Highlights of Tennessee AFP at the 2011 AAFP National Conference of Family Medicine Residents & Medical Students held the end of July in Kansas City. See page 17

Join us in Gatlinburg October 25-28 for the TN AFP’s 63rd Annual Scientific Assembly! See page 12

NATIONAL TAR WARS POSTER CONTEST
Tennessee’s Brooklyn Driver places 2nd!!! See page 8
Breast cancer is the most common cancer among women in the United States with over 200,000 new cases diagnosed each year. Most breast cancers present in the early stage and are treated with surgery and, when appropriate, radiation therapy, endocrine therapy, and/or chemotherapy. Chemotherapy is generally administered for patients with tumors at a higher risk of systemic recurrence including larger size, lymph node involvement, HER2 overexpression, and lack of estrogen/progesterone/HER2 positivity (triple negative tumors). Chemotherapy is most often administered after surgery, in the adjuvant setting. However, for patients with larger tumors, tumors which are fixed to the chest wall, or those with clinically matted lymph nodes or skin involvement, the neoadjuvant approach to chemotherapy is often used. In the neoadjuvant setting, patients receive chemotherapy prior to surgery to decrease the size of the tumor to make it more amenable to surgery. Another common reason to give chemotherapy prior to surgery is to allow for a lumpectomy rather than a mastectomy in a patient who prefers a lumpectomy but in whom such a surgery would not be feasible due to tumor size relative to her breast size.

As chemotherapy in the early stage setting is usually given for three to six months and leads to numerous toxicities, some of which may be long-term, neoadjuvant chemotherapy also provides an excellent opportunity to observe whether a particular regimen is actually beneficial. When chemotherapy is given in the adjuvant setting, no “marker” is available to determine whether a treatment is eradicating micrometastatic disease; neoadjuvant administration allows the primary breast mass to function as this marker. If the primary breast tumor responds to neoadjuvant chemotherapy, any systemic micrometastases are also presumably sensitive to the same chemotherapy. If the primary tumor starts growing while a patient is receiving neoadjuvant chemotherapy, the treatment can be changed to a regimen which could be more effective in targeting both the primary mass and any micrometastases. Furthermore, neoadjuvant chemotherapy allows patients time to undergo genetic testing if there is a suspicion for an underlying BRCA 1/2 mutation. If found to carry a BRCA 1/2 mutation, patients may consider a mastectomy or even a bilateral mastectomy rather than a lumpectomy.

From a research perspective, one of the more compelling reasons for administering neoadjuvant treatment is the ability to obtain biopsies before and after treatment to better understand the true targets of the study drug. Whether a study drug will be beneficial will be evident quickly by observing whether a tumor is shrinking from week to week. After neoadjuvant treatment, the amount of disease remaining in the breast at the time of surgery can serve as a prognostic indicator of likelihood of recurrence of disease. The prognosis for triple negative tumors, which are particularly aggressive and have high rates of systemic recurrence, is markedly improved if a patient is found to have no evidence of disease (pathological complete response) at the time of surgery after neoadjuvant treatment. Information regarding the amount of residual disease can also be useful in guiding treatment after surgery, in the adjuvant setting.

A recent clinical trial in which Vanderbilt was a major contributor involved patients with HER2 overexpressing breast cancers which were greater than 3 cm in size. Patients were administered two agents which target HER2 in different ways, hereceptin and lapatinib. Hereceptin is a monoclonal antibody to HER2 and lapatinib is a small molecule tyrosine kinase inhibitor of HER2 and EGFR (epidermal growth factor receptor). Neither is a cytotoxic chemotherapy. After 12 weeks on therapy, 28% of the patients were found to have a pathologic complete response. Although all patients on study were offered a standard four to five month-long chemotherapy regimen for HER2 positive disease after surgery, the hope is that we will be able to omit chemotherapy for a subset of these patients in the future--perhaps those who attain a pathologic complete response.

Currently, Vanderbilt has an ongoing clinical trial of cisplatin and paclitaxel with or without everolimus, an mTOR inhibitor (see figure), for patients with triple negative breast cancer. Preclinical data has shown that cisplatin and everolimus modulate the p53/p73/p63 pathway which is important in ensuring that cancer cells appropriately undergo apoptosis. Biopsies collected during various timepoints of treatment will inform correlative studies to validate the rationale and to help guide future treatments. Another neoadjuvant study for estrogen receptor positive tumors using endocrine therapy in combination with a PI3K inhibitor (see figure) is expected to open later this year. Patients receiving any type of neoadjuvant chemotherapy who have residual disease with high risk features at the time of surgery may also qualify for clinical trials offering extended or alternate treatments after surgery.

Despite the many benefits of neoadjuvant treatment, it is important to realize that it is not recommended for all patients with early stage disease. The most important and difficult aspect of the treatment of breast cancer is weighing the risk/benefit ratio carefully. Most drugs available for breast cancer treatment carry the risk of substantial toxicities, and if there is a possibility that surgery could downstage a patient so that they would not need the therapy in question, it is prudent to proceed with surgical resection first. This especially comes into play with estrogen receptor positive tumors which do not have involvement of the lymph nodes. Depending on the pathological features of these tumors, many (even those greater than 2 cm) can be treated with endocrine therapy alone.

Neoadjuvant treatment for early stage breast cancer offers patients a unique opportunity to follow the effectiveness of a therapy and to potentially expand surgical resection options. Any patient with a palpable tumor should be referred to medical oncology for consideration of neoadjuvant therapy. Research studies in the neoadjuvant setting are appealing because patients are able to receive cutting-edge therapies which are often based on rational molecular targets, and correlative tissue studies can help verify the effects of these drugs in the tumor.
TENNESSEE FAMILY PHYSICIAN
AN OFFICIAL PUBLICATION OF THE TENNESSEE ACADEMY OF FAMILY PHYSICIANS

Fall 2011
Vol. 4 Number 3

President’s Corner

Editorial

Tennessee Places 2nd at 2011 National Tar Wars Contest

2012 TNAFP Officers & Board of Directors Nominees

Leaders on the Move

TNAFP at the National Conference

2011 Outstanding Student Award Winners

HIPAA Changes You Need To Know
The year has quickly passed as so many in this position have said. Fall has once again returned and the Annual Scientific Assembly in Gatlinburg is just around the corner. It has been an honor to have served as your President. The experience has enriched me and given me the opportunity to represent a strong and respected organization. I had the privilege to work with other officers that are committed to this organization and saw it continue to grow and improve. It is in good hands! Doctor Gregg Mitchell of Jackson will do a wonderful job in the upcoming year as President of our organization.

