News from TexMed 2014

The Texas Medical Association’s (TMA) annual meeting, TexMed, was held in Fort Worth, May 2-3. Here is a briefing on what occurred:

Elections

Saying he will work to stop physicians from “being marginalized out of the health care debate,” Abilene otolaryngologist Austin King, MD, became the 149th president of TMA at TexMed 2014.

The TMA House of Delegates, composed of Houston cardiologist and former HCMS President Tom Garcia, MD, as president-elect, adopted a resolution directing that TMA “work to permanently delay the implementation of ICD-10.”

Delegates also:

• Called for changes in the Affordable Care Act (ACA) to prevent recoupment of payments to physicians made during the ACA grace period when physicians have not received adequate notice that the patient has not paid his or her premiums.
• Adopted resolutions to fight air pollution and improve immunization rates;
• Directed TMA to work with other organizations to “aggressively pursue the reduction or elimination of as much of the documentation burden as possible”;
• Established new TMA policy on the number of attempts and amount of time allotted for passage of medical licensing exams;
• Called for insurance companies to provide real-time adjudication of claims;
• Approved a phased-in dues increase of up to $12 per year for five years; and
• Rejected a proposal to eliminate TMA’s International Medical Graduate Section.

Marketing on a shoestring budget - June 11 meeting

Want to develop your patient base and referral network? The Harris County Medical Society (HCMS) can help! Building and enhancing your patient base is not easy. Regardless of whether you are a young physician developing your practice or an established physician facing a retiring referral base, it is important to know the tools available that can help you grow your practice. Many physicians assume that the process is expensive and time consuming. It does not have to be. HCMS can help. It is a free member benefit.

Attend “Marketing 101: HCMS Resources to Develop Your Patient Base,” at 6:00 p.m. on Wednesday, June 11, at The John P. McGovern Museum of Health & Medical Science (The Health Museum). The evening will start at 6:00 p.m. with half an hour of networking. The presentation will begin at 6:30. The lecture will offer you tools that will fit any budget. The event is free of charge and is designated as a one-hour ethics CME. A light meal is included and free parking is provided in the HCMS parking garage. Registration is required. To register, go to www.hcms.org and select Events/Other, then click on Marketing 101.

Medicare corner

How to calculate nonparticipating physician payments

All physicians enrolled in Medicare regardless if they are participating or nonparticipating are required to file claims to Medicare. If physicians who are enrolled in Medicare choose not to file claims to Medicare they can be subjected to the following sanctions, civil monetary penalty up to $2,000 for each violation, a 10 percent reduction in payment, and/or exclusion from the Medicare program.

The difference between participating and nonparticipating physician is that participating physicians have agreed to accept assignment and be reimbursed at 100 percent of the Medicare Physician Fee Schedule (MPFS) allowable, minus the coinsurance and deductible.

See MEDICARE CORNER continued on page 4
Medical staff bylaws

I often hear physicians complain about hospitals treating them unfairly or feel that hospital is overreaching. Remember the buck stops here. As physician leaders, we have to participate in hospital boards and approved by the governing body and is responsible for the quality of care that is provided to patients by the hospital. The practice of medicine must remain separate from business interests and agendas in order to provide safe and quality care.

It is our responsibility to have a strong voice to write the bylaws that are self-governing. The medical staff bylaws should provide a binding, mutually enforceable agreement that both the medical staff and hospital board must follow. It is not a document imposed on us by administration. To create bylaws that do not provide for physician due process. Also, it may be necessary to reassign measures that should be in bylaw not be hospital policy. As such, the medical staff must be in charge of caring for patients. The medical staff and hospital boards must be sure that it is. Also, physicians need to know what is in hospital policy and if they need to create new bylaws to protect physicians against unfair policies.

The Joint Commission requires hospitals to implement Codes of Conduct defining "disruptive" conduct, which are interpreted by the hospital to restrict the behavior of physicians. The Joint Commission requires hospitals to implement Codes of Conduct defining disruptive, inappropriate conduct, and inappropriate conduct. For example, watch out for language in Code of Conduct, which defines as inappropriate conduct, any negative statement about hospital services, or any activity that is disruptive to hospital operations. These terms are so broad that they could prohibit constructive criticism, or financial interests in anything from a surgery center to a gift shop. This means physicians must uphold these Codes of Conduct and apply equally to all physicians.

