical students. Whenever I have the opportunity to interact with med students, I am always impressed with their energy, passion and commitment. At the House of Delegates, both with the TMA and the American Medical Association, the Medical Student Section comments and resolutions reflect the best of the calling of medicine.

When I was a medical student if I had heard the President of TMA was in town, I would have thought, “Why would I want to waste my time listening to an old doctor involved in organized medicine?” Oh, what I didn’t know! But there they were, on a beautiful day with perfect weather after being inside all day with classes, to listen to me. I proceeded to tell them about what the TMA is about, its importance and what we are doing to improve the profession and protect our patients. We talked about what we can offer them and how important it is to get involved, and then I began to give advice on the practice of medicine. I talked to them about the privilege and the joy associated with this calling of medicine. I advised them never to get down on themselves and never to think they are indispensable.

I stressed to them the importance of finding a mentor to whom they can turn during a difficult time. I told them that I pray every day to stay competent, up to date and to be able to roll with the changes.

In the hotel that night, I thought about the day and realized how shortsighted my comments to the students were in the bigger context. In the Hippocratic Oath, it implies an obligation to those who came before us and to those who come after us.

Think about what medicine would be if those physicians before us just “wanted to ride out the wave.” When Isaac Newton was lauded for his accomplishments, he said, “If I achieved anything it was because I stood on the shoulders of giants.” The advances in medicine that we enjoy today would not have happened if the physicians of the past just wanted to work and go home. The good environment we practice in today in Tennessee would not be possible without those past generations of physicians who gave of their time and talents to make the TMA what it is.

Are you making medicine better or just working out your time?

We all took an oath. Remember? +

Share your thoughts with Dr. Hale at president@tnmed.org.
EMPLOYEE BENEFITS
WE’VE GOT YOU COVERED!

Not only do we have you covered with a full line of Employee Benefits Insurance Plans, but also by working hard to ensure that you have the right plan design, at the best price available, with the carrier that is right for your practice. And, we’ve been doing so for nearly 30 years! Following are some of the plans we offer:

- Medical
- Medical Bridge
- Life
- Dental
- Vision
- Short Term Disability
- Long Term Disability
- AD&D
- Critical Illness
- Cancer

For more information or a quote, contact us today.
When I am outside the office and meet new people, they ask what I do for a living. I say I work for physicians … it’s much easier than explaining association management or explaining the world of medical associations!

This always begs the next question, “Do you run a practice, or…?” So then I have to explain the medical association functions. To the layperson, this seems like an easy job. “Obviously every doctor belongs…” to which I reply that we do work that helps all physicians, but membership is voluntary. They are appalled when I explain that less than half of Tennessee physicians are current members of TMA and their local medical societies.

When I started with the TMA in the 1980s, my predecessors spoke of the good ole days when everyone was a member. In the 1970s, TMA, its component societies and even the American Medical Association had more than 80 percent membership. What happened?! Do medical societies do less important work? Is it too expensive to belong? Are there other organizations that do the same thing at a better value? The answer to these questions is yes AND no.

The division of the medical profession – which started in the 1980s with diagnosis-related groups, resource-based relative value scale and other payment models – strategically pitted physicians against one another for pieces of the ever-shrinking reimbursement pie. As former TMA CEO Don Alexander famously used to say, “When the pie shrinks, table manners change.” TMA was left to take on the big issues affecting all physicians such as medical liability reform, TennCare, insurance industry litigation for unfair downcoding practice and the like. Other entities were freed up to reform, TennCare, insurance industry litigation for unfair downcoding practice and the like. Other entities were freed up to take on the more granular financial issues, often at the federal level.

Long before NCQA, there were peer review committees and, before that, the medical societies were the peer reviewers. To be on the medical staff at the local hospital, you had to be a member of the local medical society. Who better to evaluate the skills and credentials of a local physician than the other physicians in the community? That is how medical societies thrived and had such high participation rates years ago.

What has to happen to bring all physicians back together today? While we lack the hook of being the de facto credentialing organization, we still have the standing to define what is good medicine – what is good for patients and for the community.

The issues we face today are arguably more important and divisive than issues in the past. Tennessee is one court case away from losing our gains earned on medical liability, and rapidly approaching payment reform models will create even more division among physicians within their specialties and even their group practices. Advancements being sought by physician extender groups threaten the boundaries of what it takes to be a physician and who is ultimately responsible for deciding patient care.

TMA’s president, Dr. John W. Hale Jr., has embarked on a tour across the state to rally physicians on these issues, but more importantly, to listen to members and nonmembers. We are finding that TMA is focused on the right issues, but we also find that many physicians “think” they are members but have let their memberships lapse or just have never taken the time to join, even though they intended to do so.

I have heard some marketing consultants blame a generational shift for our participation woes. “This generation is value-focused, and you need to sell your value proposition,” they say. While that may have some merit, the future of the medical profession and the medical association – new practicing physicians – are not being engaged by their peers and mentors.

The “pitch” is fairly straightforward: “This is the physicians’ professional association and we need to support it. If we don’t, then all that we have achieved and what status we have in healthcare will erode. Reimbursement will continue to go down, workload will go up, others will gain the ability to do what physicians do and physicians will face more liability for that work.”

Does that sound fair?

It’s past time for all the physicians in Tennessee to come together. The greater the challenges, the steeper the climb, the more you need to unify.

Tennessee physicians have a long tradition of accomplishing great things when they join together to address huge obstacles, like starting a medical liability insurance company or bringing about tort reform, just to name two.

Whatever your practice environment is now or what you expect it to be in the future, first ask yourself, “Will it be better or worse if there is not an organization to take on MY issues as a physician?” Then have the conversation in your practice, staff, leadership committee and other professional circles about supporting your TMA.

The issues are increasing. Take the lead by becoming involved. Don’t let your colleagues sit back and let you and others do the work that really matters.

Share your thoughts with Mr. Miller at russ.miller@tnmed.org.
I know people you might call perennial and ubiquitous true believers. Some of them perseverate with only one subject, whereas others may take up one cause after another with vigor, pursuing it avidly until it flags and another more exciting one comes to their attention. Still others arrive at conclusions based on fact or sometimes fantasy that ultimately take possession of them and even become their religion, as, for example, Communists (or Democrats or Republicans, for that matter.) Unless I am self-deluded, which is always a possibility for any of us, I suppose, I think I restrict that sort of faith to God and some of the things I believe about Him and His activities on behalf of His most notable (I think - I am not quite a true believer there) and at the same time most troublesome (I am a true believer about that) creation. I read a book once called The True Believer that I found entertaining and sometimes showing insight into man’s behavior, but I also thought sometimes not. At this much later date I don’t recall exactly why I thought either of them, but since it doesn’t really matter for this discussion, I don’t propose to pursue it any further.

The term true believer has assumed, maybe because of that book, a distinctly pejorative connotation. It is generally applied in that sense to someone or ones of a different persuasion than yours, such as, again, Communism, or even standard religions and other things in between, which is what the book was mostly about. There are other for instances, which are more to the point here, having to do with the activities of governmental officidom, such as, for instance, the way in which the United States government through various of its agencies has treated with disdain those individuals accepting some other etiology than that prescribed by them for the Gulf War Syndrome. The government and the Pentagon have really taken a hit on that one, having had to change their story a number of times, thereby even further eroding the already shaky confidence the public has in its government.

Even when sleeping dogs are let lie, whether literally or figuratively, they sooner or later rise up again. And on the figurative side, at least, the government is never impressively smart about choosing its targets or very carefully taking aim to put them to rest. This time their chosen target is, once again, the apparently open sore caused by those accepting, or more particularly espousing, the notion that we - that is, Planet Earth - have been visited on numerous occasions by inhabitants of another one. I’m not necessarily one of those espousing that theory. I only know what I know, and it is all second hand. On the other hand, the first hands belonged largely to individuals of impeccable veracity, which I do know for a fact. So I largely accept my second-hand accounts for that reason.

