Georgia Society of Anesthesiologists, Inc.
scope Newsletter
Fall 2011

Payment ADVOCACY

CMS LCDs impact patient care

By Raphael Gershon, MD

Editor's Note:
Drs. Raphael Gershon and David Gale serve as the GSA representatives to the Carrier Advisory Committee (CAC) for Medicare and Medicaid. On behalf of GSA members, they met with the Cahaba Medical Director at Emory Midtown in late July to advocate for changes and clarity in current payment procedures. Dr. Gershon filed the following report.

Dr. Gale and I are privileged to serve GSA members as reps to the CAC. This update begins with a primer on terminology and process.


Dr. Gershon

CAHABA, GBA
CAHABA Government Benefit Administrators®, LLC (Cahaba GBA) administers Medicare health insurance for the Centers for Medicare & Medicaid Services (CMS). Cahaba has been a Medicare contractor since the inception of the program in 1966. They are the J10 A/B Medicare Administrative Contractor (MAC) for the states of Alabama, Georgia and Tennessee and currently remain the Part B Carrier for Mississippi.

LCD
A Local Coverage Determination (LCD) is a decision by a MAC whether to cover a particular service on a MAC-wide basis in accordance with Section 1862(a)(1)(A) of the Social Security Act (i.e., a determination as to whether the service is reasonable and necessary). For a complete overview of LCDs, access the Program Integrity Manual (PUB 100-08) Chapter 13 at http://www.cms.hhs.gov/manuals/downloads/pim83c13.pdf.


Dr. Gale

Draft LCDs
When a new or revised LCD requires comment and notice, Cahaba GBA is required to provide a minimum comment period of 45 calendar days on the DRAFT LCD.

Instructions regarding comment submissions can be found on their LCD Comment and Reconsideration page. Cahaba GBA considers all

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GSA joins MAG third-party payer resolution service

GSA members may now access the highly-effective third-party payer claims resolution program run by the Medical Association of Georgia (MAG). The GSA Board approved the relationship at its July 2011 meeting.

> "Members who participate may realize significant compensation."

Here's how the program works:
Participating specialty societies pay MAG a service fee each year. MAG will then charge the physicians who use the service a recovery fee, including 10 percent of the claims that are recovered for members of GSA or MAG. Physicians who are not members will be charged 25 percent of the claims that are recovered.

To get started, go to www.gsahq.org to access the form.

"GSA constantly seeks to provide additional value to membership," GSA President Dr. Tim Beeson said. "Members who participate may realize significant compensation that otherwise would remain mired in third-party red tape."

If a practice that includes both members and non-members submits claims for assistance, the individual physician's claims will serve as the basis for the recovery fee (e.g., if physician A is a member and physician B is a non-member, the recovery fee for physician A will be 10 percent while the recovery fee for physician B will be 25 percent).

MAG's Director of Health Policy Cam Grayson will oversee the program. She stresses that practices must exhaust every contractual remedy and appeal before submitting a claim to MAG, adding that claims information must be submitted to MAG in an electronic format and must also include…

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Editor's Corner

Kathryn Stack, MD, Chair, Communications Committee, Editor, GSA *scope*

Passing milestones in uncertain times

I hope you are all well as, at last, the humidity of another hot Georgia summer fades. Certainly, the economy remains in the forefront on the minds of most Americans. All of us know someone who is really struggling in these times, and it's very easy to get caught up in the bad news. Yet, despite the slow economy, the GSA has attained some notable milestones this year.

The 2011 annual summer meeting held at the King and Prince Beach & Golf Resort on St. Simon's Island marked the first time in GSA history that the ASA jointly sponsored our state component society meeting. Co-directed by Drs. Ken Stewart and David Pae, the meeting attracted a powerhouse of ASA leadership. GSA members were treated to a weekend of great lectures, quality beach time and a great opportunity to speak with ASA leaders.

After years of tireless work by many within the GSA, Office Based Surgery (OBS) regulations are around the corner. During the 2010 legislative session the Georgia House of Representatives and Senate each passed resolutions urging the Georgia Medical Board to create guidelines for office based anesthesia and surgery. These guidelines were completed in June, and the Board of Medicine expects to publish them soon for comment. The 2011 legislative session brought passage of the Prescription Monitoring Program (PMP) designed to identify and discipline those who operate "pill mills" within Georgia.

The GSA has accomplished so much more as you will see in this edition of *scope*. Many thanks to Jet Toney and his team for their work on behalf of the GSA and to those members of the GSA who dedicate their valuable time to the benefit of their anesthesiology colleagues and the patients of Georgia.

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St. Simon's Island event a 'sell-out'

Location and course content drew more than 100 physicians to the highly successful summer meeting July 22-24 at the King and Prince Beach & Golf Resort on St. Simon's Island, Georgia. The "sell-out" attendance marked three consecutive CME meetings to have generated registration over the century mark. The event also holds the distinction of being the first jointly-sponsored by the GSA and the ASA under a pilot program to determine whether such arrangements are valuable to both organizations.