“Long to embrace change and you will begin to recognize that life is in constant motion, and every change happens for a reason. When you see boundaries as opportunities, the world becomes a limitless place, and your life becomes a journey of change that always finds its way.” – Author Unknown.

In my first “Corner” change was the theme and I suspect it will remain the focus of this organization and medicine for the foreseeable future. We will have to transition into an organization that is able to communicate in new ways to the membership and strive to remain vital to our members by providing them with services of value. I have been a part of this organization for just over 20 years. There were no cell phones, Facebook or electronic health records. How we relate to our members and how that is structured will need to continually change if we are to be a successful organization in the years to come.

The other thing that I have continued to mention this year is involvement. We have wonderful leadership currently, but we continually need new members to step up and become involved in this organization. It is the only way we will continue to grow and be successful.

There are a number of positive items involving our organization that I would like to mention. First, Brooklyn Driver of Lafayette, winner of the State Tar Wars Poster Contest this year, placed second in the National Tar Wars Poster Contest in July. The Tar Wars program continues to be successful and I hope you will consider teaching it in your community.

Remember the Annual Scientific Assembly in Gatlinburg October 25-28. The program looks great and I hope you will make an effort to attend. This is always a great opportunity to obtain CME in a wonderful environment. There will also be a number of activities and opportunities to be involved with the Tennessee Academy of Family Physicians’ Foundation in Gatlinburg. I would encourage you to become more familiar with the Foundation and its efforts. Additionally, Doctor Reid Blackwelder, who currently serves on the American Academy of Family Physicians’ Board of Directors, will be running for the Presidency of our national organization next year. He will require our support to be successful in that endeavor. It would be a wonderful achievement for him and our state.

Again, I thank you for this opportunity! As ominous as the future seems on occasion, I remain encouraged and hopeful. Medicine is still a great career. To be allowed the opportunity to serve others as we do is a blessing not afforded to many. Stay encouraged, stay involved and always remain grateful!

Wes Dean, M.D., FAAFP, Powell
President
The Shuttle was visible from the fourth floor of Huntsville Hospital that summer of 1978. Vibration testing was being done by the Marshall Space Flight Center on Redstone Arsenal to certify the fitness of the ceramic tiles to the rigors of launch and reentry. The gantry stood 12 stories tall in the distance west of the city and was testament to our national excitement about the beginning of a new era of space flight. I just finished the first month of residency training and my ER rotation. Those early morning rounds before dawn gave us the spectacular view of a slice of NASA space history. Sunrise would illuminate the tower while leaving the foreground strangely indistinct. We came to accept the apparition as normal each morning before the summer haze obscured it altogether. It wouldn’t be long before we saw the Shuttle leave piggy-backed on the Boeing 747 destined for Florida and the maiden voyage the spring of 1981. It would be years until we added the 1996 Challenger disaster and the disintegration of the Columbia in 2003 to our collective consciousness. We were fixed in the moment of possibilities. So much potential lay ahead. The dangers of cold ‘O’ rings and the shattering of a few tiles by foam at a launch would never have entered our minds. We still lived in the ‘can do’ mindset of American dynamism. Residency training in Huntsville was no different. We lived to work and push our boundaries beyond individual limits. We were twelve residents in a race to learn all we could and see all that there was to make us the best family physicians that we could be.

That same summer, Debbie O. was in the ER for a severe yeast infection that her general practitioner just couldn’t seem to clear. He perhaps knew something that we didn’t because over the next three years, we bonded with Debbie on family medicine service. She was insulin dependent and was pregnant in addition to having that yeast infection. Debbie didn’t have a clue how to control her diabetes and as a rebellious adolescent left her parents and doctor frustrated in every attempt to change her behavior. Her blood sugar was 400 and she felt terrible most of the time. Over the next 6 months Debbie was forced to grow up and accept her surprise motherhood. We were able to do what today would be considered the standard of care. She was the first diabetic in our clinic to monitor her blood sugars four times a day and use short acting insulin to keep her blood sugars under 150. She was the first diabetic to have her own glucometer. I remember our senior residents raising eyebrows at this pregnant diabetic managing her own condition on the family medicine service (not the obstetric service). We patterned her care after a Parkland Hospital protocol for ‘tight control’ of pregnant diabetics. Then, it was cutting edge and very exciting to engage this problem patient with our obstetrics consultants all the while keeping her in the family medicine fold. I will forever be indebted to the Ames Company for getting her that glucometer before they were released to the general public. The result of that summer and fall of care was an emancipated diabetic who never again had yeast infections due to uncontrolled sugars. She survived pre-eclampsia and the resulting C-section to have a healthy daughter who is now a mother herself. She never risked another pregnancy. She transformed into an excellent mother. She did as much for me as I did for her. Learning became a fascinating and engaging process that has never left me in the practice of medicine. We cannot know every clinical condition that will be inside the next examination room. What gives me the confidence to open the door is the knowledge that I can deal with the uncertainty and get the answers if I do not know what is wrong.

The shuttle program came to an end on Thursday July 21st marking three decades of human achievement like none other in recent memory. We hold memories of success and failure close to our hearts as the final chapter closes. It now remains to be seen what is next. After 30 years in medicine I ask that question more often in the work I do. I see fewer new things and the days seem more routine than extraordinary. But future trends hold promise of genomics for diagnosis and therapy. We have potential to engage stem cells in rebuilding some tissues and invigorating others. Chemotherapy is now a
refined art of regulating receptors of tumor cell growth. I will enter these arenas only by reading consultation letters and journal articles. There remains one great challenge on my horizon that most of us are crossing. As we enter the electronic medical record era, we embark on the digitalization of medical information. This is no small undertaking as most of us realize when entering histories, illnesses, conditions, and infirmities that present to us in the vast human experience. We should be attentive to the specifics and accurate to the level of diagnostic certainty. As we move from the hand written or typed format to the digital, we are transforming the work we do and the way we will access future inquiry into health and illness. We will potentially be linked together in ways that we are yet to imagine that will revolutionize our already engaging enterprise. Just as our Internet capacity gives us real time information, our digital patients will become cohorts in a matrix of possibilities based on family history, current conditions, ongoing medications or treatments. We are at an amazing threshold no different than 1978 in a shuttle program. The potential for disaster is married to the equally compelling luster of success. We cannot know everything that this transition holds save for the change it brings to the work we do. We should be faithful to the task at hand. We should toll for accuracy and completeness because our patients deserve no less. We ‘can do’ this. The horizon waits with a new dawn. ‘Earth-rise’ for our medical generation is yet to be painted. Future clinicians will wonder how we could have not seen the advantages and possibilities sooner. For now, we toil on in faith that dividends follow for those who invest.

