Alabama Chapter, American College of Surgeons Journal

AUGUST 2015

Alabama Chapter, ACS Annual Conference
June 4-6, 2015
The Grand Hotel, Marriott Resort, Golf Club and Spa

A quarterly publication of the Alabama Chapter of the American College of Surgeons

Letter from the President

Bill Richards, M.D.
Alabama Chapter,
American College of Surgeons, President

Dear Colleagues:

The Annual Meeting, American Chapter/American College of Surgeons, Point Clear, Alabama, June, 2015, was most informative and enjoyable. The presentations-from-platform and poster sessions by visiting professors, faculty, healthcare executives and attorneys-at-law, and surgical residents were exceptional.

In this issue of the Newsletter, I wish to focus upon the perspectives shared by Donald E. Williamson, M.D., Public Health Officer, State of Alabama, regarding the Alabama Medicaid Agency. During his service as Chairman, Medicaid Transition Task Force, he has argued that the Alabama Medicaid Agency is "integral to the entire state healthcare system" and that if the Medicaid Agency is not adequately funded "it would not only devastate the lives of Medicaid recipients, but also cascade by shattering healthcare services for all Alabamians independent of their socioeconomic status." Dr. Williamson is acknowledged as a very intelligent, conscientious, efficient, and capable leader and public servant.

Medicaid Provides Coverage For:
- 53% of All Alabama Deliveries
- 43% of All Alabama Children
- 60% of Nursing Home Residents

To ensure access to care, both primary and specialty care physicians, who accept Medicaid patients, must be compensated at a minimum of Medicare rates.

Alabama Medicaid Agency has an annual budget of $6 billion of which 66% has been provided by Federal Matching dollars. Only 10% of the entire Medicaid budget has been provided by General Fund Tax Revenues. The remainder of the state contribution has been accomplished by a "Provider Tax" upon hospitals, nursing homes, and pharmacies. Those fiscal arrangements are unsound, unsustainable, and do not adhere to Federal Guidelines to receive matching funds.

Governor Bentley has recommended a tax revenue increase to fully fund multiple State Services, including the Medicaid Agency. I agree with that recommendation and have so communicated to my State Senators and Representatives. I seek your advice and counsel in these regards and encourage you to also discuss them with your legislators.

Respectfully yours,

William O. Richards, M.D., F.A.C.S., President
Professor and Chairman, Department of Surgery
College of Medicine and Medical Center
University of South Alabama
Mobile, AL 36617

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Alabama Chapter, ACS Annual Conference
The Grand Hotel, Marriott Resort, Golf Club and Spa

The Alabama and Mississippi Chapters of the American College of Surgeons held its annual conference June 4-6 at The Grand Hotel Marriott Resort in Point Clear, Alabama. Surgeons from both states gathered to hear panel discussions on topics such as: *Colorecal Carinoma, Regional Surgical Care, Legislative Update, Complex Abdominal Wall Hernias, Current Trends in Surgical Oncology, Inspiring Quality / Highest Standards / Better Outcomes*, and *Surgical Critical Care*.

We were pleased to welcome Steven Stain, MD, FACS who spoke on The General Surgery Workforce. Dr. Stain is Chair of Surgery at Albany Medical Center in Albany, NY. Addison K. May, MD, FACS spoke on I*schemia/Reperfusion/Injury*. He joined us from Vanderbilt University where he serves as Director of Surgical Critical Care. The Honorable Gerald O. Dial, Chair of Health and Human Services Committee, Alabama Senate sat on our panel for *Inspiring Quality*. The William Albert Maddox MD, FACS Memorial Lecturer was Marcus, Tan, MBBS, FACS who spoke on *Current Trends in Surgical Oncology: Melanoma*.

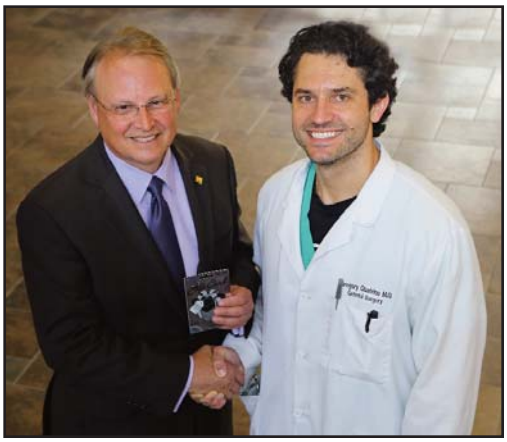
Recognition was given to Dr. W. Keith Adkins MD, FACS for his year of service as President of the Alabama Chapter.