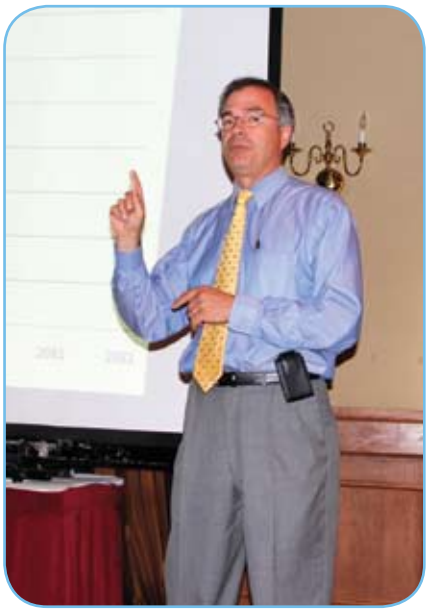
"I want to personally thank Dr. Stewart and Dr. Pae for their dedication to creating a truly effective learning environment and relevant, patient-centered curriculum," GSA President Dr. Tim Beeson said. "Program and Education Chair Dr. Carolyn Bannister has GSA's CME program clicking on all cylinders."

Dr. Kenneth Stewart and Dr. David Pae, the summer activity co-directors, are Assistant Professors of Anesthesiology at Emory University and Attending Pediatric Anesthesiologists at Children's Healthcare of Atlanta's Egleston Hospital.

An additional highlight was attendance and participation by five ASA Officers and the first anesthesiologist elected to the U.S. Congress. Dr. Andy Harris, U.S. Representative from Maryland, met attendees over coffee for personal conversations on medical issues and then presented in the CME meeting on the impact of the federal government on patient care and physician payment.

ASA officers participating were ASA President Dr. Mark Warner, ASA VP for Professional Affairs Dr. Bill Johnstone, ASA VP for Scientific Affairs Dr. Arnold Berry, and ASA Vice-Speaker of the House of Delegates Dr. Steve Sween. Special guest John Thorner, ASA Executive Vice-President, also attended and presented at both the CME meeting and the GSA Board meeting.

The outstanding faculty members were awarded high marks in post-meeting surveys of attendees. Eight Emory residents and one medical student presented scientific posters which were displayed through the lecture room.



U.S. Rep. Dr. Andy Harris, R-Maryland

Dr. Ahsan Qadeer

Faculty
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Darlene Mashman, MD, Atlanta, GA
Arnold J. Berry, MD, Atlanta, GA
Ahsan Qadeer, MBBS, Augusta, GA
Tina Frey, RN, Charleston, SC
Roman Sniecinski, MD, Atlanta, GA
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Mark A. Warner, MD, Rochester, MN
Lena Sun, MD, New York, NY
John Thorner, Park Ridge, IL
Kenneth Stewart, DO, Atlanta, GA
David Pae, MD, Atlanta, GA

(L to R) David Pae, M.D., ASA President Mark Warner, M.D. and Kenneth Stewart, D.O.

GSA Summer Faculty Dr. Darlene Mashman (l) and P & E Chair Dr. Carolyn Bannister

Photos by Dr. Ken Stewart

Surveys say: Exhibitor contact 'good' for all

Dale McMillon, MD
Chair, Vendor Relations

GSA values the participation and support of exhibitors at both of the Society's annual meetings. Exhibitor participation assures the following benefits to GSA members who attend the Society's CME conferences:

- 'Hands on' exposure to the newest equipment, software, consulting and products specifically for anesthesiologists
- Face-to-face exposure to the personnel who provide these products/services
- Financial support to the GSA which makes meetings viable
- Financial support which keeps registration costs low for GSA members
- Creates a dynamic atmosphere of professionalism at the meetings
- Provides a social atmosphere where doctors can associate with vendors as desired.

More than 20 vendors exhibited and participated in the functions at the Society's July 22-24 summer meeting at St. Simon's Island. After the meeting, GSA headquarters issued surveys to both attendees and to exhibitors to measure satisfaction and opinions about how GSA includes exhibitors/vendors in the annual meetings.