Michael Hartsell, M.D., Greeneville Co-Editor

The Tennessee AFP wishes to thank each member who served as the Tuesday Doctor of the Day during the 2011 Tennessee Legislative Session!

ACTIVE MEMBERS:
Charles Ball, M.D., Columbia
Lee Carter, M.D., Huntingdon
R. Wes Dean, M.D., Powell
Walter Fletcher, M.D., Martin
Doreen Feldhouse, M.D., Dyersburg
T. Michael Helton, M.D., Smyrna
James D. Holt, M.D., Johnson City
Ernest Jones, M.D., Carthage
Charles Leonard, M.D., Talbott
Daniel Lewis, M.D., Greeneville
Tersa Lively, D.O., Crossville
Gregg Mitchell, M.D., Jackson
Jim O’Connell, M.D., Hixson
D. Gabriel ‘Gabe’ Polk, D.O., Columbia
Raymond Walker, M.D., MBA, Bartlett
B. Alan Wallstedt, M.D., Brentwood
Ty Webb, M.D. Sparta
Roger Zoorob, M.D., Nashville

RESIDENT MEMBERS:
Louis Castillo, M.D., Nashville
Maureen Seitz, M.D., Nashville
Craig Wright, M.D., Jackson
This free CME program for primary care physicians is coming to Nashville!

Saturday, November 5, 2011, 7:30 a.m. – 12:30 p.m.

Loews Vanderbilt Hotel, Nashville, Tennessee

The American Urological Association invites you to attend this complimentary CME activity with the latest research from expert urologists and primary care providers on the urologic issues most relevant to front-line patient care. This free, half-day course will enhance your knowledge to help improve patient care in the following areas:

- LUTS: Overactive Bladder/Benign Prostatic Hyperplasia/Other Causes
- Erectile Dysfunction/Hypogonadism and Cardiometabolic Syndrome
- Prostate Cancer
- Interstitial Cystitis/Urinary Tract Infection

The American Urological Association

Throughout our 100-year history, the American Urological Association (AUA) has dedicated itself to promoting the highest standards of urological clinical care through physician education, research and health policy. We recognize that primary care physicians are often the first stop in diagnosing patients with symptoms of urologic conditions and disease. Primary Care Update in Urology will enhance your knowledge and provide you with valuable practice tools that will improve patient outcomes.

For more information, or to register, visit AUAnet.org/PrimaryCareTNAFP

Accreditation
The American Urological Association (AUA) is accredited by the Accreditation Council for Continuing Medical Education (ACCME) to provide continuing medical education (CME) for physicians. The AUA takes responsibility for the content, quality and scientific integrity of this CME activity.

Credit Designation
The AUA designates this live activity for a maximum of 4.50 AMA PRA Category 1 Credits™. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

AAFP Accreditation
Application for CME credit has been filed with the American Academy of Family Physicians. Determination of credit is pending.

Following this activity, participants will complete an evaluation and obtain a certificate of attendance, which will indicate activity type, location and credits designated for this activity.

Tennessee Nurses Association Accreditation
This activity has been submitted to the Tennessee Nurses Association for approval to award contact hours. Tennessee Nurses Association is accredited as an approver of continuing nursing education by the American Nurses Credentialing Center’s Commission on Accreditation.

Support provided by educational grants from Abbott Laboratories; Astellas Pharma Global Development; Endo Pharmaceuticals; Ethicon, Inc.; Lilly USA, LLC; Pfizer; and Slate Pharmaceuticals.
2011 NATIONAL TAR WARS POSTER CONTEST

Tennessee Places 2nd at National Tar Wars

Congratulations to Brooklyn Driver of Lafayette, Tennessee’s 2011 State Tar Wars Poster Contest Winner, on placing second at the National Tar Wars Poster Contest in Washington D.C. in July!

Additionally, congratulations to June Spears, Drug Free Coordinator & Health Educator for Macon County Schools, on receiving the National Tar Wars’ “Star Award” in Washington D.C. June was nominated by the Tennessee AFP Board of Directors for her long term support of and teaching of Tar Wars in Macon County’s 4th and 5th grade classrooms.

“THANK YOU RECEIVED”

To: Tennessee Academy of Family Physicians

Please accept my BIG thanks for nominating me as a recipient of this Year’s Star Award 2011. Through your generosity I was honored to represent Tennessee on July 13 on Capitol Hill in Washington D.C. to receive my Star Award.

I have always loved the Tar Wars program and have a great time each year presenting the program to my students in Macon County. My goal as a health educator is to help students adopt and maintain lifetime healthy behaviors. Therefore, the Tar Wars program helps me to make that goal successful.

I want to thank the Tar Wars program for the help in providing outlets to millions of children to promote lifelong importance of being tobacco free, and also for the opportunity you give a student to win a dream come true trip to Washington.

Tennessee Academy of Family Physicians is very fortunate to have Cathy Dyer as the Tar Wars Coordinator. Brooklyn Drive (Tennessee Tar Wars Winner 2011) and I believe that Cathy Dyer is the best Coordinator in the nation.

Thanks again from the bottom of my heart for having the faith you had in me to nominate me for the Star Award and for the wonderful trip you provided for me.

Sincerely,
June Spears
Macon County Health Educator,
Lafayette, Tennessee
Go Paperless and Get Paid
Register NOW for CMS Electronic Health Record Incentives

The Centers for Medicare & Medicaid Services (CMS) is giving incentive payments to eligible professionals, hospitals, and critical access hospitals that demonstrate meaningful use of certified electronic health record (EHR) technology.

Incentive payments will include:
• Up to $44,000 for eligible professionals in the Medicare EHR Incentive Program
• Up to $63,750 for eligible professionals in the Medicaid EHR Incentive Program
• A base payment of $2 million for eligible hospitals and critical access hospitals, depending on certain factors

Get started early! To maximize your Medicare EHR incentive payment you need to begin participating in 2011 or 2012; Medicaid EHR incentive payments are also highest in the first year of participation.

Registration for the EHR Incentive Programs is open now, so register TODAY to receive your maximum incentive.