Service-and peer reviewed - The core purpose of the medical staff is to provide a structure for ongoing peer-to-peer quality patient care improvement. However, as physicians are more stretched providing patient care, the health care system continues to become more sophisticated, medical staffs must find the lines of peer review process slipping away, with quality measures and the focus of quality studies being dictated from hospital administration or the hospital system. While joint Commission Accreditation is the frequent reason given for gathering and measuring data, physicians should know that the Commission expects peer review to be conducted by peers, not administration. This means physicians must participate in quality review and be willing to censure other physicians for professional performance if indicated. We must take the responsibility of our own medical staffs and the bylaws that create our quality review and malpractice reporting. These professional liability insurance providers are offering a single-source solution.

Preventive Medicine Physician Search Bellaire / West Houston Market Board Certified M.D. (any specialty) join looking to an Ob/Gyn and Internal medicine practice who is on the cutting edge of medicine. Preventive medicine entails real health and wellness and is the future of medicine. Specialty Healthcare & Wellness employs and works with nutritionists, and is ready to expand our practice another forward thinking, established M.D. Using our research and education along with the newest advances in medicine, we have blended traditional medicine with nutrition and vitamins and have therefore elevated our practice into both a cash and insurance based business. Resumes and calls may be sent to Dan Ginsberg, MD 281-229-3018 or email at dags@yahoo.com

Harris County Physician Newsletter / May 15, 2014 / www.hcms.org
June Calendar
Visit the calendar online at www.hcms.org

Monday 2
6:30 p.m.  Houston Dermatological Society, Mr. Peoples, 1191 Bagby St.
Tuesday 3
6:30 p.m.  Houston Infectious Diseases Society, Location TBA
June 7-11
AIW Annual Meeting at the Hyatt Regency in Chicago

In Memorium
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HCMS offers discount to Alley Theatre & more
HCMS offers a discount to the Alley Theatre, so members and their families can attend and Spike, winners of the 2013 Tony award. HCMS members and their families can get computer and Astros tickets. Visit the HCMS website and click on the box under the calendar offer and how to purchase tickets.

Business of Medicine
New practice models
Over the next few months HCMS is going to be publishing information explaining some of the new practice models and new contracting language forming as a result of the Affordable Care Act (ACA) and value based payments. Also, HCMS will introduce members to some practice models that are oldies, but goodies, to give members an idea on their options if they choose to make a change.

Tips for payer credentialing
What is physician credentialing? It is simply the process of establishing and confirming the physician’s qualifications and history. Payers, health care organizations, and hospitals all require physicians to be credentialed with their organization. The seemingly straightforward process can become very complicated and time consuming, but there are ways to improve the process. It is possible to ease the payer credentialing process by completing a profile with the Council for Affordable Quality Healthcare (CAQH). It is possible to complete a profile with the CAQH Universal Provider Data Source (UPDS) located at http://www.caqh.org/overview.php. Completing the online UPD application will help streamline and improve the payer credentialing process.

When starting to credential with payers, it is important to identify which payers are accepting new physicians into their networks because not all payer panels are open. A payer panel may be closed due to reasons such as, too many physicians of the same specialty within the same locality. Prior to submitting your credentialing application/packet to the payer, it will be important to identify who will be handling the case and develop a rapport with the representative. In order to ease the payer credentialing process, it is important to ensure the paperwork is accurate and complete. Another tip to help ease the credentialing process is to submit all requested information at the same time and verify that the information was received by the payer. The last tip to remember is to manage the process by tracking and following up on the status of the credentialing application. Following these simple steps will help lessen any dilemmas that may arise.

Source: American Association of Professional Coders (AAPC) Presented by the HCMS Board on System Improvement

www.hcms.org | Harris County Physician Newsletter | May 15, 2014

Tide Mark: Meaningful Use exemption deadline
Physicians who did not successfully meet Meaningful Use (MU) in 2013 or will not be ready to participate in MU in 2014, may be able to file for a hardship exemption before the end of 2014. Starting in 2014, physicians who are not using an electronic health record (EHR) and not participating in MU will incur Medicare penalties beginning in 2015. The penalties will begin at one percent in 2015 and increase one percent every year until it reaches five percent. If more than 75 percent of office-based physicians are using an EHR and participating in MU by 2017, the penalty will be capped at three percent.