On July 7, 1947 I was an army surgeon (there was as yet no Air Force) stationed at Craig Field (which the Air Force later redesignated Craig Air Force Base) just outside Selma, Alabama. That is the now suddenly ludicrously disputed date ("ludicrously" because their are contemporary newspapers verifying the date) of the now controversial crash of an airborne vehicle of disputed parenage in the desert near Roswell, New Mexico. If the event excited any comment at Craig, I was either unaware of it or was little enough impressed by it that it has slipped my memory. It not unlikely had something to do with the event’s having been given very little media attention due, it has subsequently been revealed, to orders from Washington, not further specified, to stonewall it. I can’t imagine what the inducement was, though the tractability of the media types may indeed have changed that much. These days those media types will do anything at all for a good story, and if necessary make one up. I guess that is as good an indication as any of how badly the government’s image has tarnished in the 50 intervening years.
In any case, it was not until I had been back in Nashville for several years, as I recall in the early 1950s, that I began hearing general talk of the possibility of extra-terrestrial visitors to this planet in "flying saucers." I think maybe the first serious discussion on that subject that I was party to was at a dinner meeting where in the course of the table conversation one or two former combat aviators commented that they and their fellow fliers had on occasion been accompanied in flight by unfamiliar aircraft of strange design that suddenly and almost miraculously appeared, flew along with them for a bit, and just as suddenly vanished with near blinding speed.

I had spent 1946 in Europe, mostly in France, as a surgeon with the 40th Bomb Wing, a B-17 outfit that had been on many bombing raids over Germany. By the time I joined its 306th Bomb Group at its base in Istres, a small town about 30 miles west of Marseilles, the war in Europe had been over for nine months. Operating from a number of bases, the wing was at that time engaged in high altitude photo-reconnaissance, photographing the entire European continent, including the Soviet Union and Africa. Despite the length of time since the fighting left off, most of the 5,000 officers and men on Istres AAFB were combat veterans. Some of them had flown a complete tour or more of bombing missions. Every now and then the conversation in the officers' club or mess would turn to the strange aircraft that would occasionally accompany them, apparently as observers, with awed comments about their extreme speed and maneuverability. The craft (I don't remember their ever being referred to as "flying saucers") had no identifying markings, and they never showed any inclination to take sides or become involved in the conflict in any way. Those occurrences were discussed in the debriefings, I'm told, and made their way into the official reports as well, but there was no evidence that the reports ever went anywhere. Nearly everybody in the outfit knew about the sightings, many of them first hand, but they had acquired no official status, and the unfounded assumption of the uninitiated (that was again nearly everybody) was that some sort of Allied secret weapon was being tested. The only explanation ever offered whenever any notice at all was made of them from higher up was a semi-official one, which was "combat fatigue" on the part of the viewers. The visitations apparently ceased with the end of hostilities, so I have only the word of friends and acquaintances I trust. Though the craft sometimes appeared during the stress of battle, they often appeared at times of tranquility and were seen by entire crews, none of whom were trying to prove anything by their reports, since at that time there was nothing to prove.

In the cool of an evening in the Garden of Eden, we're told that God came a'callin' on his crowning achievement, but CA, aka A&E were nowhere to be found. When He called to them, they answered that they had thought they might be having company, and that they'd better get dressed, since they were en dishabille. God asked them, "Who told you that you were naked? Have you eaten the fruit of the tree that I told you not to eat of?" To which Adam said, in effect, "No, Boss. Not me. You got it all wrong. The woman that you gave me, she..." Ever since then it has been an article of faith in the counter-intelligence business that you never, ever tell the truth, even when it might serve you better. In the government service, if your superior says that the sun set at 7 a.m. this morning and looks at you and says, "Didn't it?" you defend his contention with your life. By doing so, the life you save might be your own (TLYSMBYO). When the President lies, which it appears these days is frequently, every mother's son (and daughter, too) anywhere nearby is under the gun. In government the truth is never just hard to come by. It is more often impossible to come by. But, as the public has found out, life goes on as usual, and since it does, the belief that telling the truth no longer matters is coming to be widely held, and the rest of the country has now caught up with Massachusetts.

So back now to articles of faith. It has been for some time now one of mine, one to which I nearly slavishly adhere, that one, particularly this one, never accepts a single statement, official or unofficial, coming from any seat of government in the world at any level past, present or future, because in that environment if the boss says lie, you had better lie. Particularly any information should be suspect if it has been filtered through the news media, since doing that simply compounds the possibility that it is spurious (or, in government-speak, "disinformation," which is distinguished from misinformation by being deliberate.)

So what really did happen at Roswell on July 7, 1947? I don't know anything more about it than what I have heard or read, and the official and the unofficial versions are widely disparate. I know nothing of little green men, or in this case gray men, I'm told. I do know a lot, though, about the veracity of officialdom, and also about the word of the fly-boys I lived and worked with and trusted for two and a half years, not to mention a few who have been my trusted friends for some 60 years. I believe in flying saucers, if that's what you like to call them, and no evidence has been forthcoming to dissuade me from the notion that they are not from any known origin, which means any on this planet.

And besides, what really happened at Roswell and the origins of the craft make no real difference to me at all, except curiosity. What does make a difference to me, and should to you, too, is that those in government continue treating the public like imbeciles and consider it their primary mission to deceive us. Who, for example, believes all those official reports and media hoopla about Mr. Foster having committed suicide on a Washington park bench? Nobody - or, in an attempt at charity, at least almost nobody, strident disclaimers notwithstanding. I could catalog a lot of other instances, too, but I think I needn't. If extra-terrestrial beings are indeed casing our planet there is a 50 year or more indication that they have no dark motives in doing so, so I say let them. To ask the public to believe that they could possibly be any more malevolent, or even as threatening to our well-being as the inhabitants of our own planet is placing an even more intolerable strain on our credulity than the Air Force's most recent (and different) official nonsense.

Though I am understandably hesitant to speak for God, I feel fairly confident that, having granted human-kind the option of sinning at will, He would be extremely loath to repeat His experiment anywhere else.
WHY TMA INSURANCE?

• We offer a full line of insurance plans to help protect you, your family and your practice.

• We’re the Exclusive Insurance Plan Administrator for the Tennessee Medical Association.

• We represent many excellent insurance carriers, all with an emphasis on quality.

• We’ve helped physicians with their insurance for 30 years, and continue to do so!

Contact Us!
800.347.1109
TMA@assoc-admin.com
Q My medical license doesn’t expire until August of 2016, and I was told that I have to get all of my CME by the end of 2015.

Is this true? That is eight months before my license expires. I thought I had until the day before my license expires to obtain all my required 40 hours of CME credits.

A Yes, the information you received is true, and you must have all required CME for your license renewal cycle by Dec. 31 even though your renewal date is in August 2016.

Rules from the physician licensing boards in Tennessee require that CME be obtained in the two years prior to the year of renewal. If your license expires on Aug. 31, 2016, you must complete all of the required CME hours by Dec. 31, 2015 for that renewal cycle. Physicians are licensed by either the Board of Medical Examiners (BME) for medical doctors or Board of Osteopathic Examination (BOE) for osteopathic physicians. Both boards promulgated rules several years ago that require a physician to obtain 40 hours of CME to renew his/her license. There is no requirement on the number of hours that must be obtained in each year.

Additionally, two of the 40 hours of CME must include a course that covers instruction in controlled substance prescribing and the treatment guidelines developed by the commissioner of the Department of Health on opioids, benzodiazepines, barbiturates and carisoprodol. The course may include topics such as medicine addiction, risk management tools and other topics as approved by the respective licensing boards. TMA offers a course that specifically addresses the two-hour requirement, and the BME approves it. The course, “Prescribing Guidelines for Pain Management and Patient Safety,” is available on TMA’s website.