For more information and to register, visit:
www.cms.gov/EHRIncentivePrograms/

For additional resources and support in adopting certified EHR technology, visit the Office of the National Coordinator for Health Information Technology (ONC):
www.HealthIT.gov
Lincoln Memorial University-DeBusk College of Osteopathic Medicine (LMU-DCOM) celebrated its Inaugural Class Graduation on Saturday, May 14, 2011, as 130 osteopathic medical students were awarded their diplomas and hoods, signifying the successful completion of their undergraduate education. This event, which was held at Tex Turner Arena on the LMU campus in Harrogate, Tennessee, marked the first time that osteopathic medical students have graduated from an institution in Tennessee.

Karen Nichols, D.O., President of the American Osteopathic Association, was present to deliver the commencement address and to welcome the new graduates fully into the medical profession. During the proceedings, the first LMU-DCOM Distinguished Service Award was presented to Autry O.V. “Pete” DeBusk, the Chairman of the LMU Board of Trustees and namesake of the medical school. The Distinguished Service Award is presented to an individual who holds service to humanity close to his or her heart and who has had a significant impact on the health and wellness of those within the Appalachian region and beyond.

In addition to the 130 graduates, several students who were part of the class when it matriculated in 2007 were recognized during the ceremony; these students elected to enhance their undergraduate medical training through one-year fellowships and are on track to graduate from LMU-DCOM with the Class of 2012.

The DeBusk College of Osteopathic Medicine, which is located on the main campus of Lincoln Memorial University in Harrogate, welcomed its first class in 2007. Since then, the school has grown to its current student body of four full classes comprised of over 600 students. From the Class of 2011, 75% will be entering a primary care program, and Family Medicine was the specialty selected most often, with 27 graduates choosing this discipline.

Gabe Polk, D.O., FAAFP, Columbia  
President, Tennessee Osteopathic Medical Association
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OF OSTEOPATHIC MEDICINE
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TENNESSEE ACADEMY OF FAMILY PHYSICIANS 63rd ANNUAL SCIENTIFIC ASSEMBLY
Convention Center, Gatlinburg, Tennessee, October 25-28, 2011

If you have not received your Tennessee AFP Program/Registration Brochure for this year’s annual meeting, please notify the Tennessee AFP office so one can be mailed to you. Or you can access a copy on the TNAFP website at: www.tnafp.org

Included again in this year’s annual assembly program is one hour on “Physician Prescribing and Monitoring of Scheduled Drugs” which will meet your 1 hour required designed specifically to address prescribing practices of the required 40 hours to maintain your Tennessee Medical License.

We hope to see you in Gatlinburg the last week of October!

SLATE OF NOMINEES FOR 2012 TENNESSEE AFP OFFICERS & BOARD OF DIRECTORS

PRESIDENT-ELECT:
B. ALAN WALLSTEDT, M.D., BRENTWOOD

VICE PRESIDENT:
BETH ANNE FOX, M.D., KINGSPORT

SECRETARY-TREASURER:
KIM HOWERTON, M.D., JACKSON

SPEAKER OF THE CONGRESS:
LANG SMITH, M.D., COLUMBIA

VICE SPEAKER OF THE CONGRESS:
TY WEBB, M.D., SPARTA

DELEGATE TO A.A.F.P.:
TIMOTHY LINDER, M.D., SELMER

ALTERNATE DELEGATE TO A.A.F.P.:
LEE CARTER, M.D., HUNTINGDON

DISTRICT 1 - DIRECTOR:
JAMES D. HOLT, M.D., JOHNSON CITY

ALTERNATE DIRECTOR:
ROBERT FUNKE, M.D., KINGSPORT

DISTRICT 3 - DIRECTOR:
MARY BEAN, M.D., CHATTANOOGA

ALTERNATE DIRECTOR:
ALLEN SHERWOOD, M.D., OOLTEWAH

DISTRICT 5 - DIRECTOR:
STEPHANIE GAFFORD, M.D., FAYETTEVILLE

ALTERNATE DIRECTOR:
J. LYNN WILLIAMS, M.D., DECHERD

DISTRICT 7 - DIRECTOR:
JOEY HENSLEY, M.D., HOHENWALD

ALTERNATE DIRECTOR:
D. GABRIEL ‘GABE’ POLK, D.O., COLUMBIA

DISTRICT 9 - DIRECTOR:
WALTER FLETCHER, M.D., MARTIN

ALTERNATE DIRECTOR:
SUSAN LOWRY, M.D., MARTIN

DISTRICT 11 – RESIDENTS:
ERIN KOSCINSKI, D.O., ETSU KINGSPORT
CRAIG THOMAS WRIGHT, M.D., UT JACKSON

THE RESIDENT RECEIVING THE LARGEST NUMBER OF VOTES AT THE TENNESSEE AFP CONGRESS WILL SERVE AS DIRECTOR; AND THE RESIDENT RECEIVING THE 2ND LARGEST NUMBER OF VOTES WILL SERVE AS ALTERNATE DIRECTOR.

STUDENT - BOARD REPRESENTATIVE:
THEO HENSLEY, JOHNSON CITY (ETSU)

ALTERNATE REPRESENTATIVE:
LEAH WARREN, MEMPHIS (UT)
Are you ready?

WEEKLY TO-DO LIST

Version 5010 Deadline:
JAN 1st, 2012

ICD-10 Deadline:
OCT 1st, 2013

Prepare Now for the Version 5010 and ICD-10 Transitions

The change to Version 5010 standards takes effect on January 1, 2012. The change to ICD-10 codes takes effect on October 1, 2013.

In preparation for ICD-10, starting January 1, 2012, all practice management and other applicable software programs should feature the updated Version 5010 HIPAA transaction standards. Providers will need to use ICD-10 diagnosis and inpatient procedure codes starting on October 1, 2013.

Make sure your claims continue to get paid. Talk with your software vendor, clearinghouse, or billing service NOW, and work together to make sure you’ll have what you need to be ready. A successful transition to Version 5010 and ICD-10 will be vital to transforming our nation’s health care system.