We appreciate those who attended the conference and hope you will make plans to join us in 2016 back at The Grand Hotel Marriott Resort in Point Clear **June 9-11, 2016!**

Resident Presentations at Annual Conference

Poster Presentations were given by 10 residents from programs including: Baptist Health System, University of Alabama at Birmingham and University of South Alabama. We appreciate all the residents that participated in the competition.

The Doyle Haynes Memorial Trauma Award was given to Dr. Daniel Freno for his Basic Science Presentation and Dr. Lauren Raff for her clinical science presentation. Pictured above are: Juan Duchesne, MD, FACS; Addison May, MD, FACS; Lauren Raff, MD; Daniel Freno, MD; and Jon Simmons, MD, FACS.



Poster Presentation First Place
Evidence of oxidative mitochondrial (mt) DNA Damage and MTDNA damage associated molecular patterns (DAMPs) in ventilator induced lung injury - **Greg Quatrino, University of South Alabama**

Poster Presentation Second Place
Inhibition of Focal Adhesion Kinase (FAK) Leads to Decreased Cell Survival in Rhabdomyosarcoma Cells in vitro and in vivo - **Alicia Waters, MD, University of Alabama at Birmingham**

Poster Presentation Third Place
Coronary Stent Indication Influences Postoperative Adverse Cardiac Events - **Carla Holcomb, MD**
University of Alabama at Birmingham

ALABAMA CHAPTER
AMERICAN COLLEGE OF SURGEONS
OUSTANDING RESIDENT AWARD

The Executive Council, Alabama Chapter/American College of Surgeons, inaugurated this award in 2014-2015. The award acknowledges a Surgical Chief Resident from each educational program within the State of Alabama, who exemplifies the vision and mission of the Chapter.

- To **SERVE** as effective advocates for our patients and the integrity of the patient-surgeon relationship.

- To **PROMOTE** the health and safety of our patients, their families, our neighbors, and our communities.

- To **FOSTER** collegiality, fellowship, mentorship, and continuing medical/surgical education among our colleagues.

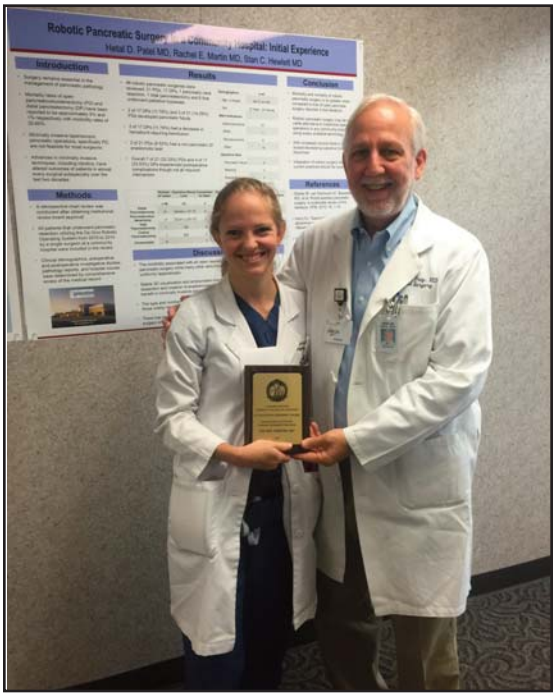
- To **CONSERVE** our resources of time, talent, and treasure.

This award was given to the following residents:

Baptist Health System, Surgery Residency Program
Rachel Martin, MD

University of Alabama at Birmingham, Surgery Residency Program
Matthew Giglia, MD

University of South Alabama, Surgery Residency Program
Jack W. Rostas III, MD



Rachel Martin, MD

Jack Rostas, III, MD

Matthew Giglia, MD

2015 Conference Exhibitors
Thanks for your support!

BG Medical
Eric Nelson
101 S. Hough Street, #6A
Barrington, IL 60010
(603) 498-8561
enelson.bgmedical@earthlink.net
www.surgimesh.com

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Warwick, RI 02886
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jay.davis@crbard.com
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Mobile, AL 36606
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talford@its.jnj.com
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Nicole Lopeman
960 W. Elliott Road #202
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(480) 756-4439
nlopeman@wlgore.com
www.goremedical.com

Insightra Medical
Susan Vickery
9200 Irvine Center Drive, Suite 200
Irvine, CA 92618
(949) 215-1835
susan.vickery@insightra.com
www.insightra.com

Merck & Co., Inc.
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245 Highland Park Drive
Birmingham, AL 35242
(205) 527-8138
angela.weir@merck.com
www.merck.com

Mobile Medical Museum
Raven Christopher
1664 Springhill Avenue
Mobile, AL 36604
(251) 415-1109
admin@mobilemedicalmuseum.org
www.mobilemedicalmuseum.org

Olympus America
Robert Smallwood
3500 Corporate Parkway
Centervalley, PA 18034
(205) 746-9631
Ward.Smallwood@Olympus.com
www.olympus.com

