

1st Quarter 2014

SCRIPTS

A JOURNAL OF THE COBB COUNTY MEDICAL SOCIETY

Navigating the Insurance Highway

I am
CCMS

with Clem M. Doxey, MD

**BEHIND THE
WHITE COAT**

With Jessica Bilotta, MD

**Time is Money -
Your Cash Flow**

By: Joanne Thurston, CPA

**Innovative Health
Care Collaborative**

By: Jeffrey Tharp, MD

**Retired
Physicians
of Cobb**

By: Walter M. Ligon, MD

Medicare D

By: Steven L. Cohen, MD

**INSIDE FIND
ARTICLES FROM**

DEBORAH FRAZIER WITH BLUEWAVE COMPUTING,
JOE WILSON, JR., MD PRESIDENT OF MAGMUTUAL,
KELLY MILLER, AAMS FROM OAK TREE GROUP
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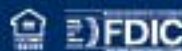
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2nd Quarter Issue
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STAN DYSART, MD | *Editor at Large*
member since '94

I am struggling with Epic. I may always struggle with Epic. I am not alone though: many of my colleagues are still struggling with this mammoth software program designed to capture, analyze and disseminate medical information to a network(s) of physicians.

There is, however, a light at the end of the tunnel. Physicians who are veterans of Epic report that once mastered, the promise is that this foray into the leading-integrated suite of health care software, available nationally, will improve patient outcomes and decreased their risk for entering the Wellstar Health System.

"Better Outcomes" has become a mantra for healthcare systems nationally and is one of the drivers behind President Obama's healthcare initiative and organizations such as the Institute for Healthcare Improvement.

Still, decreasing risk for our patients is critical and is a national emergency. In 2010, a Harvard study published in the *New England Journal of Medicine* reported that as many as 25 percent of our patients are harmed by medical errors.

"We are burying a population the size of Miami every year from medical errors that can be prevented," says Leah Binder, president and CEO of Leapfrog.

Yes, preventable medical errors have been touted as a leading cause of death in our hospitals, the very institutions that patients are admitted to in order to stay healthy or combat disease.

Reasons for medical errors are not hard to find. Just ask any physician.

Imagine for a second performing hospital inpatient rounds on those entrusted to your care and being unable to read a consultant's handwritten notes. This consultant was specifically requested for his or her specialized expertise in the clinical management of your patient, yet, because the notes are illegible it is, unfortunately, all too often ignored...or even worse: inaccurately interpreted.

Indeed, prior to Epic's institution, this was one of the common-knowledge facts that physicians dealt with on a daily basis.

It does not take much of a leap of faith to understand how scribbled and inscrutable notes, poorly understood, might negatively influence patient outcomes.

It does not take a leap of faith to understand that medication errors have been a source of clinical error forever and yes: indecipherable physician's orders have been a strong contributor to the problem.

It does not take a leap of faith, then, to envisage that a type-written note or order might help solve this and other issues.

Medical care is often fragmented and opaque, in part due to the lack of physician networks and technology designed to put every data point into one system, available to everyone, for the patient's and treating physician's benefits.

Epic is that system and is one step in the right direction. Wellstar's decision to 'go live' with this system December 1st of 2013 was an appropriate step in the direction of improved healthcare.

Technology has been cursed and sometimes ignored but we have been on an inexorable march for decades into the field of healthcare technology. This march will not end until patient care improves, preventable errors are - well - prevented and information can be shared and accessed across the many physicians in the network that must have information to properly and expertly treat the patients that are entrusting their lives to the medical profession.

I was smiling this weekend when I was able to access data on my inpatients by using an app on my iPhone.

Deborah Frazier, an author in this issue, is smiling too, but most importantly: my inpatients experienced better care.

Enjoy,
Stan Dysart, MD MBA
Editor at Large



CCMS

Be a Contributor

Nominate yourself or a fellow CCMS peer for article submission. Send article inquiries and requests to joanne.thurston@cobbdoctors.org



Cobb County Medical Society had a great year, and this is primarily due to the countless hours that Joanne Thurston, executive administrator of CCMS, has worked to make sure the society represents our doctors well in Cobb County, Atlanta and beyond. However, the physicians that volunteer to lead this society have seen the fruits of their labor produce many results as well. Among these results is a twenty percent increase in membership. By doctors inviting doctors to join we multiply ourselves and expand the areas of influence we have in the places we work. The PAC contributions have increased by thirty-five percent. The swell in contributions may be due to an election year, but also an enhanced interest in the political arena. The circulation of Scripts has increased from 1,500 to 2,000 this year, thus broadening the sphere of influence of our doctors who choose to publish their work in the magazine. And finally, we had the largest gathering of physicians in the history of the state of Georgia when Dr. Ben Carson came to speak at our annual joint meeting with other Atlanta area medical societies. Thank you for letting me serve as your President this year. Meeting doctors from around the state and giving input into the operations of the society has allowed me to grow as an individual as well as a physician. I will continue to serve on the board to improve the quality of our society in the years to come.

MARK HUFFMAN, MD | CCMS President
member since '11

2014 President: Despina Dalton, MD

Dr. Dalton is Board Certified in Pediatrics, Pediatric Emergency Medicine and Clinical Nutrition. She speaks English, Greek and Spanish. She is a member of Cobb Disaster Response Team and served as Training Director. Dr. Dalton received her MBA from George Washington University in August 2010. From June, 2011 to June, 2013 Dr. Dalton served as Chief of Staff at WellStar Cobb Hospital.

The Society




Today's hot topic in the news, on Facebook, in the waiting rooms, in the hospital and the physicians' lounge is HEALTHCARE. Questions are what is covered or not covered, who is covered or not covered, what is the cost, what are the co-pays, and how much is the deductible? You don't hear "how is my physician going to keep practicing in this environment?" The impact on each of you will be traumatic. I'm not being a little over dramatic on this issue. Physicians are now "providers." Your reimbursements are decreasing and new regulations are added daily. Your medical society is advocating for YOU, the physicians, in this process. We are joining forces with other Medical Societies, Healthcare Systems, and Specialist Societies with the focus on allowing the Physicians to practice medicine in a "physician/patient relationship." CCMS asks the questions: Is it good for the physician? Is it good for the patient? It is good for medicine?