Visit www.cms.gov/ICD10 to find out how CMS can help prepare you for a smooth transition to Version 5010 and ICD-10.
MEMBERS OF THE 2011 TENNESSEE AFP CONGRESS OF DELEGATES
Speaker: Lang Smith, M.D., Columbia; Vice Speaker: Ty Webb, M.D., Sparta

DELEGATES:

DISTRICT 1 (John Sevier Chapter)
W. Allan Garrett, M.D., Johnson City
James Holt, M.D., Johnson City
Danny Lewis, M.D., Greeneville

DISTRICT 2 (Tennessee Valley Chapter)
Gregory Blake, M.D., Knoxville
Charles Leonard, M.D., Talbott
Jose Malagon, M.D., Clinton

DISTRICT 3 (Chris Graves Chapter)
Stephen Adams, M.D., Chattanooga
Mary Huff, M.D., Sweetwater
Alex Zotos, M.D., Signal Mountain

Kenneth Dale Beaty, M.D., Livingston
Chet Gentry, M.D., Cookeville
Tersa Lively, D.O., Crossville

DISTRICT 4 (Tom Moore Chapter)
Albert R. Brandon, D.O., Manchester
Christopher Gafford, M.D., Fayetteville
Christy L. Pettes, M.D., Winchester

DISTRICT 5 (Nathan Bedford Forrest Chapter)
T. Michael Helton, M.D., Smyrna
Ruth Stewart, M.D., Nashville
Roger Zoorob, M.D., Nashville

DISTRICT 6 (Andrew Jackson Chapter)
Charles Ball, M.D., Columbia
Joey Hensley, M.D., Hohenwald
Lawrenceburg
D. Gabriel Polk, D.O., Columbia

DISTRICT 7 (Nathan Bedford Forrest Chapter)
Patrick N. Andre, M.D., Humboldt
P. Andrew Coy, D.O., Jackson
Kevin J. Wheatley, M.D., Jackson

DISTRICT 8 (Forked Deer River Chapter)
Doreen Feldhouse, M.D., Dyersburg
Walter Fletcher, M.D., Martin
William Kirk Stone, M.D., Union City

DISTRICT 9
Wm. MacMillan Rodney, M.D., Memphis
Perry Rothrock, M.D., Memphis
Raymond Walker, M.D., Bartlett

DISTRICT 10 (Memphis Chapter)
Collins Rainey, M.D., Memphis
Trishul Tunga Reddy, M.D., Johnson City
Craig Thomas Wright, M.D., Jackson

DISTRICT 11 (Resident Chapter)
Beth Anne Fox, M.D., Kingsport
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R. Wesley Dean, M.D., Powell
Joanne Filchock, M.D., Knoxville
Sherry L. Robbins, M.D., Knoxville

Paul L. Dassow, M.D., Chattanooga
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Chad Griffin, M.D., Sparta
Thomas A. Jenkins, M.D., Cookeville
Ernest Jones, M.D., Carthage

Richard C. Cole, M.D., Tullahoma
T. Scott Holder, M.D., Winchester
J. Lynn Williams, M.D., Decherd

Robert Bain, M.D., Mt. Pleasant
Matthew C. Dobias, M.D.,
---

Kim Howerton, M.D., Jackson
Timothy Linder, M.D., Selmer
Michael McAdoo, M.D., Milan

Monique Casey-Bolden, M.D., Dyersburg
John B. Clendenin, M.D., Union City
Mark W. Fowler, M.D., Union City

Gloria Burns, M.D., Cordova
Gisele Allen Goff, M.D., Cordova
Gregory Laurence, M.D., Germantown

Holly Spurlock Blankenship, D.O., Hixson
Chayla Muriel Chasten, M.D., Nashville
Jonathan Ben Laymance, M.D., Knoxville
Bylaws Amendment 1-2011: FAMILY PHYSICIAN OF THE YEAR AWARD NOMINEES
TO AMEND THE BYLAWS of the Tennessee Academy of Family Physicians in Chapter VII, Section 1 (D) by adding an additional paragraph at the end concerning nominees for the Family Physician of the Year Award.

Nominating - Section 1 (D), Nominating Committee
It shall be the responsibility of this committee to be sure there is an entity within the TAFP in charge of assuring there are nominees received each year for the Family Physician of the Year Award.

Bylaws Amendment 2-2011: SUNSET OF THE TENNESSEE AFP MEMBERSHIP COMMITTEE
TO AMEND THE BYLAWS of the Tennessee Academy of Family Physicians in Chapter VII, Section 1 (A) by deleting this section in its entirety, sunsetting the Membership Committee.

RESOLUTIONS RECEIVED FOR INTRODUCTION TO THE 2011 CONGRESS OF DELEGATES
At the time of publication of this journal, no Resolutions for the 2011 Tennessee Academy of Family Physicians' Congress of Delegates had been received.

LEADERS ON THE MOVE
INFORMATION FOR MEMBERS

► Congratulations to D. Gabriel 'Gabe' Polk, D.O., Columbia, on being elected President of the Tennessee Osteopathic Medical Association. Doctor Polk serves on the Tennessee AFP Board of Directors.

► Congratulations to Vanderbilt's Family Medicine Interest Group and Tennessee AFP member Doctor Ruth Stewart, FMIG faculty advisor, on receiving the 2011 AAFP Program of Excellence Award for their outstanding activities in generating interest in family medicine.

► Congratulations to Tennessee AFP members Randall C. Rickard, M.D. and Susan T. Andrews, M.D., Murfreesboro, for receiving Recognition from the Physician Practice Connections for the Patient-Centered Medical Home (PPC-PCMH) program for using evidence-based patient-centered processes that focus on highly coordinated care and long-term participative relationships.

► Tennessee AFP President, Wes Dean, M.D., Powell, and Cathy Dyer, represented the TNAFP at the 2011 AAFP National Conference of Family Medicine Residents and Medical Students in Kansas City the end of July.

► Reminder: The Tennessee AFP website is located at: www.tnafp.org and offers up-to-date and current information and also links for your convenience in contacting other useful websites such as: Tennessee Department of Health, Governor's TennCare Website, AAFP, CDC, Tennessee General Assembly and many others.

MARK YOUR 2012 CALENDAR FOR THESE IMPORTANT DATES:
TNAFP Practice Enhancement Seminar, March 17 – Embassy Suites at Cool Springs, Franklin
TNAFP 64th Annual Scientific Assembly, October 30-November 2 – Gatlinburg Convention Center
If you are looking for a partner or a practice location, send information preferably by email to: tnafp@bellsouth.net; or by snail mail to: TAFP, 500 Wilson Pike Circle, Suite 212, Brentwood, TN 37027; or by fax to: 615-370-5199. Information for practice opportunities will be accepted only from TAFP members and will be placed in the Tennessee Family Physician at no charge. You are required to include your name, address and/or telephone number and/or fax number and/or email address as contact concerning opportunities will be made directly between interested parties and not through the TAFP. Information will be placed in four (4) editions unless the TAFP is notified otherwise. Deadline for the next issue (Winter 2011) is Friday, October 14, 2011.