2011 Summer Meeting Exhibitors

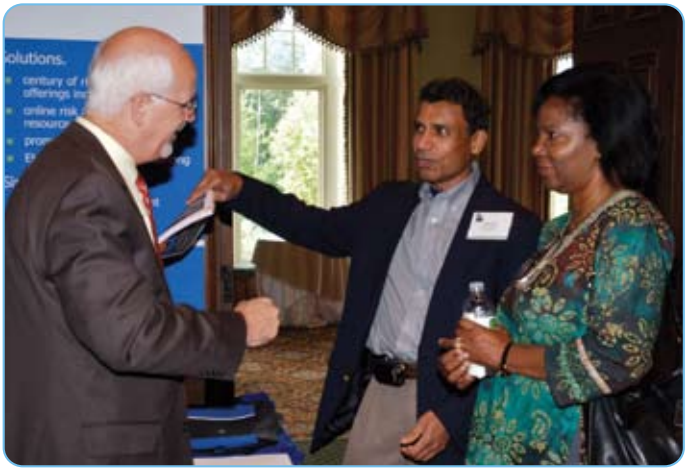
I am pleased to report that results of the survey confirm that both doctors and exhibitors value the opportunity of interaction at the meetings. Generally and overall, survey responses were extremely positive. More than 35 percent of attendees responded and nearly all exhibitors returned completed survey instruments.

The following summarizes the survey responses:

Vendors
Very positive, with most survey items graded "excellent". The items graded as "good" were 1.) space provided, 2.) time for exhibitor setup, and 3.) quality of the breaks and receptions. Several vendors commented that the space was "tight", so this will be addressed at future locations/meetings. Some exhibitors stated they would like more time with the physicians during exhibit times.

Members
Overall responses were very positive, with the current breakfast and break schedule rated as effective by 93% of respondents. The amount of doctor/vendor social interaction was also rated appropriate by most attendees.

The Vendor Relations Committee will continue to measure satisfaction of our exhibitors, especially those who are regularly participants, and work toward even more effective interaction.



GSA will return to the palatial Ritz-Carlton Lodge at Lake Oconee/Reynolds Plantation for the July 20-22, 2012 Summer Meeting.

Abbott
Melinda Montgomery

Cadence Pharmaceuticals
Chad Sharp
Todd Shirley

CIVCO Medical Solutions
Leeann Haberman

Covidien Respiratory & Monitoring Solutions
Dallas Shults
Matt Miller

Covidien Respiratory & Monitoring
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Surgical Information Systems
Robert Schoy
Cathleen Olguin

ZymoGenetics a Bristol Myer Squibb Company
Dana Turley

Nominating

Steve Walsh, MD
GSA President-Elect & Chair, Nominating Committee

GSA stronger through service

Do you want a stronger GSA? Why do I ask? Because, often times the first step toward reaching a goal is to start with a question. As a fellow member I am confident in saying we share the same answer: "Yes!" to a stronger GSA.

The desire to be stronger takes nothing away from the position we hold today. The GSA track record is formidable. The actions our leaders have taken create a better environment for Georgia anesthesiologists and their patients. Their actions have also equipped them to become leaders within the ASA. Elected positions show both current and past success.

Currently, we have Dr. Arnold Berry as ASA VP of Scientific Affairs and Dr. Steven Sween as Vice Speaker of the ASA HOD. Dr. John Neeld is a Past-President of the ASA. Current appointments have Dr. Carolyn Bannister on the BOD of ASA-PAC.

So how do we get stronger? Look no further than the GSA Mission Statement. There you will find 10 extremely effective action words: associate …affiliate …engage …interest …encourage …raise …safeguard …develop …educate …and elevate. These are the keys to our stronger future.

Each year membership has the opportunity to take action through the recommendations of the nominating committee. Under GSA bylaws, the nominating committee will organize to review the positions of vice -president, president-elect, secretary/treasurer, GSA and MAG delegates and alternates, ASA directors and alternates, and standing committee appointments. Our GSA committees are what fuel our mission within the areas of academic anesthesia, anesthesia care team, advocacy, awards, carrier advisory, communications, education, membership, practice management, and vendor relations.

Within our mission is a place for your interests and talents. GSA committee work is accomplished through conference calls with convenient schedules.

Within our mission is a place for your interests and talents.

Should you have an area of interest or just wish to help your GSA contact me at stevenwalsh@bellsouth.net or the GSA office at heather.atha@politics.org. The GSA wants you to take action. A sports team's success is improved by the depth of its bench. The same holds true for the GSA. Let's fill the bench with your interests and talents and implement those actions needed to build our stronger future.

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Representative to Medicare & Medicaid
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David Gale, MD, Rep. to Carrier Advisory Committee

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Arnold Berry, MD, MPH
Edwin Johnston, MD

Newsletter Editor/Communications Committee
Kathryn Stack, MD, Editor
Carolyn Bannister, MD, Senior Editor
Howard Odom, MD

CMS LCDs ...continued from page 1

comments and revises the LCD as needed. Once finalized, the comments and responses will be compiled into a document which will be accessible within the Final Draft LCD under the "Related Documents" section. Cahaba GBA shall provide a minimum notice period of 45 calendar days on the Final Draft LCD.

Your GSA contingent simply stated that 'appropriate training' involves going to medical school.