For 2014 only physicians can apply for a hardship exemption if their EHR vendor was unable to obtain the 2014 certification for their EHR system or if the physician was unable to implement MU due to 2014 EHR certification delays.

Note: Exemptions are not automatically assessed and physicians must apply for an exemption annually.

For the full list of hardship exemptions and instructions on how to apply, visit www.hcms.org/practice-resources/hitm.us.

Meaningful Use attestation issue
It has come to our attention that a successful attestation submission may be voided if the submitter logs back into the Centers for Medicare & Medicaid Services (CMS) attestation portal post-submission. Any edits made post-submission, even something as small as hitting the “space bar” could void the original submission. Therefore, after successfully completing attestation, take a screenshot for your record in addition to any records that you will receive from CMS. If you are experiencing this issue, submit an appeal with the appropriate documentation of your original acceptance. To start the appeal process, please call CMS at 1-888-734-6433, option 1. For more information on meaningful use please visit www.hcms.org/practice-resources/hitm.us. For additional information, contact quality@hcms.org.

www.hcms.org | Harris County Physician Newsletter | May 15, 2014

To protect you from employment-related issues, TMLT provides EPLI and EPLIPRO™ to all policymakers.

Call 800-580-8658 or go to www.tmlt.com/join

Speak to us
Talk to a TMAT Advisor about insurance for you, your family, and your medical practice.
We can help you choose the right coverage from an array of plans including medical, dental, vision, life, short-term disability, long-term disability, long-term care, and office-overhead expense.

TMLT®
EPLIPRO™
EPLI™
Professional Liability
Professional Errors and Omissions Insurance

Nationally Recognized
Expert Medical CPA
Consultant/Business Advisor/Author/Speaker

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Complying with HIPAA security—Ethics CME

Register today for the Texas Medical Association (TMA) “Complying with HIPAA Security” live webinar from Texas Medical Liability Trust. The HIPAA Security Rule aims to protect confidentiality, integrity, and availability. The webinar offers detailed instructions for implementing particular standards, but some of these are “addressable.” This means each medical practice must decide whether it is a reasonable and appropriate safeguard in that practice’s environment.

This course offers 1 AMA PRA Category 1 Credit™, with 1 credit in medical ethics and/or professional responsibility as well as 1 credit for TMLT. Physicians who are insured with TMLT may earn up to three percent discount (not to exceed $1,000), which will be applied to their next eligible policy period.

The cost is $59 for TMA members.

The website has recently changed. On the Novitas homepage under “Self Service Tools”, searching capabilities, an interactive directory for locating provider contacts, new resources for healthcare professionals at www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMaterials/Articles/Downloads/661242.pdf. This reference provides helpful resources with reporting the service correctly.

Where do I locate information about how to use the Interactive Voice Response Unit (IVR)? The website has recently changed. On the Novitas homepage under “self Service Tools”, select “Interactive Voice Response (IVR).” This will list all the steps you need to navigate through the IVR.

Public Health Focus

Inactivity related to chronic disease in adults with disabilities

Half of adults with disability get no aerobic physical activity. Working age adults with disabilities who do not get any aerobic physical activity are 50 more likely than their active peers to have a chronic disease such as cancer, diabetes, stroke, or heart disease, according to a Vital Signs report released today by the Centers for Disease Control and Prevention (CDC).

Nearly half (47%) of adults with disabilities who are able to do aerobic physical activity do not get any. An additional 22 percent are not active enough. Yet only about 44 percent of adults with disabilities who saw a doctor in the past year got a recommendation for physical activity.

“Physical activity is the closest thing we have to a wonder drug,” said CDC Director Tom Frieden, M.D., M.P.H. “Unfortunately, many adults with disabilities don’t get regular physical activity. That can change if doctors and other health care providers take a more active role helping their patients with disabilities develop a physical fitness plan that’s right for them.”

Want to lead your Society? Nominations due May 30

Nominations for 2015 elected positions within the Harris County Medical Society (HCMS) are due by HCMS by May 30.