Department of Family and Community Medicine Faculty Position - The Department of Family and Community Medicine at Meharry Medical College is currently seeking a Board Certified Family physician to serve as a full-time faculty. The position includes faculty appointments at Meharry Medical College and Vanderbilt University at the level of Assistant or Associate Professor depending on experience and qualifications. Previous academic experience as a residency or clerkship faculty, or fellowship training is required. Nashville is an excellent community and offers many amenities. The department has eighteen Family Medicine Residents and also administers Preventive and Occupational Medicine Residency Programs and a Sports Medicine Fellowship. For Further Information Contact: Roger Zoorob, MD, MPH, FAAFP, Meharry-Vanderbilt Professor and Chair, Department of Family Medicine, 1005 Dr. D. B. Todd, Jr. Boulevard, Nashville, Tennessee 37208. rzoorob@mmc.edu; 615-327-6572; familymedicine.mmc.edu Meharry Medical College is an Equal Opportunity Employer.

Summit Medical Group, Outpatient Practice Opportunities, Family Medicine - Partnership Opportunities Available.

Summit Medical Group is looking for quality-minded family medicine physicians. Enjoy the benefits of being employed by a physician owned and operated business with 225 primary care physicians. Opportunities are available in practices located in Knox and surrounding counties in East Tennessee. Partnership is discussed after 24 months of employment. Positions start as employed positions and have the following benefits: Paid Malpractice Premiums, Health, Dental, Vision and Disability Insurance Options, Twelve Paid Vacation Days & Six Paid Sick Days per Year, Five Paid Days and $3,000 for CME per Year. For more information, please email your CV to Cheryl Crye at cjcrye@summithealthcare.com

America’s Family Doctors & Walk-In Clinics (AFDclinics.com) is looking for a Family Physician for full or part time work. We have locations in Brentwood, Smyrna and Spring Hill TN. For further information, contact Medical Director S. Steve Samudrala MD at DrSam@AFDclinics.com or 615-497-9575 anytime.

Medical Director for FAITH FAMILY MEDICAL CLINIC. Faith Family Medical Clinic is a 10 year old primary care nonprofit outpatient clinic in Nashville, TN serving Middle Tennessee’s working uninsured and their families. Our mission is “to follow the commitment of people of faith to provide hope and medical care for the working uninsured by meeting their physical, emotional and spiritual needs.” We are modeled after the Church Health Center in Memphis, TN.

Our current Medical Director is retiring after 10 years of service and we seek to have a good “handoff.” The clinic is financially strong, has a well-trained and stable staff in place and a supportive and engaged Board of Directors. Funding is comprised of patient fees and donations or grants from individuals, foundations, corporations and churches.

Clinical responsibilities (approximately 75%) vs. Non-clinical (approximately 25%) including: Direct patient care; Lead clinical staff (3.2 nurse practitioners, 2RNs, 1MA); Work with Executive Director and Board of Directors on strategy and establishing priorities; Recruit volunteer physicians to see patients for specialty care; Some community and donor relations. No after hours call, no weekends and no managed care hassles. Most patients are between the ages of 19 to 64.

Requirements: Must have completed a Medical Degree from an approved training program and hold current Board Certification in primary care specialty (Family Medicine, Internal Medicine, or IM/Pediatrics) Preferably five years+ experience. Leadership & computer/EMR technology are preferred.

Financials: A competitive employment agreement will be offered by the clinic’s Executive Director to the most qualified candidate. Excellent pay and health care benefits; CME, generous vacation and pension plan. For additional info, please see the website at www.faithmedical.org; or, contact Tony Ross, M.D. at 615-351-2949 or tross02@comcast.net; or, contact Laura Hobson at 615-305-3805 or lhobson@faithmedical.org.
TENNESSEE AFP AT THE 2011 NATIONAL CONFERENCE OF FAMILY MEDICINE RESIDENTS AND MEDICAL STUDENTS

Once a year, family medicine leaders and educators come from across the nation to share their knowledge with family medicine residents and medical students at the American Academy of Family Physicians’ National Conference of Family Medicine Residents & Medical Students (NCFMRMS) held in Kansas City.

Your Tennessee AFP and Tennessee AFP Foundation supported the attendance of a total of 22 medical student members from the four medical schools in Tennessee to this year’s NCFMRMS. The Tennessee Family Medicine Residency Programs, along with the Tennessee AFP, occupied booths in the “Follow Me To Tennessee” row in the exhibit hall at the conference.
Tennessee Academy of Family Physicians

Dear Tennessee AFP:

I would like to first thank the Tennessee Academy of Family Physicians for your thoughtfulness and award of the Outstanding Student in Family Medicine Award. I am truly grateful and honored. I have thoroughly enjoyed my interaction with members of the Academy here in Tennessee and with the national body of family physicians, AAFP. I am blessed to be surrounded by individuals who are truly passionate about the mission of family medicine and patient care. I hope to emulate the compassion and charisma that this body possesses. Thank you once again. Have a great rest of the week.

Tolulope Adeyemo, M.D.
(Meharry)

Dear Tennessee AFP:

My name is Jason Meredith, and I was chosen to receive one of the Outstanding Student in Family Medicine Awards for this year. I am attaching a picture of my wife and I from the awards ceremony. Sorry for the delay, but the military just now got our household goods to Nebraska and I was able to dig up the camera to send the picture. I want to thank y’all so much for the award and support over the last several years.

Jason Meredith, M.D.
Captain USAF MC
(UT Memphis)

Dear Tennessee AFP:

I was so honored to receive this award, just as I am honored, humbled, and excited to be beginning my Family Medicine Residency. I have so enjoyed being a part of the Tennessee Academy of Family Physicians as a student, and though I will be training in Kentucky, I very much hope to continue in close touch and I am looking forward to future work and training in my home state. Again, thanks to you and to all members of the TNAFP board for this honor.

All best,
Kristin Cardona, M.D.
(ETSU)
INTRODUCTION

Exactly one year since the H.R. 3590 (Patient Protection and Affordability Care Act) was enacted by President Obama in January 2010, the House Congress voted, 245-189, to repeal the Affordable Care Act by passing H.R.2. As a family medicine resident, I have seen far too many families suffer because of the politics of health care. A better approach to primary care is imperative for improving the delivery of health services to our nation’s population.