Two new LCDs were discussed that affect the out-patient pain management realm. In both of these, the bottom line is limiting utilization. The two new LCDs relate to policies covering payment for Epidural Steroid Injections, Facet Joint Injections, and Radio-frequency Neurolysis of Facet Joint Nerves. As many know, there is a huge push to restrict access to these procedures. The carrier in Oregon and Washington (Noridian) has sought to issue non-payment for any facet joint procedure citing lack of medical evidence. This also follows position papers from the American College of Physicians who feel ALL spine pain needs to be treated with only NSAIDS, physical therapy and a interdisciplinary approach.

LCD One

One can see the battle brewing ahead. The first LCD states that no more than four Epidural Steroid Injections (ESI) will be allowed per year without regard to cervical, thoracic or lumbar region. This goes back to the WellPoint stance (they own Georgia BCBS as well as many of the Medicare Carriers) of 3-4 years ago that they will only consider four injections/year. No other insurer in Georgia has followed their lead except for BCBS. However, if it is limited by Medicare, then all other private payers quickly will follow suit. They have no specific rationale for four per year, but cite various 'guidelines' and lack of RCTs (randomized controlled trials). Georgia Medicaid supports six per year, which is based more on total steroid dosing.

Of further concern is the proposal to allow Nurse Practitioners, Clinical Nurse Specialists, and PAs to perform ESIs as long as they have had "appropriate training in interventional pain management". So, now we see where they want to limit physician utilization, as well as open the door for "certified" RNs and PAs to engage in interventional pain management.

LCD Two

The second new LCD relates to Facet Injections and Radiofrequency Neurolysis and has similar language attempting to restrict utilization and open up for nonphysician proceduralists. Specifically, noted restrictions of "at least 3 months duration…" is problematic for someone in severe pain who has failed conservative treatment. Many elderly cannot participate in physical therapy and do not tolerate opioids. NSAIDS are mentioned, but these drugs are essentially contraindicated in elderly with any history of GI, renal, or cardiac disease.

The LCD would also deny all intra-articular facet injections for therapeutic purposes. Also they state a required 80% improvement/reduction in pain criteria during diagnostic medial branch nerve blocks before allowing radiofrequency denervation. This means a patient starting with a pain score of 6/10, who goes to 2/10, does not get the treatment. If a patient starts out with a pain score of 8/10 and goes to 2/10, he/she STILL does not get the treatment. It will also allow only two radiofrequency sessions per year regardless of location in the spine.

This is just one of the many points which come under, I believe, non pain specialists practicing pain management.

We spent at least 30 minutes educating the Carrier Medical Directors on these subjects, and they appeared to be open to GSA's suggestions. The most active discussions were about the fact that both of these LCDs would allow Nurse Practitioners/PAs/Nurse Specialists to perform ESIs, facet injections and radio frequency as long as they demonstrated "appropriate training." Several other physicians from other specialties voiced strong disagreement to this as well. Your GSA contingent simply stated that 'appropriate training' involves going to medical school.

The ESI and Facet LCDs are currently under the six-week comment period that ends 8/24/2011. Anyone can add their comments to CAHABA about LCD 32112 (ESI's) and LCD 32116 (facets and RF) by going to...
www.J10LCDComment@cahabagba.com

LCD Three

The third new LCD, initially presented at the CAC in March 2011, concerns Continuous Peripheral Nerve Blockade (CPNB). During the previous CAC meeting in March, CAHABA presented this LCD to mainly cover peri-operative use of continuous peripheral catheters for post-op pain--e.g. femoral nerve catheter for post-op ACL repair pain control. The initial LCD totally bundled payment for this service into the primary anesthetic unless it was placed AFTER the patient was discharged from the PACU. We have ultrasound guidance or peripheral nerve stimulation to help with efficacy and safety. The draft LCD also allowed "other qualified practitioners" to perform CPNB providing they have "appropriate training". (Some weekend ultrasound course no doubt!). This insertion is very concerning as the nursing lobby is quite strong.

We discussed during that March CAC meeting that payment needs to be allowed in a similar fashion as payment policy allows for epidural catheters used for post-op pain. However their re-wording of the LCD was still quite a bit nebulous about payment when a general anesthetic was also involved. At our latest meeting, we received a verbal commitment from Drs. Humpert and McKinney (the CAHABA Medical Directors) that if a CPNB catheter was placed in the 'peri-operative' period but is NOT the primary anesthetic (i.e. patient is undergoing general anesthesia), the procedure will NOT be bundled as long as it's primary purpose is for post-op pain control. So just as with epidural catheters, we must document that the CPNB catheter is being placed to assist with post-op pain and the surgical procedure or patient co-morbidities is such that a continuous catheter is necessary.

GSA / MAG ...continued from page 1

- A record of every attempt to collect the unpaid claims
- A brief synopsis of the issue
- All supporting documentation
- A signed business agreement giving MAG the authority to view information that is covered by HIPPA.