Become involved, stay aware, keep informed and be active in your medical society.

Joanne

JOANNE M. THURSTON | CCMS Executive Director
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MEDICARE D

HOW A FEW MINUTES COULD HELP SAVE YOUR PATIENTS THOUSANDS OF DOLLARS.

BY: STEVEN L. COHEN, MD
member since '91

Dr. Steven L. Cohen is a graduate of the University of Michigan and earned his Doctorate in Medicine from Emory University Medical School in Atlanta, Ga. He has been in practice since 1986 and is board certified by the American Board of Internal Medicine. He is also a contributing author of "Transforming Health Care Through Information." He was recognized by the National Committee for Quality Assurance (NCQA)'s Bridges to Excellence program for their quality diabetes care and management.



Are you willing to spend a few minutes learning so that your patients and relatives with Medicare can save hundreds to thousands of dollars every year? If the answer is "yes," you need to visit medicaredrugssavings.org, a website reviewed by Clark Howard.

Since 2006 people with Medicare have been able to sign up for Medicare D or Medicare Advantage plans. Under traditional Medicare, the government directly pays the provider for rendered medical services. In contrast, private insurance companies (Blue Cross, Aetna, and many others) sell Medicare D and Advantage plans to people on Medicare, while the government subsidizes the premiums on these plans.

However choosing the best Medicare D or Advantage plan can be next to impossible. In the Atlanta area one can choose from over fifty possible plans, which cover different medicines and have different copays, premiums and deductibles. A 2012 study showed that the average person on Medicare D who is taking a specific group of medicines could save \$368 annually by choosing a different plan which covered the same medicines and that many people could save much more than this. This study found that only 5% of people chose the least expensive plan. The savings are probably greater for those who have a Medicare Advantage plans.

On www.medicare.gov you can enter your zip code and medicines and get a report showing the estimated annual out-of-pocket cost for all of the available Medicare D and Advantage plans. Unfortunately few people are aware of this tool and many older people on Medicare don't have the computer literacy needed to take advantage of it.

As a general internist in Austell, Georgia, I see many people who have trouble paying for their medicines. In late 2012 an elderly patient came in on the verge of tears. She was unable to pay for her food, mortgage and medicines, so she was going to move in with relatives and let the bank foreclose on her home. After seeing this, I set up a free nonprofit educational website: medicaredrugssavings.org. A video on the web site clears up confusing details about Medicare and shows you in a step-by-step fashion how to find the least expensive plan which covers the medicines which a person is taking. The Healthcare Professionals tab has a four minute video showing ways to help your patients as well as handouts you can download and give to your patients. The Georgia chapters of the American College of Physicians and the American Academy of Family Physicians, WellStar, Apollo MD, the Georgia Council on Aging and Georgia Cares plan to promote medicaredrugssavings.org. Congressman Gingrey's office recommended it as a resource to the other congressional offices in Georgia.

How much could this initiative help? As noted above, the average person on Medicare D would save \$368 annually. Extrapolating this to the US Medicare population of 46 million people would yield an annual savings of \$16.9 billion. The state of Georgia subsidizes the Medicare D and Advantage costs for the 131,231 people who are on both Medicare and Medicaid and a larger group of 304,514 people who have low incomes. If the state could help these groups find a less expensive plan, \$368/person/year yields an annual savings of \$48 million for the Medicaid population and \$112 million for the lower income population. **S**

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INNOVATIVE HEALTH CARE COLLABORATIVE

WellStar Independent Physician Association

BY: JEFFREY THARP, MD
member since '92

Dr. Tharp earned his Doctorate of Medicine and completed his residency at the University of Tennessee in Memphis. He is board certified in internal medicine. He was recognized by the National Committee for Quality Assurance (NCQA)'s Bridges to Excellence program for his quality diabetes care and management. Dr. Tharp is Chief Medicine Division Officer for WellStar Health Systems. He is past-president of CCMS.



As an opportunity to utilize the best of our local health care resources, WellStar Health System launched an Independent Physician Association (IPA) in January 2013. This collaborative embodies the enormous potential that an association of independent physicians, employed physicians, and health systems can have on patient quality and cost savings. The WellStar IPA stands to have a great impact on health care delivery within Cobb, Bartow, Cherokee, Douglas, Paulding counties, and beyond. Over one thousand physicians in our area have joined the WellStar IPA.

Historically, the networking of independent and employed physicians and hospitals is not new. In the mid-1990's, the Physician-Hospital Organizations (PHO's) were vehicles of bonding physicians and hospitals into a unified negotiating entity with respect (primarily) to managed care contracting. The current concept of the IPA's focuses more on savings through improved quality, as well as operations-based cost savings. Often, regulatory and compliance concerns limited affiliations; the IPA model and, particularly, the concept of a Clinically Integrated Network (CIN) appear to have fulfilled requirements for realization of "claimed efficiencies" (FTC 1996), and its formation is congruent with tenets of national health care reform.

The IPA's objectives include improving quality by coordinating systematic patient care models. One of the most challenging aspect of improving quality is in data collection. Quality improvement requires good data. While an integrated electronic health record is preferred, other relevant information may be collected through claims data. This process has been done effectively across the nation.

Joining the WellStar IPA allows collaboration with other community providers. In addition, IPA group purchasing mechanisms can lead to cost savings, and membership in the WellStar IPA results in eligibility to see patients insured by the new Piedmont-WellStar Health Plan.

One of the earliest 2013 initiatives of the WellStar IPA has been to advance the formation of a Clinically Integrated Network (CIN). The CIN can serve as a collaboration between private practice and employed physicians as well as hospitals to develop "home grown" initiatives which improve the quality and efficiency of how we deliver care, locally. For these initiatives to be successful, the network members have a high degree of cooperation and interdependence, and the CIN systems have been recognized by the FTC, thereby allowing joint-managed care contracting to accelerate improvements in health care delivery.

The mechanics of the network include identification and adoption of "best practice" treatment plans, development of monitoring of outcomes data, collaboration with WellStar Health System to improve processes of care, and participation in contractual arrangements that financially recognize the physicians' efforts to improve quality and efficiency. Some potential metrics include: chronic disease management, care episode management, generic drug use, patient satisfaction, and improved communication among specialties for care coordination.