Election Committee Guidelines: New Officers. The HCMS Nominating Board (President Elect (one-year term); HCMS Board Experience Required), Vice President (one-year term), Secretary/Treasurer (one-year term), Member-at-large on the Executive Board (four-year term), Board of Ethics (three-year term) (two positions available). Candidates should have experience in peer review, Board of Medical Legislation (four-year term) (three positions available), Board on Socioeconomics (three-year term) (three positions available); Alternate Delegates to the TMA (two-year term). HCMS Committee appointments will be made by the HCMS President Elect Bradford S. Patt, MD, in the full. Candidate nominations can be submitted at any time throughout the year. Positions are available on the following committees: Bylaws Committee, Community Health Improvement & Communications Committee; Emergency Care Committee; John P. McGovern Complacent Physicians Award Judging Committee, Health Care Quality Committee; Health Information Technology; Membership Committee; and Physicians Counseling Committee.

If you would like to serve or nominate someone to serve in an elected position, mail or fax this form to HCMS. Forms are also located online at www.hcms.org. If you make more than one nomination, please photocopy the form. If possible, include letters in support of the candidate.

Fax to: Attn: HCMS Nominations 713-942-7072

Name of nominee: ____________________________

Position of: _________________________________

Address: ___________________________________

Presented by the HCMS Nominating Board

Improving your health: Drink one less sugary drink

Did you know that just drinking one to two sugary drinks a day could increase your risk of developing type 2 diabetes by 25%, increase your risk for heart attack by 20%, and increase your child’s risk of becoming obese by 60%? Harris County Medical Society has brochures and magnets to assist you in your discussions with patients. The Shut Out Sugar brochure has helpful information to help your patients in making healthier choices. The campaign is supported by the Texas Medical Association Foundation.

Presented by the HCMS Community Health Improvement & Communications Committee

New date for Boy Scout Physicals June 28

Volunteers needed!

Volunteer four hours on Saturday, June 28, from 8 a.m. to noon, to give physicals to scouts in the Urban Scouting Program so they can attend Scout Camp this summer. Physicians, medical students and nursing students are needed. The physicals will be held at the Boy Scouts headquarters at 2225 North Loop West (T.C. Jesper and 610). The Houston Academy of Medicine and the Harris County Medical Society (HCMS) have supported the Urban Scouting Division of the Sam Houston Area Council Boy Scouts of America since 1984, by providing free physicals to inner-city Boy Scouts. By volunteering your time and skills, you are helping Scouts who cannot afford the necessary physical to attend camp. You are giving these Scouts the opportunity to gain important life skills and values.

For those unable to volunteer but would still like to contribute, you can make a “Black Bag” donation, which includes: stethoscopes, blood pressure cuffs, otoscopes, reflex hammers, eye shields, weight scales, and height charts. For more information or to volunteer, contact Scott Atkins at scott_atkins@hcms.org or 713-524-4267, ext. 269. Please send all donations to Houston Academy of Medicine, Black Bag Donations, 1515 Hermann Drive, Houston, 77094.

Presented by the HCMS Community Health Improvement & Communications Committee

Novitas top provider inquiries – First quarter 2014

Below are the top five most frequently asked questions that came to Novitas Solutions (Texas Medicaid Administrative Contractor for MACs) from Texas practices from Jan. 1, 2014 – March 31, 2014, and the answers to these questions.

1. I received a remittance, but only for part of my claim. Why were some line items not paid on it? Some items may have been unprocessable due to missing or incorrect information. These items would be rejected separately to allow the rest of the claim to process. You will receive a 115 percent of the allowed nonparticipating physician amount. This amount can be calculated through the IVR.

2. How should I bill TMLT for services to report CO-151 denials? Bilateral services (procedures having a (1) Bilateral Surgery Indicator displayed on the CMS Fee Schedule Search) must be reported using modifier 50 and with one for the number of units. Do not report bilateral services using separate lines.

3. Can a 59 modifier be used for a duplicate denial since the description of the modifier is for separately identifiable procedure? The 59 modifier is primarily used to address most Correct Coding Denials. If your service denied as duplicate you would want to use another modifier to show that it is a repeat procedure by the same or different physician. The only exception to this is duplicate laboratory services. A 59 or 91 modifier can be used to show duplicate but distinct services.