To learn about all the CME requirements, waivers, exemptions and penalties for non-compliance, you are encouraged to view our Spotlight Video on CME at tnmed.org. In the top tool bar, click on the arrow next to Professional Development and choose Spotlight Videos in the dropdown list. The legal department has created several of these spotlight series videos. Videos are approximately 10 minutes long and cover topics that are important to physicians and medical practices. In addition to the video on CME, TMA also currently offers Spotlight Videos on these topics:

• The Tennessee Professional Privilege Tax
• Background Checks Required by Tennessee Law and TennCare
• The Medicare Access and CHIP Reauthorization Act of 2015 (the federal law repealing the SGR formula)
• The Tennessee Healthcare Innovation Initiative (Payment Reform) Technical Advisory Groups.

In the next few months, TMA plans to add Spotlight Videos on legal issues regarding the treatment of minors and the health plan credentialing law passed by the General Assembly in 2015.

Contact the legal department with any questions at 800.659.1862 or legal@tnmed.org.
Save Time and Administrative Costs

Determine patient liability before or at time of care

You can enjoy the convenience of determining accurate BlueCross BlueShield of Tennessee patient liability at or before the time of care through the real-time claims adjudication tool available in the provider secure area of bcbst.com.

By using this tool, your billing staff will know the exact amount your patient is required to pay under his or her BlueCross health plan. It helps eliminate confusion at the point-of-service and helps avoid the administrative burden of balance billing or refunds.

For more information on how real-time claims adjudication works, log on to bcbst.com today!
George Woodbury Jr., MD, said his daughter, Emily, was key in encouraging him to become active in healthcare advocacy.

Dr. Woodbury, a dermatologist in Memphis, was dealing with two lawsuits from patients in the late 1990s when Emily, who was taking part in a youth legislator program, gave him some advice.

“She told me ‘Dad, don’t get mad, get active,’” he said.

Dr. Woodbury followed her counsel, and has gone on to become a strong healthcare advocate, publishing a monthly newsletter on healthcare issues for patients, forging connections with legislators, donating to TMA’s political action committee (IMPACT) and making frequent trips to the state capitol.

“Essentially, advocacy is part of what I do,” he said. “It’s kind of hard to separate healthcare advocacy from providing service.”

One of the first political issues Dr. Woodbury worked on was opposing a proposed rule from the Tennessee Board of Medical Examiners which would have mandated that procedures on children 14 and younger requiring the use of lidocaine be done at a licensed surgery center.

The regulation would have caused the families of some of Dr. Woodbury’s patients – about 40 percent of whom are children – unnecessary cost and burden in order to travel to a surgery center and have procedures done there.

In response to the proposal, Dr. Woodbury rallied dermatologists in the Memphis area to oppose the rule. After several hearings over the course of months, it was revised so that only procedures where children under 14 were to go under conscious sedation would have to be performed at a licensed surgery center.

In the eight or nine years since Dr. Woodbury started his monthly newsletter, called the “Health Enewsletter,” readership has continued to grow, and it now goes out to about 800 people by mail and another 5,000 people by email.

“It builds upon itself, and as I become aware of issues then I can put them on the table,” he said.

It’s vital for physicians to be involved in advocacy efforts because there is a stronger impact if legislators can hear from a broad spectrum of physicians, Dr. Woodbury said.

“Involvement does make a difference, and politics is not all about making donations, but about working with legislators,” he said.

Dr. Woodbury said that TMA is helpful in his advocacy by focusing existing healthcare issues into a single platform and coordinating efforts. That’s why doing things like donating to IMPACT is important.  

(Continued on p. 15)
TM A President John W . Hale Jr., MD, has pledged to carry the TMA banner throughout the state during his term . He began his campaign in August by visiting hospitals and medical groups in East Tennessee and promoting TMA membership. His trip also included a stop at his alma mater, East Tennessee State University’s Quillen College of Medicine.

The Memphis Medical Society participates in orientation and hosts a welcome reception for first-year medical students at the University of Tennessee Health Science Center every year. This year, the reception took place on Aug. 11 at the Dixon Gallery and Gardens. About 200 students and their guests attended the reception.

Legislators meet with Memphis Medical Society members

Physicians on the MMS legislative committee met with state legislators in August.

MEMPHIS MEDICAL SOCIETY HOSTS RECEPTION FOR STUDENTS

Physicians on the MMS legislative committee met with state legislators in August.
MEMBERS IN THE NEWS

DR. BARRETT HAIK RECEIVES LIFETIME ACHIEVEMENT AWARD

Barrett Haik, MD, FACS, has been announced as the winner of the 2015 Memphis Business Journal Health Care Heroes Lifetime Achievement Award for his work of more than 20 years to improve health in Memphis.

Dr. Haik is director of the University of Tennessee Department of Ophthalmology Hamilton Eye Institute. He chaired the department during the creation of the institute.

Dr. Haik has developed an ocular oncology center at St. Jude Children’s Research Hospital, served in leadership roles for more than 60 organizations and professional medical societies, served as editor or reviewer for 17 publications and has authored or co-authored more than 160 peer-reviewed journal articles, 55 book chapters and four books, according to the Memphis Business Journal.

DR. ADELE LEWIS APPOINTED TO STATE OFFICE

Adele Lewis, MD has been appointed to serve as interim chief medical examiner for the state of Tennessee.

Dr. Lewis is filling the role while the Tennessee Department of Health moves forward with a nationwide search to replace Dr. Karen Cline-Parhamovich, who announced her resignation in July.

Dr. Lewis is the president and chair of the board for the Nashville Academy of Medicine.

Do you know a TMA member who has made a great career move, received a big honor or gives to the community in a significant way? Please let us know! Submit your story to katie.brandenburg@tnmed.org.

BOOK REVIEW

WAKING UP BLIND: LAWSUITS OVER EYE SURGERY

by: Tom Harbin, MD, MBA, MACS

Hardcover; 230 pages; © Langdon Street Press, 2009
Reviewed By: Josh Grossman, Colonel, retired, U.S. Army Medical Corps, MD, FACP
Rating: Five Stars ★★★★★

As a Native of Baltimore – having made rounds at our Johns Hopkins University Hospital – I know well and respect our Wilmer Eye Clinic of Johns Hopkins. I was drawn to the ethical issues noted in this exemplary text, which should be on the reserve shelves of all of our city, county, university and college of medicine libraries.

Our first year ophthalmology residents should be given a copy to read and to discuss with their mentors and probably a copy of “The Business Side of Medicine. What Medical Schools Don’t Teach You” (Mill City Press, 2012), also by Dr. Tom Harbin. +

PHYSICIAN SPOTLIGHT... (Continued from p. 13)

“By participating in IMPACT, you can have a much bigger effect upon these issues,” Dr. Woodbury said. “The bottom line is, there is strength in numbers.”

Dr. Woodbury also participates in a TMA program called Dialogues in the District, which encourages small-scale meetings between physician members and legislators in order to allow them to discuss important issues and develop more meaningful relationships without distractions.

In August, for instance, he had lunch with Sen. Reginald Tate, D-Memphis, and brought along a group of medical students from the University of Tennessee Health Science Center College of Medicine.

The meeting was a way to teach young medical students about advocacy, Dr. Woodbury said.

“We’re getting them started from the get-go,” he said. +
Thank You to our 2015 IMPACT Donors!
These supporters have stepped forward with their commitment to keep friends of medicine in office. We have made great strides in recent years but the challenges never end. Join us by making your contribution today!