Grayson also emphasizes that MAG will not collect money from patients; it will only do so from public and private payers. For issues not directly related to the recovery of funds, MAG will provide its members and GSA members with a preliminary consultation of up to one hour of staff time at no charge. MAG will refer practices to an outside attorney for consultations that require more than one hour of staff time – and the practice will be responsible for any fees that are required by the referral attorney. MAG will not charge a fee for referrals.

Contact Grayson at 678.303.9275 or cgrayson@mag.org for additional information on MAG's Third-Party Payer Advocacy program.

Talent, energy fuel resident goals

Editor's Note: The GSA Resident Section conducts its governance meeting at the annual GSA summer meeting. Among the action items are election of officers and setting of goals for the year. Names of new officers are published on Page Two. Following are select reports from officers.

Danika Little, MD

Treasurer

This summer's GSA-RC meeting was quite successful as we had the largest turnout in years and a great amount of enthusiasm in making the resident component productive. Wonderfully talented and energetic people were elected officers: President Vikas Kumar, MD (MCG), VP and President-elect Justin Drummond MD (Emory), Secretary Andrea Dillard MD (Emory), Treasurer Danika Little MD (Emory), and Resident Liaison to the GSA Government Affairs Committee Hailey Gillis MD (Emory).

One of the bigger – and more exciting – goals of this year's Executive Committee is the organization of a day conference for residents with sessions designed to help with the transition to "real life." Topics being considered are various types of business practices and their pros and cons, how to know which type of practice is best for you, how to effectively look for a job and interview well, how to negotiate contracts, how to navigate the muddy waters of life and disability insurance, and other generalized transition-to-practice issues. This type of conference has occurred in the past and has been well received. Most residents are eager for this information, as it's generally not covered in great extent during medical school or residency training, and is one of the biggest sources of stress and frustration when finishing and leaving residency.

Another goal for the resident component is to aggressively seek 100% resident participation in donating to the ASA and GSA PACs from all Georgia anesthesia residents. In this time of economic recession and uncertainty in the political-medical environment, it is vital that we take an active interest in protecting our professional future. As anesthesia is often overlooked in terms of legislation, we need to fight to keep the public and government officials aware of our field, our expertise, and the need for well-trained and qualified anesthesia providers.

This year's resident component seems to be academically strong, motivationally energetic and intrinsically humanitarian. This bodes well for not only what we can accomplish as a group this year, but for the future of anesthesiology in Georgia and across the U.S.

Vikas Kumar, MD

President

The GSA 2011 summer meeting was a great experience as it has been in the past. Added to it was the wonderful atmosphere and an excellent location. I would like to congratulate the newly elected members of the resident component of GSA. To further promote the mission statement of GSA, i.e. general elevation of the standards of medical practice and patient safety, the resident section will work towards creating political awareness among all Georgia anesthesiology residents and aim for 100% involvement with GSA and ASA PACs.

Hailey Gillis, MD

Government Affairs Liaison

The primary goals set forth by the resident section are as follows:

1. 100% donation to PACs
2. Resident attendance at the GSA winter meetings
3. Obtaining speakers for resident specific issues including pursuing fellowships vs. private practice vs. academic assignments upon graduation, disability insurance, etc.

Justin Drummond, MD

President-Elect

During this time of economic uncertainty and pending change in the scope of our practice, it is even more imperative that residents are prepared for securing either a fellowship or job. The resident component goal is to bring in experts to assist with making this transition as smooth as possible with the support of GSA and sponsors.

'will work towards creating political awareness'

...academically strong, motivationally energetic and intrinsically humanitarian.

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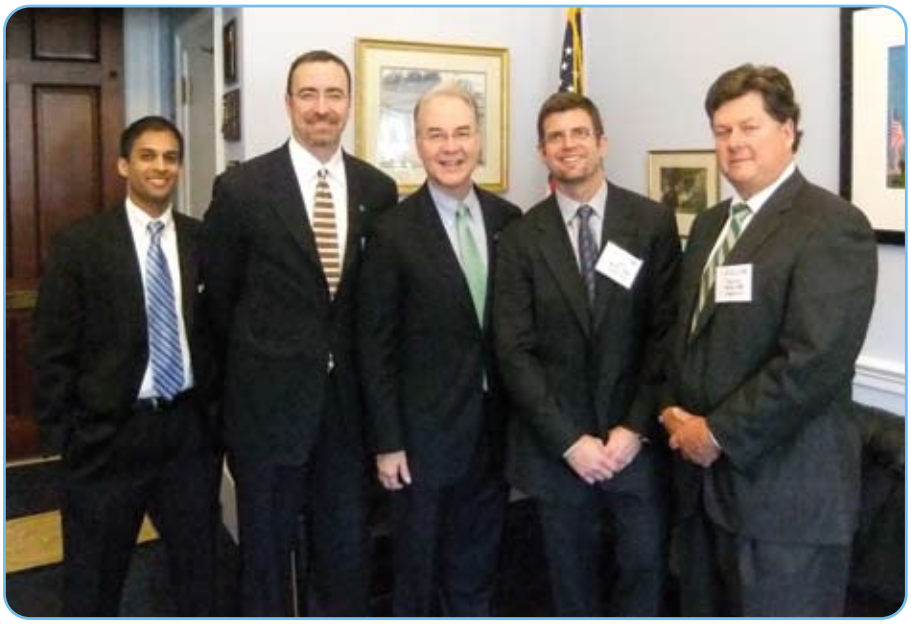
Raising (debt) ceiling, anesthesia issues