4. Where is information pertaining to billing the correct Influenza procedure code? Corrections to the reported influenza procedure code can easily be corrected through the claims correction process. However, comprehensive information pertaining to influenza procedure codes, please refer to MLN Matters article, 2013-2014 Seasonal Influenza (Flu) Resources for Health Care Professionals at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNMatters/Articles/Downloads/661242.pdf. This reference provides helpful resources with reporting the service correctly.

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Presented by the HCMS Nominating Board

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Presented by the HCMS Community Health Improvement & Communications Committee

Medicare corner

How to calculate nonparticipating physician payments

Continued from page 1

Nonparticipating physicians are also considered enrolled in Medicare, but have not agreed to accept assignment and can charge the Medicare "limiting charge." This charge is set by law at 115 percent of the allowed nonparticipating physician amount. This amount can be calculated by taking the Medicare allowable and multiplying it by 95 percent, because the law indicates that Medicare will reimburse nonparticipating physician at 95 percent of the MFPS amount (the fee schedule amount). The law also allows nonparticipating physicians to charge 115 percent above the nonparticipating physician payment amount. This means nonparticipating physicians can increase their revenue without raising the Medicare fee amount by 115 percent to gain the limiting charge. Another way to determine the limiting charge amount for nonparticipating physicians is to multiply the MFPS by a factor of 1.0925 (or 109.25 percent).

Participating Physicians

Assume Part B deductible has been met. The nonparticipating physician amount is for separately identifiable procedure.

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<tr>
<th>CPT code</th>
<th>MFPS or Medicare allowable</th>
<th>Total amount paid by Medicare minus coinsurance</th>
<th>Patient's 20% coinsurance</th>
<th>Medicare minus coinsurance</th>
<th>Total amount paid by nonparticipating physician (73.56% x 95%)</th>
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</thead>
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<td>$58.85</td>
<td>$14.71</td>
<td>$48.80</td>
<td>$69.88</td>
</tr>
</tbody>
</table>

Nonparticipating Physicians

Assume Part B deductible has been met and the physician chooses not to accept assignment.

<table>
<thead>
<tr>
<th>CPT code</th>
<th>MFPS or Medicare allowable</th>
<th>Allowed nonparticipating physician payment amount (73.56% x 115%)</th>
<th>Limiting charge amount (69.88 x 111.5%)</th>
<th>Total amount paid by nonparticipating physician</th>
</tr>
</thead>
<tbody>
<tr>
<td>99213</td>
<td>$73.56</td>
<td>$89.68</td>
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‘HOT’ Member Benefit Check out our new & improved website!

Same address, better site! The Harris County Medical Society (HCMS) website is new and improved. Take a look at www.hcms.org. The enhanced site offers superior searching capabilities, an interactive calendar, and works on smart-phones and tablets. The site makes it easy to find the HCMS Online Directory, HCMS Discount offers (including the Auto Program), free and low-cost ways to market your practice, information on the the Marketplace, and so much more. Check out HCMS at www.hcms.org.

Presented by the HCMS Community Health Improvement & Communications Committee

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CMEs in your inbox

Looking for continuing medical education (CME) that is timely and practical? Need help wrapping your head around new rules and regs? Go to the Harris County Medical Society website www.hcms.org and click on "Education" and "CME Programs." Subscribe to them.

To go to www.hcms.org/HCMS_eNews/ to have information on local CME seminars sent directly to your inbox.

New publications, and/or seminars are added every month on the TMA's Education Center at www.texmed.org/education. To find out what's new each month, subscribe to TMA's e-newsletter, CME Spotlight. The newsletter brings you a quick summary of new and timely education available to you at special TMA member pricing, with links for more information.

To subscribe, log in to the TMA website at www.texmed.org, and go to the Subscriptions page (www.texmed.org/Profile/ Subscriptions/). Checkmark "CME Spotlight Newsletter" to find out what's new each month in the TMA Education Center.

Discovery Camps at The Health Museum!

Enroll your child now for the fun-filled education summer Discovery Camp at The John P. McGovern Museum of Health & Medical Science (The Health Museum). Registration is going on now! The Health Museum offers a hands-on, interactive summer camp program for children ages 5-13. Features include, Mini Medical School and Super Sleuths as well as the new and exciting Nanotechnology 101 and Lego EXHIBITAWAY.