The IPA has partnered with Provista Group Purchasing Organization to provide cost savings, better service, and administrative ease to participating practices. An estimated 12-15% savings are expected to be realized in supply chain savings on overhead items from office supplies and surgical supplies to office pharmaceuticals and practice administration (which would include computer systems and furniture).

The physician leadership of the WellStar IPA is divided equally between independent and employed physicians on the "Board of Participant Representatives," with Dr. Arif Aziz serving as chairman, and Dr. Barry Mangel serving as vice-chairman. Quarterly education sessions are held at multiple locations in the area to provide information on products and services for IPA providers and office staffs. Newsletters have also been distributed to the participants.

Membership eligibility requires a physician to have admitting privileges (in good standing) or to have a written relationship with another MD with admitting privileges at one of the five WellStar Hospitals. Members relationships with other health systems are required to be free of conflicts of interest. For more information please contact Doug Harvill, Dir. IPA Ops. at 470-644-0177 (doug.harvill@wellstar.org) or Cindy Toler, Mgr. Provider Relations at 470-644-0175 (cindy.toler@wellstar.org).



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WALKING DOWN THE RISKY CORRIDOR OF OBAMACARE

BY: SEN. JUDSON HILL (R-MARIETTA)

Sen. Judson Hill serves as Chairman of the Georgia Senate Finance Committee, the Cobb and Fulton County Legislative Delegations and a national legislative Healthcare Task Force. He represents the 32nd Senate District which includes portions of Cobb and Fulton counties.



Over the past few months, we have heard many disparaging stories about health care in Georgia: good doctors leaving practices, nurses being pressured to focus on quantity over quality and office staff becoming overwhelmed by new insurance requirements. Unfortunately, I'm afraid stories like these will only become more common.

The common denominator is the continued implementation of a federal health care reform plan that is exceeding all expectations, and not in a good way. I'm not sure even former Speaker Nancy Pelosi realized the extreme adverse consequences of this legislation when she told America they needed to pass the Bill to learn what's in it. This is not to say that the consequences of Obamacare were never intended by its authors.

When President Obama signed the Affordable Care Act (ACA) into law in 2010, he publicly praised Congress for their efforts to provide healthcare to individuals with pre-existing medical conditions. Ironically, just three years later one health insurance program has already stopped enrolling new pre-existing condition patients, citing a need to control costs. And that's not all. Individuals who enrolled before the cutoff date for the Pre-existing Condition Insurance Program (PCIP) were thanked with, not lower, but higher out-of-pocket expenses - up to a \$6,000 increase for in-network physician services plus an increase to \$10,000 for out-of-network services. The PCIP is not really affordable for most individuals.

Obamacare has been plagued with problems since the beginning - no surprise to conservatives. To counter some of the bigger political problems with the law, President Obama is now unilaterally changing the ACA without required Congressional authority. He is intentionally circumventing the Constitutional checks and balances that were established to protect our personal liberties.

Recently the Obama White House proposed a one-year extension of current health insurance policies with the hope that state insurance commissioners and insurance companies will reinstate the millions of canceled policies. These policies that Obama wants to temporarily extend still violate Obamacare and will be cancelled at the end of 2014. Most of the people cancelled are young and healthy which puts the financial sustainability of many insurance companies at risk since less-healthy people require more expensive healthcare. Obama's short-term political "fix" actually causes greater problems and adversely affects millions of Americans. Many now believe the ACA's indirect intent is to put most private insurance companies out of business, forcing Americans into a government-run single provider healthcare program, like Medicaid.

Another consequence of Obamacare is its increased price tag for State Medicaid plans. So far it has cost Georgia taxpayers more than \$150 million. Next year Georgia is estimated to pay an additional \$150 million to finance Medicaid's new federal insurance premium taxes, increased Medicaid enrollment, added provisions for teachers and state employees, and increased primary care physician reimbursement rates. Georgia's Medicaid enrollment has always been below the national average; however, Obamacare's mandates are now expected to increase Georgia's Medicaid population over 20 percent in the next six years, with corresponding cost escalations.

For a limited time period, ending 2014, Medicaid reimbursements for primary care physicians will increase almost 100 percent. Doctors, and all health care professionals, deserve to be paid fairly for their services. These higher payments, however, only last 24 months and are paid with money we do not have. When 2014 comes to a close the money runs out and these physician reimbursements will probably be lowered to "traditional" levels. Then it will be even more difficult for patients to find doctors who will take Medicaid and for hospitals to absorb the additional expense of many more patients in their Emergency Rooms. It's rather insidious that the White House is offering this temporary money to doctors with the full knowledge that the money comes with another promise the government does not intend to keep.

The mesmerizing Obamacare promise of "affordable, quality health care for all" comes at a tremendous cost. Even now medical professionals are leaving the field; and more will follow. Health insurance premiums for middle class families are skyrocketing and businesses are being forced to choose between keeping people employed, cutting employees' hours or closing their doors. The financial, business and industry expense of Obamacare have risen far beyond their early projections. While the initial cost estimates for the "un-Affordable" Care Act was a price tag Americans could not afford to pay, the real cost is even higher. Without quick action accessible and affordable healthcare will end and with it healthcare as we know it. Now is the time to renew our resolve to repeal Obamacare and to aggressively support the numerous conservative healthcare reform solutions to truly bring patient-physician-centered affordable healthcare to all Americans.



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FUTURE OF HEALTHCARE INFORMATION TECHNOLOGY

BY: DEBORAH FRAZIER - BLUEWAVE COMPUTING, INC., HEALTH IT SALES MANAGER

What do the Affordable Care Act, Meaningful Use, HITECH, HIPAA, ACO's, and Pay-for-Performance all have in common? Answer: They are all dependent on the efficiency of the network. Most people in the healthcare field think of the network infrastructure as the necessary evil, but in the very near future it will be considered a necessary tool for doctors to get paid, receive referrals, and improve outcomes.