CORPORATE MEMBERS
Advanced Diagnostic Imaging, PC
Anesthesiology Consultants Exchange, PC
Chattanooga Neurosurgery and Spine
Core Physicians
The Jackson Clinic
Maury County Medical Society
Mid Tennessee Bone and Joint Clinic, PC
Nephrology Associates, PC
Southern Oncology, Inc.
Tennessee Interventional and Imaging Associates
University Surgical Associates

CAPITOL HILL CLUB MEMBERS
Yasmine Subhi Ali, MD
Maysoon Shocair Ali, MD, FACP
Subhi Dawud Suboh Ali, MD
Newton Perkins Allen Jr., MD
Rebekah Crump Austin, MD
Samuel Ray Bastian, MD, FACP, FAAP
James Howard Batson, MD
Leonard Allison Brabson Sr., MD
Richard M. Briggs, MD
Tommy J. Campbell, MD
Cathy Marie Chapman, MD
Barton A. Chase, III, MD
Dewayne P. Darby, MD
Richard J. DePersio, MD, FACS
Robert Marshall Dimick, MD
Scott C. Dulebohn, MD
James K. Enson, Jr., MD, FACP
Tamara P. Fozl, MD
Eric G. Fox, MD
Timothy Lee Gardner, MD
David George Gerkin, MD
Paul W. Gorman, MD
Mark E. Green, MD
John W. Hale, Jr., MD
James E. Jolley, II, MD
Keith Gregory Anderson, MD
Robert Ashley Kerlan, MD, FACP
James D. King, MD
Ronald H. Kirkland, MD, MBA
Kenya Kozawa, MD
Jeffrey P. Lawrence, MD
George R. Lee, III, MD, MS
Adele Maurer Lewis, MD
Robert M. Maughon, MD
Michael A. McAdoo, MD
Robert Wallace McClure, MD
Michel Alice McDonald, MD
Fredric Ronald Mishkin, MD
Brent Robert Moody, MD, FACP, FAAD
Kofi W. Nuako, MD
Edmund T. Palmer, Jr., MD, FACP
Rodney A. Poling, MD
James E. Powell, MD
F. Bronn Rayne, MD
Wiley Thomas Robinson, MD, FHM
Perry Clyde Rothrock, III, MD
Wayne T. Scott, MD
Scott W. McCall, MD
Nita W. Shumaker, MD
Jane Meredith Siegel, MD
Douglas John Springer, MD, FACP, FACG
William Kirk Stone, MD
George Milum Testerman, MD
Bob Vegors, MD, FACP
John J. Warner, MD
Charles W. White, Jr., MD
William Turney Williams, MD
George R. Woodbury, Jr., MD
Christopher E. Young, MD

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.

To join IMPACT or to make a corporate donation contact Kelley Mathis at 615.460.1672, 800.659.1862, or Kelley.Mathis@tnmed.org.
Please make your check out to IMPACT and send to 2301 21st Ave. S. Nashville, TN 37212.
Graduating medical students across the country increasingly dread that, as their fellow students get matched with residency programs, they will instead be left to the scramble. The scramble, said Jensen Hyde, MD, a second-year internal medicine resident with the University of Tennessee, Chattanooga, is a term for the process medical students who aren't initially matched with a residency program go through when looking for a spot among unfilled resident positions. The spots left over are often in less-desirable specialties and locations.

Dr. Hyde didn’t have to go through the scramble. She was matched with her residency program. But she said not matching with a residency program is a real concern for medical students – especially those in competitive specialties or those with lower test scores – illustrating a growing need for more resident positions supported through graduate medical education funding.

Niva Misra-Sammons, MD, a third-year internal medicine resident at the University of Tennessee Medical Center, Knoxville, said she worked hard to make sure she stood out among candidates for residency spots, including doing an away rotation at UT Knoxville.

“I definitely felt that I needed to be competitive in order to get a spot,” she said.

The Tennessee Medical Association is dedicated to seeing graduate medical education funding increased on the state and federal levels to help train and keep more young physicians in Tennessee and address the current and future physician shortage.

In 2010, the state of Tennessee stopped funding its share of graduate medical education as part of budget cuts. The Tennessee Hospital Association agreed to an assessment fee for hospitals, and a portion of those proceeds has gone to temporarily restore GME funding.

But residency spots in some programs have already been dropped. If hospital funding goes away, or the federal government makes cuts to GME, millions of dollars in funding to educate the next generations of physicians could be lost.

TMA representatives made a presentation to the Tennessee General Assembly last year about the need for more GME funding. TMA leadership has also asked both the State Department of Finance & Administration and Gov. Bill Haslam to request a raise in the cap on Medicaid GME funding in a future TennCare waiver request.

James “Pete” Powell, MD, chairman of TMA’s recently-formed education committee, said the committee was initially focused on increasing the opportunities for continuing medical education for TMA members.

Dr. Powell said the committee has been successful in those efforts, and he hopes members will start taking a more comprehensive look at education issues in the future.

That discussion could include looking at new ways for TMA to serve residents and fellows, such as giving them outlets to present their academic work or providing training on the administrative side of medicine.

“Our future is our young doctors,” he said. “If we don’t support them and give them a place to talk about their work, who’s going to do that?”

Dr. Powell said meeting the demand for medical services means not just providing the right number of physicians, but making sure they are able to serve both rural and urban areas.

“As the population grows, you basically have to provide care where the population is,” he said.

Part of the solution will be collaborating with physician assistants, advance practice nurses and other mid-level providers in a team-based approach, Dr. Powell said.

In the 2016 session of the Tennessee General Assembly, TMA will advocate for passage of the Tennessee Healthcare Improvement Act, which would create a physician-led, patient-centered, team-based care model for healthcare delivery.

Under that model, relationships between physicians and advanced practice nurses would strengthen, with greater collaboration and defined roles for physicians as the team leader in coordinating patient care.

SCOPE OF THE SHORTAGE

GME funding is important to Tennessee because a growing population, aging demographics and a rising number of people with medical coverage under the Affordable Care Act mean demand for physician services is expected to quickly outpace supply.

A March report commissioned by the Association of American Medical Colleges projects a physician shortfall of between 46,100 and 90,400 physicians nationwide by 2025. Total physician demand is expected to grow by between 11 and 17 percent during that period while the supply of doctors is expected to increase by only about 9 percent.

Population growth and aging account for the biggest portion of the increased demand – about 14 percent – but expanded medical coverage under the ACA is also expected to increase demand by about 2 percent by 2025, according to the report.
The physician shortage isn’t simply theoretical. It’s a reality doctors are already experiencing, Dr. Hyde said.

“It’s a problem that exists already and is going to get worse for sure,” she said.

Working at a resident-run clinic, Dr. Hyde said she sees patients every day who otherwise might go to the emergency room for non-emergency medical needs or not see a doctor.

“Right now we see people day in and day out who cannot get in to see a physician,” she said.

Patient loads make it a challenge for doctors to provide the kind of care they want to provide and at the same time try to see as many patients as possible.

It doesn’t make sense to cut GME funding when her experience shows a physician shortage already exists, Dr. Hyde said.

“You can increase the medical school classes all you want, but if doctors can’t train, they can’t practice,” she said.

A report from the Robert Graham Center looking at 2010 primary care staffing levels in Tennessee found that the state needed to add 1,107 additional primary care physicians by 2030 just to maintain its current rates of primary care utilization.

Dr. Hyde believes high patient volume can be a disincentive for medical students to go into primary care while doctors practicing in the most popular subspecialties typically do not have to turn patients away.

Justin Calvert, MD, a radiologist at Tennessee Interventional and Imaging Associates in Chattanooga, said the pay discrepancy between primary care doctors and those in other specialties is also a barrier to raising the number of doctors providing primary care.

Primary care will be increasingly important as the baby boomer generation ages and retires, he said.

“There needs to be more of an incentive for physicians to go into primary care so we can take care of this ever-growing retirement situation,” Dr. Calvert said.

The existing physician population is aging along with the population it serves, which adds to a need for new, young doctors. Only 15.8 percent of active Tennessee physicians in 2012 were under 40 while 26.5 percent were 60 or older, according to an AAMC report.