Michael McPherson
VP/Research, Cornerstone Communications Group



Washington, D.C. – GSA members discussed health care bills with U.S. Rep. Tom Price, R-GA earlier this year.

As the debate over the debt ceiling polarized the nation's attention this summer, many of the Congressional issues important to Anesthesiologists were put on the back burner. Now that the ceiling is a little higher, it is time for Georgia's Anesthesiologists to raise the roof on a few issues close to home. The following bills are ASA's top legislative issues and deserve GSA member support:

HR 452 "Medicare Decisions Accountability Act of 2011"
Sponsor: Rep. Phil Roe, R-TN
Co-sponsors (200 bipartisan): Rep. Paul Broun, R-GA; Rep. Phil Gingrey, R-GA; Rep. Jack Kingston, R-GA; Rep. Tom Price, R-GA; Rep. Austin Scott, R-GA; Rep. Lynn Westmoreland, R-GA

S 668 "Health Care Bureaucrats Elimination Act"
Sponsor: Sen. John Cornyn, R-TX
Co-sponsors (32 R's): Sen. Johnny Isakson, R-GA; Sen. Saxby Chambliss, R-GA

Both HR 452 and S 668 address the repeal of the Independent Payment Advisory Board (IPAB) created through the passage of the Patient Protection and Affordable Care Act. Medicare payment rates for anesthesia are extremely low at 33 cents on the dollar compared to private payment rates. Decisions made by IPAB to slow growth in expenditures could drag anesthesia reimbursement rates to new lows, as the attempt to restrain Medicare growth is scheduled to focus on Medicare Parts B, C, and D until 2020. Furthermore, the Medicare sustainable growth rate (SGR) formula does not distinguish between programs that lend greatly to ballooning Medicare spending and those that do not, such as anesthesia.

HR 452 needs more co-sponsors from Georgia's Congressional delegation. If your congressman is not on the list of co-sponsors above, contact him. Ask your legislator to co-sponsor and pass HR 452. Ask him to oppose SGR cuts and hold anesthesiology harmless. Hospital costs are a large part of Medicare expenditures; informing your legislator of new and innovative programs, such as the peri-operative surgical home concept, will give them more of the tools they need to help lower rising Medicare costs.

HR 451 "Healthcare Truth and Transparency Act"
Sponsor: Rep. John Sullivan, R-OK
Co-sponsors (45 bipartisan): Rep. Phil Gingrey, R-GA; Rep. David Scott, D-GA

The nomenclature of providers, number of degree acronyms, advertisements and marketing lend themselves to patient uncertainty across the spectrum of health care delivery. HR 451 aims to help clarify patient confusion when dealing with health care providers by enhancing transparency requirements surrounding advertising and marketing to help ensure patients receive accurate information. If your legislator is not on the list of co-sponsors, ask him to sign on to this important bill to help empower patients with accurate information when they are making important health care decisions.

HR 1044 "Medicare Access to Rural Anesthesiology"
Sponsor: Rep. Lynn Jenkins, R-KS
Co-sponsors (22 bipartisan): No GA Reps on bill to date (8-10-11)

Rural hospitals have a difficult time retaining anesthesia providers due to low patient volume, and Medicare Part B payments for anesthesia at 33 cents on the dollar does not help the situation. As an incentive for provider retention, a Medicare Part A pass-through is allowed for some rural hospitals, yet the pass-through is only allowed for payment of non-physician anesthesia providers; the arrangement is inequitable and adds to the retention difficulties rural hospitals face. Georgia has 22 rural hospitals. Contact your legislator and ask him to co-sponsor HR 1044 in order to help rural hospitals retain providers and ensure rural patients have access to the skilled professionals that they deserve.

S 296 "Preserving Access to Life-Saving Medications Act"
Sponsor: Sen. Amy Klobuchar, D-MN
Co-sponsors (11 D's): No GA Senators on bill to date (8-10-11)

Drug shortages often lead to the use of unnecessary alternative measures and disruptions in care that increase potential harm to the patient. From 2006 to 2010, new drug shortages rose from 70 to 211- many of which are used for anesthesia and chemotherapy. There are many reasons a shortage may occur, one of which is the interplay between the FDA and the manufacturers. Contact our Senators and ask them to sign on to S 296 and to push for a thorough investigation into the causes of drug shortages. Also, contact your congressman and ask them to support companion legislation in the House.