ProAssurance Indemnity
Tom Phelps
100 Brookwood Place
Birmingham, AL 35209
(205) 877-4400
tphelps@proassurance.com
www.proassurance.com

Shire
Jose Cortina
330 Hill Drive
Bedminster, NJ 07921
(850) 525-9051
jcortina@npsp.com
www.npsp.com

The Medicines Company
Tom Jeffries
8 Sylvan Way
Parsippany, NJ 07054
(205) 862-9177
thomascjeffries@yahoo.com
www.themedicinescompany.com

Practice Management Corner

Recovery Audit Contractor update

On July 10, the Centers for Medicare & Medicaid Services (CMS) withdrew its request for quotes for the next round of Recovery Audit Contractor (RAC) contracts. The Agency plans to update its Statement of Work for the RAC program and release requests for proposals soon. Last Spring, the U.S Court of Appeals for the Federal Circuit ruled that CMS' proposed new contracts for Medicare RACs violate contracting requirements and the U.S. Court of Federal Claims prohibited CMS from proceeding with contracts under its original requests for quotation. Current RACs will continue auditing through at least Dec. 31, 2015.

Congress itself recently demonstrated a renewed interest in overhauling the RAC program. The Medicare Audit Improvement Act of 2015, H.R. 2156, would change the way RACs are paid from a contingency fee to a retainer and would not allow RACs to use information physicians did not have at the time of admission. Additionally, the Senate Finance Committee reviewed draft legislation that would, among other provisions, exempt providers with low error rates from RAC and MAC audits for one year and adjust the number of medical records a RAC could request.

Save the Date

ACS Clinical Congress
October 4-8, 2015
Chicago, IL
Register Online: www.facs.org

Changes to Medicare physician opt-out requirements

Prior to enactment of the Medicare Access and CHIP Reauthorization Act (MACRA), physicians who elected to opt out of Medicare and enter into private contracts with Medicare beneficiaries had to update an affidavit every two years to maintain their opt-out status. A provision in MACRA eases these requirements so that valid opt out affidavits signed on or after June 16, 2015 will automatically renew every two years. Physicians filing affidavits effective on or after June 16, 2015 that do not want their opt out to automatically renew at the end of a two year period may cancel the renewal by notifying all Medicare Administrative Contractors with which they filed an affidavit in writing at least 30 days prior to the start of the next opt-out period.

CMS to permit non-specific ICD-10 codes for one year

The Centers for Medicare & Medicaid Services (CMS) announced a set of new policies related to the Oct. 1, 2015 transition to ICD-10. For the first year that ICD-10 is in place, Medicare claims will not be denied, and eligible professionals will not be penalized under PQRS, the value-based payment modifier or meaningful use based soley on the specificity of the diagnosis codes, as long as they are from the appropriate “family” of ICD-10 codes. In addition, CMS will authorize advance payments to physicians should Medicare contractors be unable to process claims as a result of ICD-10 complications. The Agency also announced plans to create a new communication center to monitor and resolve issues as quickly as possible, as well as an “ICD-10 Ombudsman” to assist providers. In a separate announcement, CMS indicated that nationally it accepted 90% of claims from more than 1,200 submitters who participated in CMS’ third round of ICD-10 “front end” (acknowledgement) testing.

Six Ways to Improve Patient Satisfaction Scores

Large physician practices and hospitals already have a portion of their payments linked to patient satisfaction. Over the next few years, it will be an integral portion of physician payment, including penalties possibly dwarfing those under meaningful use. More about this program, known as the Clinician & Group Consumer Assessment of Health Providers and Systems (CG-CAHPS) can be found on the Agency for Healthcare Research and Quality's website.

Here's the government's hypothesis in a nutshell:

• Patients who like their doctors are more likely to be compliant patients;

• Compliant patients are healthier patients;

• Healthier patients are less expensive; so

• Physicians with satisfied patients should be paid more than physicians with dissatisfied patients.

The Affordable Care Act introduced a different set of quality metrics than used by the Institute of Medicine (IOM): quality, patient satisfaction, and payment. Quality is a key element with both programs, but there's an important difference with the reform law: your patients are the arbiters of quality. Quality more or less equals patient satisfaction.

What's being measured?

CG-CAHPS measures the patient experience, an expansive proxy for quality that takes into account the following:

• Timely appointments

• Timely care (refills, callbacks, etc.)

• Your communication skills

• What your patient thinks about you

• What your patient thinks about your staff

• Your office running on schedule

I have been in enough medical practices — both as a patient and as an administrator — to know there's a method to this madness. It's less about the care and more about the caring. Here's what I suggest for improving your quality measures via these proxies.