Camps are filled on a first-come, first-served basis. All camps meet from 9 a.m. to 3 p.m. An extended camp day option (7:30 a.m.-5 p.m.) is available during all camp sessions for $50 per child. Lunch is provided to every camper. Go to the www.thehealthmuseum.org, to view a complete camp schedule and registration details. Or contact the summer camp office at 713-733-3841.

Source: American Association of Professional Coders (AAPC) Presented by the HCMS Board on Socioeconomics

HIT Parade

Meaningful Use attestation issue

It has come to our attention that a successful attestation submission may be voided if the submitter logs back into the Centers for Medicare & Medicaid Services (CMS) attestation portal after submission. Any edits made post-submission, even something as small as hitting the "space bar" could void the original submission. Therefore, after successfully completing attestation, take a screenshot for your record in addition to any records that you will receive from CMS. If you are expressing this issue, submit an appeal with CMS and provide appropriate documentation of your original acceptance. To start the appeal process, call CMS at 1-888-734-6433, option 1. For more information on meaningful use please visit www.hcms.org/practice-resources/hit/mu.

Tips for payer credentialing

What is physician credentialing? It is simply the process of establishing and confirming the physician's qualifications and history. Payers, health care organizations, and hospitals all require physicians to be credentialed with their organization. The seemingly straightforward process can become very complicated and time consuming, but there are ways to improve the process. It is possible to ease the payer credentialing process by completing a profile with the Center for Affordable Quality HealthCare (CAQH) Universal Provider ID service (UPID) located at http://www.caqh.org/overview.php. Completing the online UPID application will help streamline and improve the payer credentialing process.

When starting to credential with payers, it is important to identify which payers are accepting new physicians into their networks because not all payer panels are open. A payer panel may be closed due to reasons such as, too many physicians of the same specialty within the same locality. Prior to submitting your credentialing application/packet to the payer, it will be important to identify who will be handling the case and develop a rapport with the representative. In order to ease the payer credentialing process it is important to ensure the paperwork is accurate and complete. Another tip to help ease the credentialing process is to submit all requested information at the same time and verify that the information was received by the payer. The last tip to remember is to manage the process by tracking and following up on the status of the credentialing application. Following these simple steps will help lessen any dilemmas that may arise.

Business of Medicine

New practice models

Over the next several months HCMS will be publishing information explaining some of the new practice models and new contracting language forming as a result of the Affordable Care Act (ACA) and value based payments. Also, HCMS will introduce members to some practice models that are oldies, but goodies, to give members an idea on their options if they choose to make a change.

Sponsoring the HCMS Health Information Technology Committee

www.hcms.org / Harris County Physician Newsletter / May 15, 2014
All articles in President’s Page The Harris County Physician Newsletter (HCPhys), executive vice president, Harris County Medical Society, 1515 Hermann Drive, Houston, TX 77030-7126. Harris County Physician Newsletters (HCPhys) is the official publication of the Harris County Medical Society. Office: 3515 Hermann Drive, Houston TX 77030-7126. Tel: (713) 721-3100, Fax: (713) 721-3204, Email: info@hcphys.org. It is published 8 times per year – twice monthly with an August-September issue. The subscription price is $5.00 per year. Single copies are $3.75 per copy. Periodicals postage paid at Houston, Texas. POSTMASTER: Send address changes to The Harris County Physician Newsletters, 1515 Hermann Drive, Houston, TX 77030-7126.

I often hear physicians complain about hospitals treating them unfairly or feel that hospital is overreaching. The buck stops here. As physicians, we have to participate in hospital staff meetings and engage in the development and maintenance of medical staff bylaws to maintain our clinical autonomy. We must work for physicians to maintain an appropriate level of control over the hospital’s medical staff.

It is especially necessary with the increased pressure by payers, hospital administration and other business entities who are trying to influence the practice of medicine. Your medical staff bylaws should be the final arbiter in disagreements between medical staff and administrative staff in the hospital or any other physicians and provide professional and legal protection, if necessary. Your medical staff bylaws are the ultimate tool in the goal of quality, safety and value. The organized medical staff and hospital governing board are jointly responsible for continuously improving quality patient care and outcomes as well as providing a safe environment for patients, staff and visitors.