Healthcare Information Technology is something to embrace, not fear. With the right plan you will feel empowered and in control of the outcome for your practice. However, the timeline to have everything implemented is two years. 2016 is the final stage of Meaningful Use 3's implementation. At this point the government's vision is to have every practice and hospital in the nation connected through Private, Regional, State, and Federal Health Information Exchanges (HIE). So what should you do over the next few years to get prepared?

1 Start Planning NOW

Similar to the physician unemployment rates, IT support professionals have a 1% unemployment rate across the nation. Out of that 1% there are only a slight fraction who have experience in Healthcare IT. If you align yourself with the correct resources now you will have a predictable plan moving forward. If you wait, those same resources will likely be strained and unavailable.

2 Get HIPAA Compliant

The final goal of the government is to have everyone's records connected. For this reason every covered entity and business associate must be HIPAA Omnibus Compliant. You must run a complete Risk Assessment of your environment, which includes 2013 HIPAA Omnibus Privacy & Security Policies and Procedures, Workforce Training, Network review of Administrative/Technical/ Physical Safeguards, Vulnerability Test, Business Associate Check, and a Remediation Plan. If you have not satisfied these requirements it is imperative to do so promptly. The audits and enforcements have begun and are ramping up.

3 Review Your Software


Many Electronic Medical Record companies are going out of business right now because they cannot afford to meet the Meaningful Use 2 requirements. Make sure your EMR provider has the financial wherewithal to meet the increasing demands.

4 Review How You Use Your Technology

Hardware is cheap. The most important thing is to think through how you are securing and utilizing your data. Here are some mistakes that have caused extraordinary downtime for the practice:

- a. Using old technology that does not work well with new software applications
- b. One point of failure
- c. Wrong bandwidth for practice needs
- d. Using antiquated software that does not meet current demands
- e. Using home equipment for business purposes
- f. Patched Together Network Plan – Fixing the symptoms rather than understanding the root cause

5 Review Your Vendors

Simply signing a business associate agreement is not enough anymore. Under the new HIPAA Omnibus you are required to verify that they are HIPAA Compliant and their subcontractors, who have access to your PHI, are HIPAA Compliant. Here are a few simple hints to get started: Ask to see a copy of their 2013 Privacy & Security policies and procedures; Ask random questions from the Administrative, Technical, and Physical safeguards; If they have problems answering these questions, then do not do business with them. How can they protect your practice if they don't understand or refuse to follow the privacy laws? 

This article is part of a series covering the future of Healthcare Technology in 2014. We will be focusing in on these same subjects throughout the year. In the meantime, remember Healthcare IT will be your most valuable tool in the future if you design it right from the beginning.



Long Term Care Insurance

BY: KELLY MILLER, AAMS - OAK TREE GROUP FINANCIAL STRATEGIES

Long term care is not just an issue that affects older Americans. It is very specific and personal to each of us and can affect us and our families differently. With the medical field making advances on diseases we are living longer. The longer we live the likelier we are to need someone to help take care of us.

Statistically at least 70% of the people over the age of 65 will need long term care services. (Medicare & You, National Medicare Handbook, Centers for Medicare and Medicaid Services November 2012). The average life expectancy after an Alzheimer's disease diagnosis over the age of 65 is four to eight years. (Alzheimer's Disease Facts and Figures, Alzheimer's Association March 2012).

Long term care covers a wide range of supportive services, provided to those who are not able to care for themselves, due to a chronic illness, disability or severe cognitive impairment where services are expected to last at least 90 days.

There are 6 basic Activities of Daily Living (ADL):

Dressing, Eating, Bathing, Toileting, Transferring & Continence.

Whether the result of an accident, stroke, dementia or other chronic illness/condition - if a person is unable to perform two or more of these activities, they may need long-term care.

Long term care is not just for nursing homes. It can occur in a variety of settings and can change over time. It may start at the patient's home with unskilled care from family and friends and then include skilled nursing and eventually the need for an assisted living facility.

Once the insured person has met the eligibility of their contract, the policy will pay a daily/monthly preset amount towards their care. Benefits will continue for the length of the policy or until the person no longer needs care. There are policies available that will cover home and community-based care services, including physical speech, occupational therapists, home health aides, visiting nurses, adult day care and hospice care. Some policies even cover care provided by the family or friends while the person lives at home. Payment is usually made to the insured but can be redirected.

What is your plan? If you or your partner had an extended care event now or in the future, what is your plan? What is your strategy? Where will your support come from: family; friends; local resources? How will you pay for it? Current income; savings; retirement savings; other assets?

There are multiple Long Term Care Insurance solutions to consider. There is not one solution for everyone.

Traditional Long Term Care Insurance can be a practical and cost-effective way to help pay for services. For many individuals, 20 years of premium payments can equal the cost of six months in a nursing home. The policies may cover you or may be offered as a shared policy with your spouse.

Linked Benefit Policies provide a convenient way to combine life and long term care insurance into a single policy. A Linked Benefit policy will create an immediate death benefit for your beneficiaries and a pool of money to reimburse expenses for covered long term care needs. With these policies, the amount of money your beneficiaries stand to inherit is reduced by the amount of money used for long term care expenses.

Life Insurance with an Accelerated Benefit Rider for Long Term Care Services is a way to access a significant part of your life insurance death benefit while alive to assist with your long term care expenses.


There are several factors to review when considering Long Term Care Insurance:

The benefit amount: how much the policy will pay per day/month for care.

The benefit period: how many years of care you receive with the maximum daily/monthly benefit.

The elimination period: how many days of care you need to pay for before the policy will start providing a benefit.

Does the policy cover home care? Does the policy offer inflation protection? Each factor has its own cost and will affect the overall cost of your policy. By considering your needs and the money you want to spend you can find a policy for you.

As with all planning - now is the time to plan. Your current age and health are factored into the cost and will determine if you qualify for a policy. With the wide range of potential solutions and the expectation of need, do not delay in creating your own Long Term Care plan. 

I am CCMS

with Clem M. Doxey, MD
member since '70



GRADUATE OF: LSU SCHOOL OF MEDICINE 1962
SPECIALTY: DERMATOLOGY
PRACTICE: : MARIEPTA DERMATOLOGY &
THE SKIN CANCER CENTER
photography by: Tim Soong

Q WHAT MADE YOU DECIDE TO PRACTICE MEDICINE?