1. Hire sunshine

I can train anyone* to do anything in our office, but I can't train sunshine. Look to hire positive and happy people, particularly for roles with lots of patient interaction. Your patient satisfaction — and thus, your "quality" — will improve. You'll also find a cost-saving benefit to this hiring tactic: employee turnover will shrink.

2. Start on time

CG-CAHPS asks patients whether they were seen within 15 minutes of their appointment times; it's even underlined for emphasis. Physicians who start on time are more likely to run on time, so have your feet set before you start running.

3. Set patient expectations

It's helpful to share with patients the FAQs about your practice so that they know what to do for refills, after-hour needs, appointment scheduling, etc. By making these answers available on your website, on your patient portal, and in your print materials, you'll better align patient expectations with patient experiences and thereby score better on quality surveys.

Some patients gauge quality by whether or not they get the antibiotic they think they need. It's helpful for primary-care physicians to include education on antibiotic overuse in their patient education materials.

Along these lines, it is important for your patient to know what to expect after their visit in terms of test results, follow-up visits, etc. I receive more complaints about the back end of our patients' experiences than anything else. Make sure you and your staff do not drop the ball as you near the goal line.

4. Listen with your eyes

Nothing says "I don't care" like having your physician focus on a computer screen rather than on the patient. This is particularly true in the first couple of minutes of each visit, and especially important with new patients.

Six Ways to Improve Patient Satisfaction Scores, continued

One virtue of using medical scribes is that you can listen with your eyes a whole lot more.

5. Put your staff in their place

Your staff has an important bearing on the patient experience. I'm a big fan of letting them know their actions influence quality. It's pretty cool, for me as a mere bureaucrat, to know that I can improve quality simply by being friendly and helpful to our patients. Make sure your staff knows that making a patient's day is a beautiful act.

6. Monkey see, monkey do

Staff will follow your lead. If your thoughts and actions emphasize running on schedule, being kind to patients and their families, and not dropping balls, they'll be stronger teammates for you.

Patient satisfaction has always been a gauge of quality, just as patient referrals remain the lifeblood of most practices. Treat this next wave as an opportunity to show off the caring that has always been a big part of the medical care you offer your patients.

* The Wonderlic Personnel Test is my tried-and-true tool for measuring cognitive acumen. Anyone who scores 20 or more on this test can be trained to do most any non-clinical task in your office. A score of 25 or more suggests an innate ability to juggle tasks under stress, a great quality in today's medical practice.

- Lucien W. Roberts, III, MHA, FACMPE

Mr. Roberts is administrator of Gastrointestinal Specialists, Inc., a 22-provider practice in Central Virginia. For the past 20 years, he has worked in and consulted with physician practices in areas such as compliance, physician compensation, negotiations, strategic planning, and billing/collections. He can be reached at muletick@gmail.com.

http://www.physicianspractice.com

Understanding Virtual Credit Cards and EFTs

Per the Affordable Care Act, health plans are required to offer electronic funds transfer (EFT) payments using the Automated Clearing House (ACH) to physician practices that request this method of claims payment. Physicians have little knowledge of this, and so despite the aforementioned provision, some health plans have begun paying physicians using payer-issued virtual credit cards, or VCCs. VCCs reward insurance companies with cash back or other perks by eroding physicians' payments via processing fees.

When paying by VCC, health plans send credit card payment information and instructions - via mail, fax or email - to physicians who must then process the payment using their in-office credit card system. This leaves physicians with up to 5% less than their contracted amount and rewards the insurance company through cash back (up to 1.75%) or other incentives as well as the bank or credit card company with a portion of the collected fees.

Top 5 Reasons to Use to EFT

1. Avoiding a shift in payment processing costs. VCCs place the payment processing costs squarely on the physician through interchange fees. ACH EFT eliminates this pay structure by keeping more of the contractual payment with the physician.

2. Maximizing payment amounts. Use of ACH EFT over VCCs saves practices money, whether by eliminating the manual processing and deposit of paper checks or avoiding costly virtual credit card fees, which can be as high as 5% of the total payment. Standard ACH EFT only costs about $0.34 per transaction.

3. Saving time and money spent on manual processes. Unlike paper checks and virtual cards, which require administrative processing by medical practice staff, payments made through ACH EFT are automatically posted to a practice's account.

4. Reducing risk. ACH EFT payments are processed directly from a health plan's bank to a physician's bank over the secure ACH Network. As a result, payments do not face the risks of lost or stolen paper checks or fraudulent use of virtual credit cards.

5. Optimizing processing of electronic remittance advice (ERA). The health care ACH EFT system was designed to enable simplified payment reconciliation when used in conjunction with the standard ERA transaction. Virtual credit card payment information cannot be sent in a compliant ERA transaction and therefore requires time-consuming manual processing.