The Joint Commission standards are the “right medical staff develops criteria to be used for evaluation of the performance of practitioners when issues affecting the practice of medicine are identified.” In other words, quality of care is the physicians’ responsibility. The Medical Councils of Participation echo this. “The hospital should have an organized medical staff that operates under bylaws approved by the governing body and is responsible for the quality of medical care provided to patients by the hospital.” The practice of medicine must remain separate from business interests and agendas in order to provide safe and quality care.

It is our responsibility to have outside counsel to write the bylaws that will be self-governance. The medical staff bylaws should provide a binding, mutually enforceable agreement that both the medical staff and hospital board must follow. It is not a document imposed on us by administration. To create bylaws that also bond the hospital, the medical staff should discuss with its legal counsel the value of language, such as “These Hospital Medical Staff bylaws are binding on the hospital and the medical staff once adopted by the hospital medical staff and approved by the governing hospital body.”

In creating or revising the medical staff bylaws, we must outline our responsibilities, define true peer review and ensure the quality and safety for our patients as the focus. If you need an attorney, the Texas Medical Association legal staff can refer you to attorneys who specialize in this kind of work.

Here are our thoughts commonly held in medical staff bylaws:

1.) Hospital Policy - Some hospitals place key issues in separate plans or manuals that, unlike bylaws, can be changed unilaterally. Watch out for language inserted in your bylaws, such as “Members shall comply with hospital policy” or “Members agree to abide by hospital and medical staff bylaws and policy.”

Criteria for membership and privileges, leadership selection and other important medical staff functions controlling who can practice what at the hospital should be in the bylaws, not a separate administrative policy. These are medical staff responsibilities.

Remember that hospital policy can drastically affect your life. For example, they could require every physician on staff to have high level administrative policy. These are medical staff responsibility.

We should be in alignment with the hospital in our goals of quality, safety and value. The organized medical staff and hospital governing board are jointly responsible for continuously improving quality patient care and outcomes as well as providing a safe environment for patients, staff and visitors.

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Medical staff bylaws

If allowed by the medical staff, hospital policy can be completely controlled by the hospital, but it doesn’t have to be that way. It is difficult to accomplish but ideally hospital medical staff should review and approve a medical staff bylaws plan which will allow you a free life and enjoy working in a collaborative model, then Vanguard Geriatrics is a great fit for you. We are looking for Full-Time and Part-Time physicians for the following positions: Medical Director and Consulting Physician. Please send your curriculum vitae to info@vecare.com. If your bylaws or rules do not provide for physician due process. Also, it may be necessary to reassure the reader that your bylaws do not “hospital policies.”

2.) Hospital-controlled medical staff leadership - Administrators and hospital boards should not dictate who is on the medical staff or who is removed. Be wary of language, such as “Before taking office, all officers must be approved by the governing body” or “Removal of any officer of the medical staff may be initiated by the Board of Directors.” If such bylaws should never allow the hospital to unilaterally suspend a physician or discharge a medical staff member. The administrators and hospital boards should provide the service of managing and overseeing the hospital and physicians should be in charge of caring for patients. The medical staff must be self-governing and the medical staff bylaws must assure that it is. This means physicians need to know their bylaws and review them on an annual basis.

3.) Disruptive physicians - Outrageous actions by medical staff members threatening hospital employees and patients are given often as the example justifying language in medical staff bylaws calling for disciplining disruptive physicians. The Joint Commission requires hospitals to implement Codes of Conduct defining “disruptive behavior” and “inappropriate conduct.” Unfortunately, some hospitals use such codes to “economically credential” physicians. For example, watch out for language in Code of Conduct, which define as “inappropriate conduct” as any negative statement about hospital services, or any activity that is “disruptive to hospital operations.” These terms are so broad that they could prohibit constructive criticism, or financial interests in anything from a surgery center to a gift shop. This means physicians must uphold these Codes of Conduct and apply equally to all physicians.