After spending three years and three summers in Chemical Engineering and finding out that my job openings when I finished would be either in Saudi Arabia or Venezuela, I took Zoology 101, audited Zoology 102 and applied to Medical School.

Q WHAT IS ONE OF YOUR GREATEST MEDICAL ACCOMPLISHMENTS?

President of the North American Clinical Dermatological Society for three years – we met internationally and during my [tenure] we met in China, Ireland and Austria. We presented research papers in coordination with the best dermatologist in each of these countries – it was exciting, informative and something that I was very proud of – I was a member from 1986 to the present time.

Q WHAT DO YOU THINK IT TAKES TO BECOME SUCCESSFUL IN YOUR FIELD?

1st: Dedication to making a difference and striving to be as knowledgeable in your field as possible – mine being Dermatology.

2nd: Love the interaction between you and your patients.

3rd: Hard work never hurt anybody.

4th: People who work with you should be as dedicated to the care of patients as you are.

Q WHAT DOES CCMS STAND FOR AND WHAT DOES IT PROVIDE FOR YOUR COMMUNITY?

CCMS has historically produced outstanding clinical physicians who have been interested in the best treatment of their patients, no matter what that required. These people have been leaders and participants in the financial, political, cultural, and scholastic advancements of our county.

Q WHAT DREW YOU TO PRACTICE IN THIS AREA?

On a vacation trip from New Orleans I stopped to visit Dr. Goodman Espy and met Dr. Lou Fortson, who both influenced me greatly in deciding to come to Cobb County.

Q NOW THAT YOU ARE RETIRED, HOW DO YOU PLAN TO SPEND THE EXTRA TIME?


I am now retired for 68 days and I do not know how I [ever] worked. I am busy constantly with one project or another and I can truly say that at no time in these 68 days have I ever been bored.

Doxey Retires

Dr. Doxey is the founder and medical director of Marietta Dermatology & The Skin Cancer Center and has been caring for his patients for over 43 years. Dr. Doxey began as a one-man show taking call 24/7 and caring for the dermatology needs of patients. He has since grown to three locations (West Cobb, Canton & the main campus in Marietta) with 11 Physicians, 7 Physician Assistants, 33 Medical Assistants and over 100 staff members.

Dr. Doxey graduated with honors from Louisiana Medical School in 1962, completed his internship at Oakmoll Naval Hospital in 1963 and attended flight surgery school for 6 months in Pensacola before the marine corps. After serving with the First Marine Brigade in Vietnam as a flight surgeon, Dr. Doxey completed his dermatology residency at Tulane University in 1970. Doxey started his medical practice in Marietta shortly thereafter, and became the founding partner of what has now grown to be the largest private practice dermatology group in the state of Georgia. Dr. Doxey has held the high distinction of being one of the very few dermatologists to hold the position of Chief of Staff of a major medical center, serving as Chief of Staff for Kennestone Hospital in 1986. An active member of the Atlanta Dermatology Association, Dr. Doxey served as President of the Atlanta Dermatology Association (1980) and was the President of the North American Clinical Dermatologic Society (NACDS) from 2006-2007, as well. Dr. Doxey is also an active member of the Georgia Society of Dermatologists.

In addition to his many contributions to the medical community, Dr. Doxey has shown the spirit of volunteerism in the Marietta community, as well, through his forty-year association with the Rotary Club. Lynn Payne has been Dr. Doxey's MA for over thirty-two years. "He is the sole reason that anyone in our practice is fortunate enough to enjoy the rewarding careers that we do," Payne states, "his vision, his compassion, his care for others and his desire to provide excellent medical care have been the foundation for an extremely successful medical career." Dr. Doxey has often been referred to as the "Patch Adams" of dermatology. It is evident that he cares for his patients, staff and peers and empowers the team he created to help represent him and his core values, regarding patient care.

Dr. Doxey's smile will be missed in the halls and waiting rooms of Marietta Dermatology and the Skin Cancer Center as well as in the lives of his patients and their families. 

UPDATE ON GEORGIA'S TELEMEDICINE RULES

BY: JOHN S. ANTALIS, MD

As a member of the Georgia Medical Board, we are tasked to perform several duties. One of them is to create rules of governance for medical practice. These rules include such recent topics as prescription pain medication use, pain clinic licenses, institutional licensure, and telemedicine. These are written, reviewed, sent out for public and physician feedback, rewritten, and then submitted as part of the Georgia Code.

The topic of my discussion is telemedicine, or telehealth. This is the application of information technology currently, and includes:

1 Store and Forward

Obtaining medical data and then transmitting this data to a physician for evaluation. It is used in radiology, dermatology, and pathology.

2 Remote Monitoring

This enables practitioners to monitor patients away from a health care facility. It is used to manage chronic diseases, such as heart disease, diabetes, and COPD.

3 Interactive Telemedicine

Most commonly thought of when it comes to telemedicine. It is the real time interaction between patient and physician.

With the explosion of information and telecommunication technology through telemedicine, patients and physicians have the increased ability to access health care with the potential to lower costs and improve the quality of care. Studies have already found this to be true in rural and underserved areas, in addition to lives saved in critical care and emergency situations.

As with any new technology there was opportunity for telehealth companies to start up overnight and begin practicing in communities in Georgia. Some companies were legitimate. However, some were based out of state without any Georgia connections, or had no direct physician-based involvement within the community they were serving, which left patients without anyone to contact if and when treatments went awry.

Over a year ago the Georgia Medical Board decided that there had to be certain fundamental medical practice principles in telemedicine to ensure the quality of care and safety of Georgia citizens.

The rules on the Georgia Medical Board website are labeled "Practice Through Electronic or Other Such Means": 360-3.07. The rules are based on the premise that telemedicine, when used, must maintain the physician-patient relationship. The term "practitioner" in the rules means physicians, physician assistants, and nurse practitioners.

Key points in the rules include that all treatments and/or consultations must be done by a practitioner licensed in Georgia. A history must also be available to the treating practitioner who is using telemedicine. There must also be complete documentation of the encounter with a copy available to the referring physician, when required.