In that same study, Tennessee ranked 26 out of 50 states based on its number of physicians by population.

In addition to the healthcare consequences of a physician shortage in Tennessee, there are also economic consequences to not having a strong physician workforce. Physicians created a total $20.1 billion in direct and indirect economic output in 2012, according to an American Medical Association report released last year.

Tennessee physicians supported 143,229 jobs in 2012. On average, each physician supported $843,263 in total wages and benefits for those jobs. They also supported $618.8 million in local and state tax revenues in 2012, according to the report.

GME funding, which supports resident positions, can help states keep the doctors they educate. About 47.4 percent of physicians stay or return to the state where they completed their most recent graduate medical education, according to the AAMC report.

Retention is higher for physicians who complete undergraduate medical education and GME in the same state. Two-thirds of those individuals remain in the state to practice, according to the report.

Dr. Calvert is among those doctors who chose to practice in the state where he did his residency.

After graduating from medical school at the University of Mississippi, Dr. Calvert did his residency at Vanderbilt University Medical Center and then a fellowship at Northwestern University in Chicago. When deciding where to practice medicine, he said he looked to return to a location with four seasons and with plenty of opportunities to participate in outdoor activities.

“Tennessee was kind of a perfect balance for me,” he said.

Dr. Misra-Sammons said she thinks many residents and medical students want to work and train in Tennessee, but more open resident positions are needed for the growing number of medical students in the state.

“They have more and more spots and more and more young people who want to be physicians in Tennessee,” she said of Tennessee medical schools.

NEED FOR ORGANIZED MEDICINE

Advocating for GME is one area where young doctors are finding that organized medicine – including TMA and local medical societies – works for them.

Dr. Hyde is currently president of the UT-Erlanger House Staff Association and a member of the board for the Chattanooga-Hamilton County Medical Society.

It’s a privilege to be able to bring up issues that are important to residents and help address them through those outlets, she said. Some of those concerns include GME funding and physician reimbursement as well as smaller issues that impact resident life on a day-to-day basis.

“It’s one thing to gripe about an issue, but standing up and trying to make it better is a better way to go,” Dr. Hyde said.

Dr. Calvert, who is a board member of the Chattanooga-Hamilton County Medical Society, said that organized medicine is important to him because it allows doctors to have a bigger voice.

“Doctors are not really allowed to unionize, so coming together in whatever way we can to at least have a voice and a seat at the table is very important,” he said.

He was active in his state and university medical associations while he was a medical student, so involvement in the politics of medicine came naturally when he was approached about joining his local medical association board.

Keeping track of what the Tennessee General Assembly is doing and having a voice there is important because government is still the top healthcare payer, he said.

“Our state legislature is literally the body that decides whether or not I get paid,” Dr. Calvert said.

Dr. Misra-Sammons is active with the Knoxville Academy of Medicine and writes a resident-perspective column for the Knoxville Academy of Medicine magazine.

She said she has enjoyed the opportunity to write and attend board meetings.

“That has helped me really understand the impact that our Tennessee medical societies can have in the community,” Dr. Misra-Sammons said.

Her father was also a member of the Knoxville Academy of Medicine, and her mother is still a member of the Academy auxiliary.

She said she was inspired by their participation in organized medicine.

“I think just knowing that they were a part of organizations that were helping the community, that was rewarding in itself,” Dr. Misra-Sammons said.

She said she wants to continue her work in healthcare advocacy and to be able to learn and contribute more.

“It’s really an inspiration to see all these physicians come together and work toward helping patients and helping other physicians,” she said.
Physician leadership and participation are a crucial part of the overall payment reform effort. It is important to be an active voice for Tennessee’s patient care and emerging health system, to deliver vital clinical input on key areas related to healthcare delivery and quality measures needed to improve patient care and population health.

So, you are asking, what can I do? TAGs are a perfect opportunity to influence the creation of value within the state’s new model.

Role of Episode of Care TAGs

Technical Advisory Groups (TAGs) are one vital group involved in the stakeholder process in the new Tennessee Health Care Innovation Initiative (THCII). TAGs are clinical workgroups comprised of both payer and provider representatives that offer clinical advice on the initiative’s design for retrospective episodes of care. The state recognizes a physician’s time is valuable. Therefore, these clinical groups may meet around three times depending on the group assignment. Diverse groups are more innovative. As such, the state seeks to create a comprehensive clinical representation from all areas of Tennessee (i.e. rural, urban, small practice and in some cases a pediatric perspective).

TAG Influence

Clinicians who participate in a TAG are asked to contribute clinical guidance on specific areas related to the episode design. These design elements are dedicated to the event which “triggers” the episode, the “quarterback” primarily responsible for the costs associated with the episode, inclusion and exclusion criteria and quality metrics.

First, committee members help identify the occurrence of an episode. This is called the “trigger.” A trigger can be activated by a diagnosis and/or procedure codes. For example, a colonoscopy episode is triggered by a professional claim with a colonoscopy procedure code and a screening or surveillance diagnosis code.

Second, the members will participate in quarterback deliberations. According to the state, a primary accountable provider “PAP” or “quarterback” is the clinician or hospital in the best position to influence the quality and cost of care in each episode. So far, physicians have been designated the “quarterback” responsible in eight of the 13 episodes of care. The responsible physician quarterbacks are in the perinatal, total joint replacement (TJR), colonoscopy, cholecystectomy, PCI, EGD, URI and UTI (outpatient) episodes. Hospital quarterbacks are responsible for asthma (acute exacerbation), COPD (acute exacerbation), pneumonia, GI hemorrhage and UTI (inpatient) episodes.

Third, TAG members are asked to help identify which services to include in total episode spending to best reflect what a patient may receive during an episode. For example, the perinatal episode has a very comprehensive definition, including the majority of claims for the mother from 40 weeks prior to delivery to 60 days after discharge. Therefore, a perinatal episode would contain any claim with a pregnancy-related diagnosis (including emergency room visits and most pharmacy). Note, the cost breakdown associated with each care category will be available to the quarterback in his or her performance reports. The care categories (or place of service) may include outpatient professional, pharmacy, emergency, outpatient lab, outpatient radiology and procedure, inpatient facility, outpatient facility and other. As part of design efforts, input is needed for setting the duration of the episode (i.e. 15, 30 or 45 days). The duration is an important aspect of the model and is used in the risk marker window calculation. For example, the episode risk marker window for TJR begins 45 days prior to the hospital admission for surgery and runs through the end of the episode.

Fourth, a complex portion of the episode of care design is the risk-adjusting and excluding portion. This element of design ensures episodes are comparable and allow fair comparisons among providers. As such, the clinical advice will be focused on the episode variation outside the influence of the quarterback. So, these TAG discussions will be concentrated on complications and comorbidities that should be considered for risk-adjustment and different patient pathways that should be excluded. Remember, each episode will have its own exclusion list. A sample exclusion illustration for TJR and perinatal episodes consists of active cancer management and HIV. Please see the episode business requirements and code descriptions available on the Tennessee Division of Health Care Finance & Administration Web page for additional details.

Finally, clinical input is most helpful in determining the
GET YOUR PRACTICE READY FOR
ICD-10 TODAY

Many Experts Recommend Access to up to 6 Months of Operating Capital; Are You Prepared?

ICD-10 Line of Credit Special
Get Ready for ICD-10 today!

- Up to $250,000
- 24 month term
- Prime - 1/4%, 3.50% floor
- Quick Turnaround

For more information:
Blake Wilson | bwilson@tmamedicalbanking.com
Patrick Wright | pwright@tmamedicalbanking.com
2106 Crestmoor Road | Nashville, TN 37215
Direct: 615.515.4272 | www.tmamedicalbanking.com

Limited time offer: Prime Rate is The Wall Street Journal Prime Rate, which was 3.25% Annual Percentage Rate (APR) as of July 1, 2015. The APR is variable, indexed to The Wall Street Journal Prime Rate, and is subject to increase or decrease as the index increases or decreases. Full principal amount as well as any unpaid, accrued interest is due at maturity date stated in credit agreement. All loans are subject to underwriting standards and credit approval. Member FDIC
Whether you work in a small physician practice or large hospital group, the Centers for Medicare & Medicaid Services Star Ratings and their documentation requirements may feel like a mixed blessing.