For more information visit the Federal Legislative and Regulatory Activities page of the ASA website: *www.asahq.org*

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GSA to fight participation as licensure condition

James E. "Jet" Toney
GSA Lead Lobbyist

The GSA is taking a leading role in organized medicine's pro-active opposition to any proposed law, regulation or public policy which would require a physician to participate in a health care plan as a condition of state medical licensure. The Society has sent to the Medical Association of Georgia a proposed resolution for consideration at its October 15-16 House of Delegates at Callaway Garden. The proposal calls on the MAG House to adopt an official policy position opposing any such condition.

The GSA action comes as a result of a motion put forth by the Board of Directors at the Society's Summer Meeting at St. Simon's Island July 22-24. The initiative was ratified by the full membership at the General Business Meeting on July 24.

"With northeastern states floating policies to require physicians to accept participation in health plans or lose one's ability to practice in that state, we can expect to see such proposals being offered in Georgia," GSA President-Elect Dr. Steve Walsh said. "Clearly, as a prominent physician's organization, the GSA should and will help lead this fight."

Other physician organizations, including the Medical Association of Atlanta, have proposed similar resolutions. The resolutions will be combined and considered as one at the MAG HOD.

A Resolution opposing any state requirement of physician participation in health care plans as a condition of medical licensure

Introduced by Steve Walsh, MD

Adopted by the Board of Directors of the Georgia Society of Anesthesiologists, Inc. on July 22, 2011 and ratified by the GSA membership on July 24, 2011.

Whereas, when our country celebrated our first 100 years, America was still a mere "colony" of European medical education. Medical care could be likened to the "wild west" with medical training having no standardization in curriculum and length of training,

Whereas, the medical profession recognized that having no standards for medical education and qualifications were bad for the patient and bad for public safety,

Whereas, the Medical Association of Georgia was established in 1849 with a mission to "promote medical science, elevate the professional character of physicians..., and protect... the lives of the community,"(1)

Whereas, through these efforts and those of the Association of American Medical Colleges, the National Confederation of State Medical Examining and Licensing Boards standards for the benefit of the profession and public were created,
Composite Medical Board to oversee the standards and qualifications of a physician on behalf of public safety,

Now therefore be it resolved, the Medical Association of Georgia shall oppose any proposed public policy, rule or law which would require physician participation in health care plans as a condition of medical licensure.

Whereas, currently all states have a medical license board to define and oversee the standards and qualifications of a physician on behalf of public safety,

Whereas, currently all states are facing the challenge of increasing health care costs and in some states the wrong legislation to control those costs has been proposed,

Whereas, both Massachusetts and Rhode Island have sought to control health care costs through a provision of a bill that requires the participation of the physician in a health care plan as a condition of licensure in those states,

Whereas, linking the participation of the physician in a health plan as a condition of licensure in those states is an exploitation of physicians when insurance premiums have continued to rise and "physician...payment... between 1995 and 2005 has declined",(2)

Whereas, such public policy sends the wrong message and is the wrong approach: For physicians, "...payment... is based on a complex array of factors, most of which is largely outside of their control"(3) and forced participation would further undermine the ability of physicians to manage revenue against the market force influences of increasing operating costs, and

Whereas, the State of Georgia should preserve the mission of the Georgia Composite Medical Board to oversee the standards and qualifications of a physician on behalf of public safety,

Now therefore be it resolved, the Medical Association of Georgia shall oppose any proposed public policy, rule or law which would require physician participation in health care plans as a condition of medical licensure.

References:
1. Information from Web site. Medical Association of Georgia. "The History of MAG". Available at http://www.mag.org/about/history-of-mag.shtml
2. Paraphrased from "The Physician Practice Environment in Georgia 2010" Medical Association of Georgia 2010, p.7 (Note: original text reads "compensation" rather than "payment")
3. Paraphrased from "The Physician Practice Environment in Georgia 2010" Medical Association of Georgia 2010, p.17 (Note: original text reads "compensation" rather than "payment")

Member Value

Wait, stop, think!

Peggy G. Duke, M.D.
ASA Director, Georgia

For anesthesiology the only constant is change. In the past, changes occurred more slowly. There was time to digest, absorb, and accommodate to the changing currents. Today, the acceleration of change is approaching warp speed. Keeping track, much less understanding, how all these changes will impact the practice of anesthesiology is a task that has become overwhelming for any single anesthesiologist and even for large group practices or academic practices.