It is also very important to the Board that the patient has access to the treating telemedicine practitioner. The patient must be given the name, credentials, and emergency contact information of the practitioner. The only exception is when the patient is in the prison system. In addition, there must be appropriate follow-up given by the telemedicine practitioner if there is need for emergency care related to treatment. Finally, the practitioner must make an effort to see the patient for a follow up at least once a year.

For a physician to delegate a nurse practitioner, or to supervise a physician assistant in telemedicine, the physician must show that it is within the extender's scope of practice and that the extender has demonstrated competency with the use of telemedicine. This situation is often seen at a public health facility, public school nurse, community mental health center, etc. Once the nurse has established a medical relationship with the patient in one of these facilities, a nurse can use telemedicine to access a licensed extender who is their equal, or a superior, such as a physician.

Other points to note in the rules state that telemedicine rules do not preclude the authorization of controlled substances for treatment of pain or chronic pain. These rules are in 360-3-.06. These rules also do not prohibit any other diagnostic tests outside of telemedicine from being done in order to make a diagnosis.

But I believe the most important rule is that the practitioner using telemedicine will be held to the same standard as those treating patients in the more traditional method of medical

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care. Failure to conform to the standard of care as the traditional method will subject the telemedicine practitioner to disciplinary action by the Georgia Medical Board.

To close, telemedicine offers multiple options of medical care delivery. It holds great promise to increase access and lower costs, and saves lives - especially in the underserved and rural areas of Georgia. If we are not careful, it also presents an opportunity to those who may use unscrupulously. The Georgia Medical Board created these rules with one purpose in mind. This was to make sure that the citizens of Georgia are protected when this technology is used. As you may note throughout the rules, the patient-physician (practitioner) relationship is paramount and must be maintained throughout diagnosis and treatment, including the aftercare. 📞

Dr. Antalis serves on the Georgia Composite Medical Board. He is a Board Certified Family Physician with many years of clinical experience in the treatment of environmental and food allergies. Dr. Antalis practice is Dalton Family Practice in Dalton, GA.





Behind the White Coat

“Making Music” with Dr. Bilotta


by: Robert Walker-Bunda

photography by: Tim Song

“In high school I had the opportunity to observe a friend’s ACL surgery... and I thought it was absolutely fascinating that a physician used power tools and tissue to create a new ligament.” This was the experience which Dr. Jessica Bilotta credits with “sealing the deal” when it came to choosing a career path. The budding Sports Medicine surgeon was young, but as she remembers, medicine and the human anatomy were always of a keen interest to her: “I took my Fisher Price doctor kit all around the house [and] would ‘cut’ my family open and scoop out the bad parts with my plastic knife and spoon, and ‘sew’ them closed.”

It was during these early years of impromptu mock-surgeries that Bilotta’s parents decided she should learn the piano. “I started around five years-old and I absolutely loved it.” Bilotta went on to continue playing piano and singing in chorus throughout grammar and high school, in addition to an already busy schedule of playing sports. However, in spite of her passion for music, medicine remained at the forefront of Bilotta’s aspirations. “The piano and singing were more of a hobby, not a possible career choice for me.”

Nowadays Bilotta plays when she “has time” – a rarity for a working surgeon who is also a wife and the mother of an eleven-month-old daughter. But the same joy brought into Bilotta’s life by music for so long is now shared by her family: “I enjoy playing for my daughter, my husband, and even my cat who comes to listen.” And all those hours spent practicing and honing her abilities are not lost or wasted in her current life and profession. “I can remember long hours of practice... I think this discipline has reached other areas of my life as well. I don’t give up easily when I want to accomplish something.”

And so, although Bilotta may never grace the stage of Carnegie Hall or compose a symphony, there is great value and pleasure, still, to be gained from the thunderous concertos of Beethoven or lyrical (and technical) etudes of Chopin. “Without music my life would definitely be more empty,” admits Bilotta. “I love to play, I love to sing – music makes me feel good.” And in the often stress-filled work of a surgeon and hectic schedule of a mother, it’s nice to find solace in life’s simple pleasures. As Bilotta puts it: “there is very little that your favorite song on the radio can’t erase after a bad or long day.” 

JESSICA BILOTTA, MD
member since '12

“I can remember long hours of piano practice... I think this discipline has reached other areas of my life as well. I don’t give up easily when I want to accomplish something.”

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What to Look For In Making Your Med-Mal Decision

BY: JOE WILSON, JR., MD, CHAIRMAN AND CEO

Joseph S. Wilson, Jr., M.D., is chairman and CEO of MagMutual Insurance Company, the Southeast's largest malpractice insurer, empowering physicians to deliver quality care by leading the way in proactive patient safety resources and unrivaled claims defense.



As both a physician and chairman and chief executive officer of a medical malpractice insurance company, I can appreciate the conflicting emotions that many physicians undoubtedly experience when faced with the task of choosing a provider for medical professional liability (malpractice) insurance. Let's be honest: Most physicians would probably prefer to spend as little time as possible contemplating the possibility of being sued for malpractice. I can certainly identify with that emotion. But in my role as CEO of MagMutual, I know just how important it is for physicians to make an informed choice for medical professional liability (MPL) coverage. For starters, I'd like to stress that medical malpractice insurance is not just a commodity, and not all MPL carriers are created equal. Unfortunately, many physicians may not appreciate the difference until they find themselves involved in a lawsuit. Ironically, the quality of coverage provided by your MPL policy is not unlike the concept of quality care in the medical profession. As physicians, we appreciate that not all practitioners are equally skilled. When we are in need of medical care for ourselves or our families, we instinctively seek the most qualified and highly-regarded physician known to us. Physicians should exercise the same degree of due diligence when seeking MPL coverage.

When choosing an insurance carrier there are a number of factors that physicians should take into consideration, some of which should be fairly intuitive. For example, you'll want to align yourself with a company that has the financial strength to pay settlements or judgments against its policyholders when required. Many Cobb County physicians will

recall the failure of an MPL carrier in the 90's, leaving them without coverage for claims. And, of course, at the risk of stating the obvious, physicians should look for an insurer that has an outstanding track record of defending its policyholders. Physicians will also want to look for carriers that provide a robust suite of risk management and patient safety resources, including accredited CME courses.