On the one hand, Star Ratings help increase the number of Medicare Advantage recipients who complete annual wellness visits and recommended preventive health screenings, which ultimately may improve health outcomes.* But the corresponding documentation requirements can also create an administrative burden for your practice staff.

Because it is a CMS requirement to release information showing care opportunities have been closed, and because closing care opportunities may help improve health outcomes, UnitedHealthcare provides resources and support to help its network care providers close care opportunities and document and submit this information for our members.

CMS uses Star Ratings to evaluate health plan quality for Part C Medicare Advantage and Part D Prescription Drug plans. Star Ratings are reported on a scale of one to five stars, with five being the highest quality score. Star Ratings give consumers information to help them compare the performance of Medicare Advantage plans. Medicare Advantage health plan overall Star Ratings determine the level of quality bonus payments earned from CMS. The ratings are published on medicare.gov every October.

CMS calculates Star Ratings based on quality measures that reflect care opportunities using the following five main data sources:

- **Claims and medical record chart data:** The National Committee on Quality Assurance's Healthcare Effectiveness Data and Information Set
- **Member survey focusing on service experience and access to care:** Consumer Assessment of Healthcare Providers and Systems
- **Member survey focusing on members’ perception of health status:** Health Outcomes Survey
- **Pharmacy measures:** Prescription Drug Event
- **Member complaints, appeals and grievances:** (from health plan operations)

UnitedHealthcare provides resources and support to help its network care providers close care opportunities and document and submit this information for our members.

To calculate Star Ratings, CMS requires medical practices to submit documentation showing care opportunities have been closed, and targeted measures have been met for their patients.

To that end, UnitedHealthcare collaborates with its network care providers by offering programs, tools and resources to help with their efforts in identifying and closing care opportunities for eligible patients—and then documenting and submitting this information to show the opportunities have been closed. (Patients do not need to sign a release to allow physicians to submit the patient-specific information required to comply with CMS quality reporting guidelines.) Some of the following programs, tools and resources are not available to all providers or members.

We encourage you to take advantage of all of the resources available to you to help close care opportunities for your patients, including those from the health insurance companies you work with. Here are some of the programs we offer UnitedHealthcare network providers:

**PATH**

PATH gives our network providers tools and support to help encourage patients to become more engaged with their preventive health care – and provides opportunities to earn additional compensation, if eligible, for exceeding quality-based performance targets. And because we understand it takes extra time to review and complete assessment forms, we offer additional compensation to recognize these administrative efforts.

(Continued on p.27)
Drowning in paperwork?

Manage ICD-10, don’t let it manage you.

You don’t have to put your practice’s technology through an extreme makeover. XMC offers an affordable electronic health records solution that integrates any patient billing and scheduling software you may be utilizing.

Special pricing available for all TN Medical Association members. Contact your local XMC office for details.
The Workers’ Compensation Reform Act of 2013 had many provisions that went into effect for dates of injury on or after July 1, 2014. By now, many of those provisions are impacting the way injured workers receive their medical care. Physicians should be aware of these changes.

Compensability, Causation Analysis and Opinions

The legislation specified that the need for treatment must arise “primarily out of and in the course and scope of employment,” bringing all injury analysis under the same definition that has been used for cumulative trauma disorders since 2011. Although compensability is ultimately a judicial decision, physicians are being asked to provide more information about the nature and extent of injuries in relation to specific and identified work activities. The legislation also now uses the same criteria for “aggravation of a pre-existing condition,” requiring that the need for treatment is “primarily” due to the workplace exposure, and not treatment of a pre-existing progressive condition.

The law gives the employee responsibility for showing that the medical condition or injury is work related.

Although 85 percent of all workers’ compensation claims have straightforward causes – for example, “my finger was smashed in a press at work today” – the remaining claims do create questions of causation. The law has directed quicker decisions in these contested cases.

Panels and Release of Information

The legislature clarified the identification of an independent physician as being one in the same practice but who sees patients at a different physical location. Tax ID is no longer a consideration.

There are now penalties to the employer for not providing panels in a timely manner to the injured worker. These panels have to be up to date, and must be made available to employees within five days of the report or known occurrence of the injury. The injured worker is to choose from the list and sign the form. If a referral from a panel physician is made to another practitioner, the employer has three days to accept the referral or present the employee with an alternative list. Otherwise, the panel physician’s referral stands.

If you are on one of these panels, it is important that you have a reasonable new patient intake policy and communicate effectively with the employer/carrier and case manager.

Employers/carriers may now have access to all medical records pertinent to the specific injury without the separate release form (C-31), but it still prudent to have the patient sign it (or an alternative form) so that he/she knows you are giving that information as required.

Pain Management

There are special qualifications for physicians treating injured workers for chronic pain in the Department of Health guidelines, and currently these are the same for treating injured workers. You should review the Department of Health and the Workers’ Compensation websites if you treat injured workers with controlled substances.

Maximum Medical Improvement and Permanent Impairment Ratings

At the time that the treating physician has judged the injured worker to be at maximum medical improvement, he/she is required to give the date in the note and issue a permanent impairment rating within 21 days (That rating is to be made to the “body as a whole” and not, as previously, to a “scheduled member”). The law defines MMI as the date at which there is no additional curative treatment planned, or a referral to pain management is requested. This means the authorized treating physician will be responsible for the impairment rating at the time a pain management referral is requested.

Pain is not to be considered separately in arriving at a permanent impairment rating. Suggestions on what this means are posted on the Bureau of Workers’ Compensation’s website.

Treatment Guidelines

The legislature directed the administrator of the bureau to have treatment guidelines in effect by Jan. 1, 2016 for the most commonly occurring workers’ compensation injuries. A consultative process has been ongoing with the Medical Advisory Committee. The administrator has chosen Work Loss Data Institute ODG. Further information can be obtained from their website.

These guidelines are “…statements that include recommendations intended to optimize patient care that are informed by a systematic review of the evidence and an

(Continued on p.28)
Prescribing Guidelines

*for Pain Management and Patient Safety*

Satisfy the BME’s requirement for two hours of CME* on appropriate treatment of chronic pain.

Take the course online at www.tnmed.org/education.

$99 Members | $199 Non-Members

*2 AMA PRA Category 1 Credits™ This activity has been planned and implemented in accordance with the Essential Areas and Policies of the Accreditation Council for Continuing Medical Education through the Tennessee Medical Association. Tennessee Medical Association is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians. Tennessee Medical Association designates this enduring material for a maximum of 2 AMA PRA Category 1 Credits™. Physicians should only claim credit commensurate with the extent of their participation in the activity.

MEMBERSHIP IS AT A 10-YEAR HIGH!

Thank you for your support!

Help us build on this momentum by renewing your membership and inviting a colleague to join today.

The value of membership in the TMA far outweighs the cost, and we need members to keep fighting your fights.

Renew by Dec. 31, 2015!
- Online at tnmed.org
- Membership@tnmed.org
- Mail to PO Box 306169, Nashville TN 37230-6069
- Call 615.385.2100

ADVOCACY. Influential voice and representation with government and regulatory entities

EDUCATION. Proprietary, accredited CME content on the topics that matter most to doctors and their patients

LEADERSHIP. Tools to excel in the medical profession, and in the community

INSURANCE. Third party intermediary between doctors and insurance companies

LEGAL. Expert interpretation and guidance, at no charge

BUSINESS. Good deals on good products and services
quality metrics required for each episode to capture sources of value. There are two types of quality metrics: those linked to gain sharing, and those for informational purposes only. Quarterbacks should know not all episodes will have quality metrics linked to gain sharing. For instance, the business requirements for perinatal has three quality metrics linked to gain sharing and four quality metrics for informational purposes only. In contrast, there are no quality metrics linked to gain sharing in the business requirements for TJR. It only has informational quality metrics associated with the episode.