Keeping abreast of and responding to changes requires many experts in multiple areas with the time, education, and motivation to stay on top of the evolving environment. These experts must be able to function as full-time anesthesiology advocates; establish task forces with anesthesiology experts to study, review and respond to changes or proposed changes in laws, rules and regulations pertaining to anesthesiology; function as a public relations firm; provide legal counsel with full allegiance to anesthesiology; and be an effective liaison to CMS and other regulatory bodies, in addition to many other tasks. It is clear that individual anesthesiologists or anesthesiology groups simply cannot possibly do all these things.

How then will we in anesthesiology manage these Herculean tasks? Not as one person, not as one group, not as one academic center. No, we must coordinate our strengths, our resources, our common goals and work in concert.

Wait! Stop! Think! Every single anesthesiologist in the United States already has access to incredible levels of expertise, support, education and many more resources. In addition, all of these resources are available to every single anesthesiologist at an unbelievably low cost. The total cost for all these resources is the cost of annual membership in the ASA and in one's affiliated component society.

Memberships in the ASA and the GSA are remarkable bargains. Now, more than ever, all anesthesiologists need the ASA and their component societies to help in tracking and understanding the impact of all the changes that bombard our specialty on a daily basis. Now is the time for all anesthesiologists to invest time, if at all possible, in the ASA and the GSA and to invest money in both the GSA-PAC and the ASA-PAC.

"Memberships in the ASA and the GSA are remarkable bargains."

Anesthesiology's message that the highest quality of anesthesia care involves an anesthesiologist being involved in some capacity for every patient having an anesthetic needs to be broadcast loudly and clearly. The public should demand it. But how will they know if we do not tell them? Who will carry the message? Who will be the voice of anesthesiology if not anesthesiologists? Who understands the delicate balance of a properly administered anesthetic for critically ill patients, from the elderly adult to the premie neonate, if not anesthesiologists?

"Who will be the voice of anesthesiology if not anesthesiologists?"

How can any anesthesiologist believe that their future will be more certain without the ASA and the GSA? Even those who may be retiring in the near future, who may say, "I do not need to participate in the ASA or the GSA; I do not need to give to the ASA-PAC or the GSA-PAC, because I will soon be out of this morass." Consider the selfishness of that thought process. What if those who came before you were in this only for themselves and did not devote time, effort and money to advocate for anesthesiology, to do research, to set up residency programs, to teach residents and fellows? Where would you be?

You or someone you love deeply will likely require an anesthetic at some time in the future. Who do you want taking care of you or your loved one? Do you want someone who is bitter, disillusioned, and uninvolved in continuing to increase the stature of the specialty of anesthesiology and who goes to work just to put in the necessary hours? Or do you want someone who cares deeply about the specialty of anesthesiology, not only in providing outstanding anesthesia care but also in giving back to the specialty.

Every anesthesiologist should consider that part of the dues we owe our specialty involves not only showing respect for those who came before us who established anesthesiology as an important specialty without which modern surgery could never have evolved to its current state, but also in the same vein (no pun intended), those of us currently in practice have a duty to the future generations of anesthesiologists. Do you think you have a duty to leave to future anesthesiologists a well respected, dynamic, quality driven , highly sought after specialty poised to move to a higher level?

American Society of Anesthesiologists

PAC $$ impact races, policy

Katie Meredith, MD
Chair, Committee for Responsible Health Care Policy

During the 2009-2010 election cycle, GSA-PAC focused more than $135,000 in campaign donations to dozens of state candidates who have demonstrated support for public policy protecting physician-led healthcare and patient safety. In more than 85 percent of those elections, many of which were heavily contested, the candidate supported by GSA won.

The importance of electing state officials who are committed to keeping physicians at the forefront of decision making between patient and provider cannot be overstated. Considering the voluminous attacks on physician-led healthcare at the federal level, GSA members should recognize the importance of keeping a strong advocacy position at the state level. To use an auto racing analogy, the starting point for state-level advocacy is the electoral process that generates the policy makers.

In preparation for next year's state legislative campaigns, GSA-PAC is again initiating an aggressive distribution of financial support for those state representatives, state senators and statewide officials who have demonstrated support for physicians and patient safety or are in a position to influence such public policy. This fall, GSA-PAC will deliver to more than 50 state legislators and statewide officials an amount of political equity exceeding $50,000 – a handsome demonstration of GSA members' support for those policy-makers who have patients (their constituents) at the forefront of their policy thinking.

The delivery of PAC contributions is significantly enhanced when a GSA member delivers the check or accompanies a GSA lobbyist. The grassroots connection between elected official and local physicians is a powerful tool when lawmakers start consideration of healthcare issues. To participate in or initiate a PAC contribution delivery, contact GSA Executive Secretary Jet Toney at jet.toney@politics.org or phone 678-222-4222.

"the starting point for state-level advocacy is the electoral process that generates the policy makers."

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