There are, however, certain considerations that might not be quite so intuitive. One such consideration is an extremely important but often overlooked item known as "consent to settle." Simply put, a "consent to settle" clause documents that the insurance carrier will take on your defense unless you decide to settle a claim based on its merits. However, not every MPL policy includes a "consent to settle" clause, and many physicians have been surprised to find that their insurance companies have settled claims on their behalf without their knowledge. This clause will provide you with some peace of mind in that you will have a chance to provide your input and have access to a lawyer to make sure you make an informed decision.

I would also like to address the concept of mediation as it pertains to the settlement of medical malpractice claims outside the litigation process. A recent article in this publication provided a useful explanation of the mediation process. However, physicians should be aware that there are potential downsides to mediation.

By definition, the concept of mediation implies an anticipated compromise between two parties. In the adjudication of malpractice claims, this often means that both the claimant and the physician will "give a little" with respect to an ultimate financial settlement. If both claimant and physician agree that a medical injury should be compensated, mediation can play a useful role in determining a mutually acceptable financial settlement.

However, if a claim appears to be exaggerated or without foundation, the physician is entitled to defend his or her actions and should not automatically feel compelled to settle. The physician should understand that by agreeing to mediation, it is likely that some level of compensation will be required, and that even if there's no formal admission of negligence the settlement will still need to be reported to the National Practitioner Data Bank and state composite board.

Physicians seeking employment should consider what kind of MPL protection is favored by the prospective employer. Some institutions incentivize employment by providing basic coverage which the physician may supplement at his or her own discretion. In other situations, the employer simply negotiates premium rates on the physician's behalf. With respect to "consent to settle," it is also worth noting that with hospitals or large practices, consent to settle often resides with the entity and not with the individual employed physician.

While many physicians may dread the process of securing medical malpractice coverage, it is well worth the time to make an informed decision. It is my hope that this discourse has served as a useful roadmap in your decision-making process.

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Retired of Cobb Physicians

BY: WALTER M. LIGON, MD
member since '68



The Retired Physicians of Cobb Group is affiliated with the CCMS. Assistance in notification mailings and venue selection and arrangements are handled by your Medical Society. Eligibility to attend this social event is open to anyone who is interested.

We met December 3rd, 2013 at the Marietta Country Club. There were about forty attendees, including retired Physicians, their wives and several widows. All of the retired Physicians were male. This pointed out the changes in our culture and society, as we have more female practicing Physicians now.

Another indication of this change was included in the discussion. The Auxiliary, which was composed of spouses, is now officially disbanded. We were informed that records for the Auxiliary dating back to 1905 (the date of the founding of our Society) have been donated to Kennesaw University for preservation and public display. If anyone has pictures, files, notes, etc on the past activities of CCMS and/or the Auxiliary please consider giving it to KSU for archiving. This information was presented to our meeting by Bebe Meadows, the widow of the founder of this Group.

We were reminded that this meeting offered a unique opportunity for all to renew our memories. The following quote was given:

"Life is short, and we do not have much time to gladden the hearts of those who travel with us, so be quick to love and make haste to be kind." - Henri Frédéric Amiel (1821 - 1881)

The only death to report for this year was Dr. Tom Cooper. Dr. Talbert Williams and Dr. Eugene Harley gave their remembrances of their partner, Dr. John Harbor, noting that he came here from Philadelphia (Mississippi). They both had praise for his wonderful clinical skills and his addition to their combined enjoyment of the practice of medicine.

Your Medical Society is fortunate to have the leadership in the front office. Through it we hosted the largest gathering of physicians in the history of Georgia when Dr. Benjamin Carson spoke to the combined CCMS and the Atlanta Medical Association. We can also boast that we are unique in that we have our own Political Action Committee. Retired physicians are urged to become active in the PAC, our profession depends on it. We were also asked to consider being a "Speaker" at community events to educate the public on "Knowing your Doctors." Call Joanne at the office to volunteer for these activities.

Parting words were:

*Fear less, Hope more, Whine less, Breath more,
Talk less, say more, Hate less, Love more,
And all good things will be yours. Swedish Proverb*

Time is Money - YOUR CASH FLOW

BY: JOANNE THURSTON, CPA
member since '01

Joanne Thurston is a consultant for Federal and State Legislators, government departments and subsidiaries. She provides support, accounting, and tax services to not-for-profit organizations, private businesses and individuals.

As our population continues to become more Medicare-eligible (Baby Boomers) the physician practice will continue to serve this population. One way to maximize your reimbursement is to know the different types of plans your patient may utilize. Individuals 65-years of age are eligible for Medicare. This entitlement is based on their own, or their spouse's Social Security contributions, and on payment of premiums. Medicare provides hospital insurance (Part A) which provides basic coverage for hospital stays and post hospital nursing facility and home health care. Medicare medical insurance (Part B) pays the provider a fee for each specific service. Prescription drug costs are partially covered under Part D, though this coverage is supplemental and not compulsory.

Medicare Part A:

pays only certain amounts for any one benefit period. A benefit period refers to the time you are treated in a hospital or skilled nursing facility or some combination of the two. The benefit period begins the day you enter the hospital or skilled nursing facility as an inpatient and continues until you have been out for 60 consecutive days. In each benefit period the patient must pay the hospital insurance deductible. This deductible for 2014 is \$1,216. If you are still inpatient on days 60-90, you must pay \$304 per day for 2014. After the 90th day the payment is limited.

Medicare Part B:

is the medical insurance. It is intended to help pay doctor bills for treatment either in or out of the hospital. Part B Medicare pays only for a portion of physician's fees, outpatient hospital and clinic charges, laboratory work, some home health care, physical and speech therapy, and very few drugs and medical supplies. There are heavy restrictions on what is covered and how much is paid. Part B Medicare pays only 80% of Medicare approved charges for a particular service or treatment. The patient is responsible for paying the other 20%. The physician can't ask the patient to pay the 20% before the charges are submitted to Medicare and the Summary Notice is received.