What TAGs Are Not
TAG meetings are not a forum for complaints or debating the decision of specifics to individual providers. The state has also explicitly said it will not discuss elements of pricing, contracting strategy or negotiations during the TAG meetings.

TAGs and Wave Impact
Stakeholder input and TMA’s advocacy has shaped the design of the THCII strategies. The modifications, adoptions and revisions have impacted episode design and reporting. Although not all physician recommendations have been or will be accepted, as of August 2015, the following recommendations from provider stakeholders were adopted by the Tennessee Division of Health Care Finance & Administration.

• **Perinatal** episode definition updated: 1) To exclude all pregnancies with three or more gestations. 2) To remove all intrauterine devices and implantable contraceptives from episode spend. 3) To include required confirming pregnancy-related diagnosis code for all emergency department visits to ensure that they are related to the episode. 4) To include revenue codes 0636 and 0770. It will not exclude members eligible for Tennessee Vaccines for Children program as those members’ vaccination status can be accurately captured. 5) To include diagnosis codes that account for history of complications during pregnancy in the list of recommended risk factors for each payer to test. 6) To remove transportation from the calculation of episode cost.

• **Asthma** episode definition was updated: 1) To add the corticosteroid quality metric. 2) To update episode logic for code 493.00 to ensure the event was asthma acute exacerbation-related.

• **TJR** episode of care was updated to remove bilateral joint replacements from the TJR episode definition.

• **Reporting** is now accompanied by an Excel file that includes data aimed at helping the quarterback improving quality and control costs.

• **Performance period reporting** will now include quality metrics results for each included episode of care, total risk-adjusted cost for each included episode of care and prescription summary of quarterback’s most frequently prescribed drugs.

• The **EGD** episode was revised to include a shortened duration of the episode to seven days before the procedure and 14 days after the procedure. The EGD quality metrics were also revised to include a facility participating in a Qualified Clinical Data Registry (e.g. GIQuIC) would be tied to gain sharing.

**LEADERSHIP OPPORTUNITY**
There is still much work to be done, especially as it relates to the risk adjustment and process transparency. Physicians need to be forward-thinking, continue to be diligent and provide a voice for their concerns over the issues. The state will soon seek nominees for additional TAGs for 2016. Consider participating in a TAG as an opportunity to be a voice and offer solutions in the transformation process.

*This project is funded under a Grant contract with the State of Tennessee. Visit the Tennessee State website for more information on the Tennessee Health Care Innovation Initiative at http://www.tn.gov/HCFA/strategic.shtml.

**REFERENCES:**


Most physicians enter the profession with a singular motivation: to help others.

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

I have learned...

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

R.B., M.D.

Tennessee Medical Foundation
Roland W. Gray, M.D., Medical Director
216 Centerview Drive, Suite 304 • Brentwood, Tennessee 37027 • (615) 467-6411
The PATH program provides several kinds of financial compensation:

- **Healthcare Quality Patient Assessment Form (HQPAF) Payment**
  Eligible network care providers can earn competitive payments for completing an HQPAF for each qualifying patient.

- **PATH Bonus Programs**
  By improving specific HEDIS measures for eligible UnitedHealthcare Medicare Advantage members, network care providers may earn annual bonus payments.

- **Annual Care Visit and Member with Diabetes Bonuses**
  For 2015, some PATH programs offer additional bonus payments for getting UnitedHealthcare Medicare Advantage members in for an annual care visit and an even greater bonus when members with diabetes come in for an annual visit. Bonus amounts depend on when the visit is completed and achieving the minimum number of member visits within the period.

### Care Management and Data Capture Application

UnitedHealthcare offers a care management application referred to as UHTTransitions that gives practices a convenient way to access open care opportunities for their members and submit required closure documentation that meets CMS requirements. It also identifies members who have preventive care opportunities. The information is updated daily. After the care opportunities are closed, providers can extract the required documentation directly from their electronic medical record system and submit it to us using the care management application.

### Practice-Based Support

Practice-based support coordinates with PATH programs to support selected practices as they care for our members by offering to:

- Review charts and electronic medical records to identify care opportunities.
- Assist your team in scheduling annual exams, preventive health screenings, services, labs and specialist visits as appropriate.
- Provide support and training for the care management and data capture application, which can help reduce your administrative burden by accessing your electronic medical record system and charts to collect care opportunity information that provides the documentation needed to support the closure of HEDIS care opportunities.

### Patient Care Opportunity Reports

Care providers receive actionable patient data in their monthly Patient Care Opportunity Report, which highlights open care opportunities for UnitedHealthcare Medicare Advantage members. It also provides practice-level data that shows the progress practices are making in helping to close those care opportunities. This information is updated daily in our care management application.

### HouseCalls In-Home Visits

HouseCalls provides eligible Medicare Advantage members with an annual in-home clinical visit at no additional cost from our trained team of licensed clinicians. The HouseCalls visit includes a health evaluation; review of medical history, medications and diagnoses and education specific to the member’s conditions. It also may include lab draws and flu vaccines where available and accepted. After the visit, the HouseCalls practitioner gives the patient a list of suggested topics to discuss with their primary care physician and we mail a copy of the results of the HouseCall visit to the individual’s primary care physician.

### Diabetes Navigator

This program provides case management by telephone to encourage eligible members to comply with their diabetes management and preventive health care programs. This increased disease management and focused treatment aim to help improve A1C levels, reduce admission rates and lower medical costs.

### Care Opportunity Patient Assessment Forms

Network physicians who do not participate in our incentive programs and treat UnitedHealthcare Medicare Advantage members with open care opportunities receive a Care Opportunity Patient Assessment Form specific to each eligible patient. These forms highlight open care opportunities for preventive services based on HEDIS performance measures. They also provide a quick way for practices to submit data to us after they have closed care opportunities.

As UnitedHealthcare’s Market Medical Director for Tennessee, I encourage you to take advantage of the resources available to you from the health insurance companies you work with. Many have access to claims data that can help you identify patients at the highest risk for having open care opportunities—and potential health complications. These are the same patients who may benefit the most from collaborative outreach.

For more information about how UnitedHealthcare helps its network providers identify and close care opportunities and earn bonus incentives for doing so, contact your local UnitedHealthcare Representative or visit UnitedHealthcareOnline.com. For more information about Star Ratings, visit cms.gov.

*Karen Cassidy is UnitedHealthcare’s Market Medical Director for Tennessee. Prior to serving in that position, Dr. Cassidy was Medical Director, Long Term Services and Support for UnitedHealthcare’s Tennessee Health Plan. She is board certified in Pediatrics, Internal Medicine and Hospice and Palliative Medicine.*
assessment of the benefit and harms of alternative care options,” according to a report from the Institute of Medicine. They are to be used in conjunction with the patient and physician discussion in choosing the best option for a particular individual clinical situation providing the patient and the physician with the most up-to-date, evidenced-based recommendations and advice. This is designed to allow cooperative decision making and documentation. Guidelines are not to be used as a primary method of the denial of service or payment, should be evidenced-based, provide some cost reductions by limiting the use of ineffective treatments, prevent duplication of services, provide consistent transparent standards or benchmarks available to all interested parties, have criteria to track outcomes and increase the speed of approvals. They should not be viewed as mandatory and should include easily accessible methods for identifying and requesting exceptions.