I see this suffering first hand in my residency training in the mountains of East Tennessee.

NO MONEY – NO MEDICATIONS

Sophie and her husband, Jay, are next, walk-ins with complaints of upper-abdominal pain becoming exaggerated with food intake. They share that they both have jobs, but no health insurance, an explanation often classified as the “working poor.”

“My belly burns after I have food, Doc,” Jay says. “I’ve tried everything.”

“We’ve both stopped eating spicy food,” Sophie explains. “We even sleep with two pillows under our heads. We’re trying to lose weight, but—”

“We don’t know what to do, Doc.” Jay says. “The acidity is killing us!”

“Have you tried any medication?” I ask. The first lines of available heartburn medications are cheap and available at our clinic. The second line is comparatively expensive and we have no samples.

“Yes, we’ve tried those.” Sophie refers to the first line medications. “But they don’t work. We’ve tried antibiotics, too, but those don’t seem to work either.”

As a long-term sufferer of heartburn myself, I can relate to the unnecessary distress they are suffering through. That very same night, my wife and I stop for a meal at a local restaurant. As we walk to the car, my heartburn flares up. I stop at a nearby pharmacy and make a purchase to quell the symptoms. It is almost a reflex to take what I need to for my health’s sake, expecting it to work as always—without a second thought.

But I feel guilty remembering the morning conversation with Sophie and Jay. The memory is vivid in my mind as I recall asking them about possible medications before they left the clinic disappointed and empty-handed. There was nothing else I could do for them then. As my own heartburn faded, I wondered if one of them might have had a stomach ulcer or worse—if they were bleeding from a possible ulcer.

PRIMARY HEALTH CARE – HAVES AND HAVE NOTS

As a doctor, I am disappointed to realize the failure to relieve human suffering, especially when the treatment was simple and available. In one of the most advanced nations on earth, I refuse to believe that there are individuals and families who cannot afford basic primary health care.

It troubles me to witness similar encounters over and over again. In most other countries citizens can live pain-free and disease-free from such conditions. Why must these patients suffer? Why are some families forsaken? Why do I have the privilege of affording simple medications while my patients cannot? Is it because I have worked hard all of my life moving up in society to a point where I can afford insurance and thus, be entitled to good health care? Why are my patients struggling through their lives as if they do not have the same rights and entitlements to good health and happiness?

It is not the individual’s fault. Our displeasure should be directed towards the faults of a structure that remains unsuccessful in properly sharing the benefits of medical discoveries and technological advances. In the name of individual responsibility, low and middle-income families have been overlooked, neglected and/or exploited by powerful for-profit companies. Such companies use the media to spin anything or anyone supporting basic health access for all citizens. Supporters of basic health access are labeled “socialist” or “European” thereby muddling the public’s understanding of the true matter at hand.

The patients I talked about earlier and whose names have been changed to protect their identity, originally had minute health issues which could be easily treated with affordable solutions under a hundred dollars. Because they had no access to a primary care physician, these patients landed in the ER while in the last stages of the disease process. Medical expenses of more than $10,000 were the result, a price eventually paid by hardworking taxpayers. This is hardly their fault.

The importance of a structure protecting every citizen’s right to primary care access is necessary. While I appreciate small government, continued on page 20>>
our current private sector approach to healthcare has been grossly unsuccessful in providing ways to share the advantages of medical innovations and advances for today’s society.

Is there a solution?

Yes. It is a two-step procedure. The first step is providing basic universal health coverage and the second is to meet the demand of the first. To do so, there should be broad access to primary care physicians. The importance of primary care must not be underestimated.

POLITICS OF HEALTH CARE

Suffering and hardships are in abundance, but when we encounter unnecessary human suffering, we should respond with compassion rather than objection and opinionated speculation towards the politics of health care. Instead of turning away from the problem, we should think in better terms, believing that “These are my fellow men and women, mothers and fathers, brothers and sisters, all who are suffering for nothing. They have a right to good health and the pursuit of happiness equal to our own.”

We all have the right to live rich and well-fulfilled lives, without our health being a burden.

I would like to emphasize that health is not a Democratic issue or a Republican issue, because it resonates deeply in both parties on many levels. This troubling situation requires action from everyone. It is universal and individual, because we can all relate to it as human beings.

Let’s not demonize one party over another and sacrifice our health because we cannot agree. Remember, for the American eagle to soar proud and high, we need both a left wing and a right wing—and they must flap together.

Trishul Reddy, M.D., Family Medicine Resident, Johnson City

Trishul Reddy, M.D., 3rd year Family Medicine Chief Resident at East Tennessee State University (ETSU), Johnson City, received the 2011 Caduceus Club Outstanding Resident Award and the 2011 AAFP Congressional Scholarship to attend the May 2011 AAFP Family Medicine Congressional Congress in Washington D.C. He is also an elected Resident Delegate to the 2011 Tennessee AFP's Congress of Delegates.

If you’ve already started saving for your retirement, congratulations. You’re on your way to fulfilling lifelong dreams and goals. But what would happen to your retirement plans if you became one of the millions of Americans to suffer a disabling illness or injury? Would you be able to continue saving for retirement without your income?

A disability could disrupt your retirement savings in more ways than one:

- Contributions to Social Security would stop.
- Contributions to your employer-sponsored retirement savings plan [such as a 401(k)] would also stop, as would any employer matching contributions.
- If you lose your job, you will no longer accrue additional pension benefits.

Fortunately, there is a way to ensure your ability to save for retirement in the event of a disability. Several insurance carriers offer a disability income insurance program that helps you continue saving for retirement. These types of programs are ideal, if you are serious about saving for retirement and have maxed out your personal disability income insurance benefits.

Upon a qualifying disability, this type of program would pay monthly benefits directly to a trust to help you continue saving for retirement. This trust then invests the benefits based on your risk tolerance. At a set age (varies by program, but typically age 65 or 67), you would start receiving income payments from the trust. These payments would continue until death or until the funds diminished.

When shopping for this type of offering, you should look for:

- A carrier that does not require you to validate your current retirement savings efforts
- Non-cancelable, guaranteed renewable coverage
- Benefit periods that will coincide with extended retirement ages (such as age 65 or 67)
- An offering that allows you to decide how to invest your benefits; based on your risk tolerance level

Overall, look for an insurance company that is financially strong and has a track record of exceptional customer service and claims handling. If the unthinkable does happen, you’ll appreciate the quality of the service you receive when you need it the most.
INSPIRIS is a solutions-driven care and care management company focused on improving the quality of life for the medically complex, chronically ill, frail and elderly. INSPIRIS offers proactive, high touch, scalable services that are provider-led and patient centric. INSPIRIS has an extensive, unmatched industry history of providing innovative care to the patient in their individual residence, skilled nursing facilities, and assisted living or other congregate housing. These programs can be as short as a single visit for clinical and HCC Risk Scoring assessment, short term for management of post-hospital discharged members to long term for those members not accessing the current PCP network.