The physician submits the charges to Medicare; Medicare issues Summary Notice to state how much the Medicare Approved charges are and how much the patient is responsible to pay. The physician's office receives the Summary Notice and invoices the patients for the balance due. Patients may not understand the Medicare Summary Notice and therefore not remit the balance due to the physician. It may take several notices to the patient before payment is received. The revenue cycle for Medicare patients may be 90 days or more. Many patients covered by Medicare are on a fixed income. The thought of the unknown - or how much that 20% amounts to - deters some from seeking medical care. A simple ailment can, and often does become a major illness because of delay in treatment. The elimination of the "unknown" is what's known as the Medicare Advantage Plan.

Medicare Part C:

Medicare Advantage Plan benefits both the physician and patient. This plan fills gaps in basic Medicare. With a Medicare Advantage plan the patient and physician no longer deal with Medicare directly. These plans may be a managed care or fee-for-service plan. Before the patient eliminates most of the "unknown" amounts they will be required to pay a co-pay at the time of service, in substitution. For the physician these plans eliminate the need to deal with Medicare programs and, instead, allows them to deal with an insurance company. Physicians also receive the co-pay at time of service, which reduces the lag in payment for services and the need to invoice the patient.

Medigap:

coverage is available for any one covered under Medicare. Medigap comes from the fact that these insurance policies are designed to cover the gaps in Medicare deductible and the patient's 20% responsibility. This policy, also called supplemental coverage, has a premium in addition to the Medicare premium. These policies are meant to close gaps, not provide separate medical insurance, as the physician's reimbursement is handled like any other insurance billing, without the need to invoice the patient.

The fee for the service provided by the physician is the same whether it is billed under regular Medicare, Medicare Advance or Medigap. The big difference is when the reimbursement is received. Time is a cost of money, therefore the quicker you receive the fee, the better. Also, the elimination of invoicing your patient is good customer service.

"I WOKE UP THIS MORNING... and found I'd been sued!"

By: Tim Bone, President
MedMal Direct Insurance Company

After only four hours of sleep, thanks to an emergency call in the night from one of your patients, the alarm rings and you head for the kitchen to make some strong coffee. On the breakfast table is yesterday's mail, and there it is: a letter from a law firm. You open the envelope and read the first sentence: "You are hereby notified that Mr. Smith, as Personal Representative of the Estate of Mrs. Smith, intends to initiate litigation for medical negligence against you"

You have just been notified that you are being sued for medical malpractice by a law firm you have never heard of, on behalf of a patient you treated like family. The letter outlines selected "facts" and "theories of negligence" that paint you as the most uncaring and clinically incompetent doctor on the planet. You tell yourself "this cannot be happening!" You feel like throwing something against the wall. You are not alone.

Ten years ago, as many as 20% of practicing physicians were involved at some stage of a med-mal claim or lawsuit. Though that percentage has now been reduced, as the frequency of filing lawsuits against physicians and surgeons has decreased in the last few years, knowing that bit of data does not help your current attitude toward the plaintiff (the person bringing the lawsuit on behalf of the patient) and their lawyer. You are angry. You are in denial. This is normal. Take a deep breath, exhale slowly, and survive.

There are many ways in which a physician can be brought into a medical malpractice lawsuit. The above method of receiving an unexpected formal Complaint from an attorney representing the plaintiff is just one. Other ways in which you may recognize the potential of a lawsuit are (a) having a discussion with a disgruntled patient, or (b) receiving a letter from a "quality control" company asking for your written explanation of the clinical treatment you provided. While you should properly resolve perceived conflicts with your patients and fully comply with formal quality control issues, you should always ask for advice from your medical malpractice insurance carrier's risk management department or claims department before you formally respond to the questions posed. There is nothing wrong with asking for advice; and by doing so you will not lose your claims free discount with your insurance carrier as this is not a "chargeable" claim. After all, this is what you are paying for! Otherwise, should you choose to go it alone, the answers you provide may come back to haunt you at your upcoming deposition. And, yes, there will be a deposition in your future.

Attached to the formal Complaint will be a series of questions that will be labeled "Interrogatories." Again, do not answer them on your own. Call your med-mal insurance carrier, who will assign you an experienced med-mal defense attorney. You just became a member of a group you thought you would never join: your litigation management team. You are a key element of this team, but neither for your knowledge of the law nor for your experience in managing med-mal claims. You are not here to be the lawyer; rather, you are the scientist - and the team desperately needs your knowledge of the medicine in this case. It is your duty to educate them completely, yet in a fashion they will understand. The word "cardiomyopathy" is not in their vocabulary. They may think you are expressing empathy about a person who has just undergone a strenuous physical work-out! Keep it simple. Be patient.

After meeting with your litigation management team, and realizing that the court docket is crammed full with medical malpractice cases, you will be told that the next piece of this puzzle for which you need to prepare is your deposition. That, we shall discuss soon. For now, just remember: when an attorney asks you what time it is, simply tell him the time. There is no need to tell him how to build a watch.

And as you head home from this litigation team meeting, remember to not direct your anger at innocent parties whom love you. Yes, being sued is very personal. But you are the consummate professional, a physician. And despite the attorneys' posturing to gain advantage for their client, you are truly in control of your own actions. You are part of the most honorable profession in the world. Rather than dwell on this pending lawsuit, remember the words of Sir William Osler: "The best preparation for tomorrow, is to do today's work superbly well."



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2nd Quarter 2014 Issue: *Emergency Medicine*
Call for Article Submissions

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Congratulations Geraldine Wade, MD

Awarded Certification in the subspecialty of Clinical Informatics.
Clinical Informatics offered the first examination for certification
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CCMS

Upcoming Events 2014

January 18th, 2014

Business of Medicine - KSU

January 22nd, 2014

General Membership Meeting - Georgian Club

January 25th, 2014

MAG Board Meeting - TBA

February 1st, 2014

Business of Medicine Part II - KSU

February 5th, 2014

CCMS Board Meeting - Sugar Cakes

February 15th, 2014

Equipping the Physician Candidate- WellStar Windy Hill Road

March 1st, 2014

SCRIPTS Articles Due - Trauma/ER Issue

Our Officers & Our Mission

Debi Dalton, MD
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CCMS was established
in 1905

Mission Statement:

- We are physicians working together to promote the healthcare of our community
- We place the welfare of patients above other concerns
- We uphold the principles of medicine that are based on careful scientific study



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