4.) Outstretched peer review - The core purpose of the medical staff is to provide a structure for ongoing peer to peer quality patient care improvement. However, as physicians are more stretched providing patient care, it is not surprising that data systems are more sophisticated, medical staffs may find the reins of peer review process slipping away, with quality measures and the focus of quality studies being dictated from hospital administration or the hospital. While Joint Commission Accreditation is the frequent reason given for gathering and measuring data, physicians should know that the Joint Commission expects peer review to be conducted by peers, not administration. This means physicians must participate in quality review and peer review and be willing to censure poor physician performance if indicated. We must take the responsibility of our own medical staff and the bylaws that create the need for peer review and responsibilities so we can provide the best care for our patients.

Medical staff bylaws

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News from TexMed 2014

The Texas Medical Association’s (TMA) annual meeting, TexMed, was held in Fort Worth, May 2-3. Here is a briefing on what occurred:

Elections

Saying he will work to stop physicians from “being marginalized out of the health care debate,” Abilene otolaryngologist Austin King, MD, became the 149th president of TMA at TexMed 2014. The TMA House of Delegates unanimously selected Houston cardiologist and former HCMS President Tom Garcia, MD, as president-elect of TMA. Houston emergency medicine physician and former HCMS President Diana L. Fite, MD, was elected to be on the Texas Medical Association (TMA) Board of Trustees.

Awards

Houston ophthalmologist Alan Baum, MD, was presented the TMA Distinguished Service Award, the association’s highest honor, at TexMed 2014. A former TMA president and longtime board chair, Dr. Baum made his mark as a leader in TEXPAC and TMA’s legislative activities. “Calling on legislators can make such a difference, when you see you’re willing to share what’s important to your patients and your practice,” he said. “Doing so, you represent so much more than yourself.”

The Resident and Fellow Section’s J.T. “Lamar” McNew, MD, Award went to Arlo Wolfe, MD, of Houston.

Resolutions: Call for permanent delay of ICD-10

Ratifying a position TMA has pushed in Congress and at AMA, the House of Delegates adopted a resolution directing that TMA “work to permanently delay the implementation of ICD-10.” Delegates also:

• Called for changes in the Affordable Care Act (ACA) to prevent recoupment of payments to physicians made during the ACA grace period when physicians have not received adequate notice that the patient has not paid his or her premium; said Congress should permanently adopt Medicare payment parity for Medicaid services provided by primary care physicians and extend that parity to all other specialties; directed TMA to work with other organizations to “aggressively pursue the reduction or elimination of as much of the documentation burden as possible”;
• Established new TMA policy on the number of attempts and amount of time allotted for passage of medical licensing exams;
• Called for insurance companies to provide real-time adjudication of claims;
• Approved a phased-in dues increase of up to $12 per year for five years; and
• Rejected a proposal to eliminate TMA’s International Medical Graduate Section.

Marketing on a shoestring budget - June 11 meeting

Want to develop your patient base and referral network? The Harris County Medical Society (HCMS) can help. Building and enhancing your patient base is not easy. Regardless of whether you are a young physician developing your practice or an established physician facing a retiring referral base, it is important to know the tools available that can help you grow your practice. Many physicians assume that the process is expensive and time consuming. It does not have to be. HCMS can help. It is a free member benefit.

Attend “Marketing 101: HCMS Resources to Develop Your Patient Base,” at 6:00 p.m. on Wednesday, June 11, at The John P. McGovern Museum of Health & Medical Science (The Health Museum). The evening will start at 6:00 p.m. with half an hour of networking. Presentation will begin at 6:30. The lecture will offer you tools that will fit any budget. The event is free of charge and is designated as a one-hour ethics CME. A light meal is included and free parking is provided in the HCMS parking garage. Registration is required. To register, go to www.hcms.org and select Events/Other, then click on Marketing 101.

Medicare corner

How to calculate nonparticipating physician payments

All physicians enrolled in Medicare regardless if they are participating or nonparticipating are required to file claims to Medicare. If physicians who are enrolled in Medicare choose not to file claims to Medicare they can be subjected to the following sanctions, civil monetary penalty up to $2,000 for each violation, a 10 percent reduction in payment, and/or exclusion from the Medicare program.

The difference between participating and nonparticipating physician is that participating physicians have agreed to accept assignment and be reimbursed at 100 percent of the Medicare Physician Fee Schedule (MPFS) allowable, minus the coinsurance and deductible.

See MEDICARE CORNER continued on page 4