Knowing prospectively what single set of criteria is used in utilization review (either in workers’ compensation or group health) should make the physician’s job (and that of office staff) easier. Most of us already are familiar with and use different types of guidelines in our practices. We also already do what is in the best interest of the patient and what is evidenced-based. Sometimes, however, we do not do a good job of documenting what we have done or said. Having an outline in advance should help to inform our patients as to what treatments fit their individual circumstances and tailor that treatment to what good scientific evidence supports.

Closed Formulary

The administrator has directed the bureau to develop rules to implement a formulary for use in workers’ compensation. It is only “closed” in the sense that some medications require prior approval when they are to be paid for by the employer or carrier. This formulary is no different from formularies for group health plans or TennCare. It emphasizes the use of generic medications, avoids combinations that are more expensive and puts some limits on the appropriate diagnoses for which certain medications may be used. In most instances, the pharmacies will monitor the list and use approved generics if that is what you allow on your prescription. Pharmacist would only call you about the exceptional prescription, just as they do now. An emergency appeal process for exceptional medications or situations will be available.

There is anticipated to be a six-month “phase-in” period for patients with older injuries (“legacy claims”) to change to approved medications. It is important to become familiar with the formulary and start using it for new injuries after January 1, 2016.

ICD-10

The bureau is seeking to require all parties to use only ICD-10 codes on or after Oct. 1 in accordance with the CMS guidelines and the agreement with the American Medical Association. There will not be any requirement that providers furnish any additional information or coding to the bureau in either format, depending on the date of service.

Medical Impairment Rating Registry

The Medical Impairment Rating Registry is available to parties disputing permanent impairment ratings. It is a group of physicians with special expertise and training and certification in the analysis of permanent impairment ratings. The process requires an in-person examination of the injured worker, review of records and the creation of a special report that is peer reviewed. Application can be made to the bureau if you are interested. The carrier or employer pays fees.

Utilization Review Appeals

If an insurance carrier has a physician review your request for a test or treatment, and denies approval (payment authorization) for your request, you or the patient (or the patient’s representative/attorney) have the right to appeal the carrier’s denial to the Office of the Medical Director at the bureau. The form is available on the website.

The bureau has made improvements in the timeliness of the appeal mechanism and has consistently tried to reduce that time to two weeks or less. This has been hindered by the failure to receive complete documents in a timely manner from all parties. By having one individual or one process in your office for responding to the bureau’s requests, you would significantly improve the response time for the appeal when your treatment request has been denied through utilization review.

Medical Fee Schedule

A thorough review of the rules for inpatient and outpatient fees is underway. The bureau’s two medical committees – the Medical Advisory Committee and the Medical Payment Committee – representing interested parties are involved in these efforts. Your input is important and the committee meetings are open to all interested parties. The meetings are publically posted.

Robert B. Snyder, MD, is the Medical Director for the Tennessee Bureau of Workers’ Compensation. James B. Talmage, MD, is Assistant Medical Director.

For more information,
go to tn.gov/workforce/section/injuries-at-work or contact:

Robert B. Snyder, M.D.
Medical Director-Bureau of Workers’ Compensation
Department of Labor and Workforce Development
220 French Landing Drive, Suite 1-B
Nashville, TN 37243-1002
Tel: 615-352-8700
Fax: 615-253-5265
E-mail: Robert.B.Snyder@tn.gov
NEW MEMBERS

BRADLEY COUNTY MEDICAL SOCIETY
Kevin B. Anderson, DO, Cleveland

CHATTANOOGA-HAMILTON COUNTY MEDICAL SOCIETY
Alison L. Bailey, MD, Chattanooga
Daniel A. Barker, MD, Chattanooga
Ryan P. Buckner, MD, Chattanooga
Adam M. Caputo, MD, Chattanooga
Melisa C. Couey, MD, Chattanooga
Zurisadai R. Franco, MD, Chattanooga
Matthew W. McClanahan, DO, Chattanooga
Thomas P. Mezzetti Jr., MD, Brentwood
Edwin J. P. Rao, MD, Chattanooga
Roxann L. Roberts, MD, Chattanooga
Judith A. Tilden-Anderson, MD, Lookout Mountain
Michael W. Yablick, MD, Chattanooga

CONSOLIDATED MEDICAL ASSEMBLY OF WEST TENNESSEE
Clarey R. Dowling, MD, Brownsville

GREENE COUNTY MEDICAL SOCIETY
John Daniel, DO, Johnson City

KNOXVILLE ACADEMY OF MEDICINE
Mark W. Browne, MD, Knoxville
William S. Cox, MD, Knoxville
Priyanka M. Gaikwad, MD, Knoxville
Michael S. Howard, MD, Knoxville
Jose L. Mejia, MD, Powell
Lenette H. Perra, MD, Knoxville
Kimberly A. Quigley, MD, Knoxville

THE MEMPHIS MEDICAL SOCIETY
Yaser Cheema, MD, Memphis
Stephen L. Gipson, MD, Memphis
Jawwad Yusuf, MD, Germantown

NASHVILLE ACADEMY OF MEDICINE
Aaron J. Broman, MD, Nashville
Catherine J. Coleman, MD, Nashville
Daniel A. Hatre, MD, Nashville
Richard J. Lancaster, MD, Nashville
Andrew J. Moreno, MD, Nashville
Todd P. Peacock, MD, Nashville
Tohida A. Shahrrokhi, MD, Nashville
Daniel T. Tamez, MD, Nashville
Allison E. Tucker, MD, Nashville
Sumreen U. Vaid-Pinyard, MD, Nashville
Andrea L. Westman, MD, Nashville

TMA DIRECT MEMBER
Stephen D. Clark, MD, Sparta

WILLIAMSON COUNTY MEDICAL SOCIETY
Sina Iranmanesh, MD, Franklin

*Does not include student or resident members.

IN MEMORIAM

RONALD C. BROOKSBANK, MD, age 78. Died September 4, 2015. Graduate of University of Western Ontario. Member of the Chattanooga-Hamilton County Medical Society.

ROBERT B. GASTON SR., MD, age 95. Died August 23, 2015. Graduate of University of Tennessee Center for Health Science. Member of the Nashville Academy of Medicine.

WILLIAM R. “BILLY” GAW, MD, age 74. Died August 7, 2015. Graduate of the University of Tennessee Center for Health Science. Member of the Nashville Academy of Medicine.

JOE E. TITTLE, MD, age 88. Died July 23, 2015. Graduate of University of Tennessee Center for Health Science. Member of the Roane-Anderson County Medical Society.
Many of the advertisers in this Journal are longstanding patrons of our monthly publication. Don’t take them for granted. Read their advertisements, and when you patronize their products and/or services, be sure to tell them you saw their ad in *Tennessee Medicine.*
We’ve got a mortgage that fits you.

Ask us about our low mortgage rates.

TMA Members and their employees are eligible to receive a $500.00 discount off closing costs on a home mortgage.

Keith Collison, Managing Director
Finworth Mortgage
keith.collison@finworth.com • 615.345.9905
NMLS #174913
Protection Is Power

SVMIC Protects the Most Tennessee Doctors

97.7%
Satisfaction rating with their defense counsel from our policyholders who have faced claims or litigation since we were founded in 1976. An expert staff of claims attorneys with the relationships, knowledge, and resources to aggressively defend your reputation sets us apart.

57,000
Hours of free consulting services provided by SVMIC to our policyholders and their practices in 2014 alone. Our services cover everything from risk evaluation and education to practice management, governance, billing, strategy, and other business issues.

100%
Of SVMIC is owned by our physician policyholders. Our structure as a mutual company ensures that your interests are our interests.

SVMIC is the exclusively endorsed professional liability carrier of TMA+.

300,000+
Hours of continuing education SVMIC has provided to policyholders and their staff over the last decade. High quality, relevant risk management education is the best way to keep patients safe and prevent malpractice litigation.

We have representatives to serve your needs. Contact us at mkt@svmic.com or call 800.342.2239.

Follow us @SVMIC • www.svmic.com