**Regional Medical Director - Multi Region**

INSPIRIS is seeking a clinical leader with expertise in adult chronic disease management and/or care of geriatric patients. This position will provide clinical leadership for small group practices of physicians and nurse practitioners in multiple markets that care for frail, elderly, chronically ill members of Medicare Advantage and managed Medicaid plans. This position will mentor local clinical leaders and serve as medical director to a centralized case management department. Board Certified in Internal Medicine, Geriatrics or Family Practice. Residence in Nashville, TN required. Ability to travel up to 50% of time. Excellent compensation and generous benefits package.

To learn more about this opportunity at INSPIRIS
Send inquiries and CVs/resumes to: kathy.rudman@inspiris.com
Or call: 310-903-3460
www.inspiris.com
MEMORANDUM

Date: August 5, 2011

From: Michael D. Warren, MD MPH
Director, Maternal & Child Health, Tennessee Department of Health

Re: Notification of Infant Deaths

The Newborn Screening Program is required by law to follow up on any abnormal newborn screen (metabolic, genetic, and hearing). For any abnormal case, attempts are made to contact the family and primary care provider until the case is closed (follow-up complete, diagnosis finalized, infant noted to be deceased, etc).

In the case of an infant death, the Newborn Screening Program is not aware of the death unless notified by a primary care provider, hospital, or local health department. Because of the requirements for follow-up, if the Program is not aware an infant death has occurred, attempts may be made to contact the family to follow up on abnormal screens even after the infant’s death. It is therefore imperative that you notify the Newborn Screening Program immediately upon the death of an infant, so the record can be marked. This helps us avoid a distressing call to the family of a deceased infant.

To notify the Newborn Screening Program, please use the following steps:

• Fax the following information to the Newborn Screening Program at 615-262-6458:
  o Your name
  o The infant’s name
  o Date of birth
  o Mother’s name
  o Date the infant expired
  o Hospital of birth
  o Hospital Medical Record Number (if known)

• Or call the Newborn Screening Program at 615-262-6304

We appreciate your ongoing support of the Newborn Screening Program. Should you have any questions or if our Newborn Screening team can ever be of assistance, please call us at 615-262-6304.
WHAT IS 5010?
Under HIPAA, covered entities must conduct electronic transactions such as claims submission and eligibility inquiries in a standard electronic format. The current standard is 4010a. As of 01/01/2012, all transactions must be transmitted using an updated standard, 5010. The 5010 transition is also an important first step to preparing your practice for the 10/01/2013 change from ICD-9-CM diagnosis codes to ICD-10-CM. The 5010 format accommodates both ICD-9 and ICD-10 by including an indicator that identifies which code set is being transmitted.

Please don’t count on a delay of the 01/01/2012 implementation date. CMS has repeatedly stated that there will be no delay. As of May 17, 2011, CMS reports that all Medicare contractors are ready to conduct 5010 transactions and have processed over 1500 claims in that format already. CMS is also conducting periodic surveys of vendors, payers, physicians, and other providers to track transition progress. A March 2011 survey of vendors indicated that most are ready to upgrade their clients or soon will be.

WHAT DOES THIS MEAN TO MY PRACTICE?
The system that you use to electronically submit and receive information will need to be updated and you will need to test the system’s ability to submit and receive 5010 transactions before the compliance date of 01/01/2012. This upgrade may be included in your system maintenance/support fees if your contract with the vendor includes HIPAA-mandated upgrades. If you are not using the current version of the vendor’s software, you may be required to upgrade to the newest version.

The good news is that as soon as your practice management software vendor completes their internal testing of their systems and provides your upgrade, you can begin testing with your Medicare contractor and/or claims clearinghouse. Most private payers will not require individual practices to test since claims typically pass through a clearinghouse but your staff should verify this for payers most common to your practice. Once you successfully transmit and receive test transactions, you can switch to 5010 and have no concerns about compliance on 01/01/2012. You do not have to wait until 01/01/2012 to start conducting transactions in 5010 format.

Your staff will also need to be trained on any changes to the information that must be entered into the practice management system. There are a large number of changes in what data and in which order data is transmitted under 5010. These changes may require changes to your practice information that goes out on claims and also to the patient, dependant, other insurance, and encounter information. Your software vendor may provide information or training sessions on these changes.

WHAT SHOULD I DO TO PREPARE FOR 5010?
If you or your staff have not already begun working with your software vendor and any clearinghouses that receive your electronic transmissions, it is time to do so now. The AAFP has a checklist for the associated tasks.

Now may also be the time to consider adding electronic transactions that you are not currently utilizing. With the increasing number of patients who have high-deductible health plans and plans that will be required to cover preventive services under ACA, verification of eligibility and benefits prior to service is more important than ever. Did you know that your staff can check eligibility with the payer electronically in batches or by individual patient before the patient presents to the office? If you are not currently taking advantage of electronic eligibility inquiry, now is a good time to consider adding this function. Other considerations are electronic remittance advice (some systems also include an automatic posting to patient accounts) and claims status inquiries.

WHO CAN HELP?
Besides the support staff of your practice management system vendor, your Medicare Administrative Contractor (MAC) and claims clearinghouse can provide you with information and assistance. If your staff will be responsible for overseeing the change to 5010, please be sure they are aware of these resources.

The Centers for Medicare & Medicaid Services (CMS) will be providing information directly and through the MACs on a regular basis in 2011. CMS calls include question and answer time so that persons unfamiliar with the topics or with specific concerns can get additional information.
Like me, you’ve probably noticed some professional liability insurance carriers recently offering physicians what seem to be lower rates. But when I took a closer look at what they had to offer, I realized they simply couldn’t match SVMIC in terms of value and service. And SVMIC gives me the peace of mind that comes when you’re covered by a company with a stellar record of over thirty years of service and the financial stability of an “A” rating or better since 1984. At SVMIC, I know it’s not just one person I rely on… there are 165 professionals who work for me. And, since SVMIC is owned by you, me, and over 14,000 other physicians across the Southeast, we know our best interests will always come first.”