Atlanta Women’s Health Group Wins Immunization Award

The Society congratulates the Atlanta Women’s Health Group for winning the Walt Ornstein award at this year’s Immunize Georgia Conference.

The Georgia Department of Public Health (DPH) announced the winners of the 2011 Walt Ornstein Champions for Immunization on September 15, 2011 at the 18th Annual Immunize Georgia Conference held in Macon, Georgia.

The Walt Ornstein Champions for Immunization Award, named after Walt Ornstein, M.D., honors those who exemplify a standard in immunization care set forth in the Standards for Child Adolescent and Adult Immunization Practices. These standards are a national strategy to protect America’s children against vaccine-preventable diseases and provide guidelines and resources to follow when providing immunizations. Ornstein achieved the highest immunization levels ever in the United States during his tenure of 26 years with the then Centers for Disease Control (CDC) focusing on infectious disease and immunizations. He later worked as the Deputy Director for vaccine-preventable diseases at the Bill and Melinda Gates Foundation, but returned to Atlanta to renew his appointment as professor of medicine in the Department of Medicine and serve as associate director of the Emory Vaccine.

The 2011 recipients of the Walt Ornstein Champions for Immunization Award include The Atlanta Women’s Health Group - one of the first OBGyn practices to implement an immunization program for their patients. The Atlanta Women’s Health Group realized it was not only good medicine but also made perfect business sense as a primary care provider. By screening and immunizing patients, The Atlanta Women’s Health Group filled a gap for preventive medicine services for their patients. In addition to being one of the first OBGyn practices to implement a full adult vaccination service for their clients, this group has greatly influenced other OBGyn practices interested in adopting this model. They presented their information to the Georgia OBGyn Society’s board meeting and are now assisting other practices to understand how to incorporate an immunization program into their own practices.

The Atlanta Women’s Health Group includes 11 practice locations and 94 providers including doctors and midwives. Immunizations have been an integral part of their practice since 2009 when the group started with the implementation of H1N1 vaccine for women.
The air is cooling and the Saturday rituals are in full swing in our college stadiums. The Society is in change mode. Our newsletter has grown and our newsletter expanded. We have partnered with Public Health on a number of grant initiatives to improve maternal health in Georgia. And we are getting ready to represent you during the 2012 legislative session in Atlanta. We will be improving our member communications over the coming year. I hope you have noticed our “new and improved” newsletter. It will bring timely and important information to you. We will be launching into the world of electronic networking during the 2012 legislative session in Atlanta. The key areas we will target are:

1. Develop THE voice for women’s legislative issues
2. Develop and offer practice survival skills and support
3. Become THE voice for women’s legislative issues
4. Develop and offer practice survival skills and support
5. Enhance communication and outreach

We offer a number of workshops and collegial activities for members and practice staff throughout the year. Our coding classes are very informative and our annual golf tournament offers a great opportunity to get together in an informal setting. We will be working with our legislators throughout the session on key issues effecting OBGyns and women’s health. On February 8th, we have a dedicated day at the Capitol for physicians to go “in force”. Information pertaining to this event will be forthcoming and I hope you will join us for the day. It is an effective way to participate in the legislative process with your colleagues.

2012 will culminate with our annual state meeting at The Cloister in August. We are building a stellar program which you will not want to miss! We look forward to seeing you there.

I welcome the opportunity to represent all of you this year as President of the Georgia OBGyn Society. Please call on me if I may be of assistance.

David Byck, MD
President, 2011-2012

2012 Georgia OBGyn Society Golf Tournament
At Bear’s Best Atlanta
A Jack Nicklaus Course
RANKED IN THE TOP GOLF COURSES YOU CAN PLAY IN AMERICA

Plan to arrive in time for lunch before tee off.

Please call the Society office for details: 770.904.5293 or look for a notice in the mail after New Years.

Wednesday, May 16, 2012

As we are all aware it has been just over one year since the Affordable Care Act (ACA) has been signed into law. Although not fully implemented, this law continues to be debated and attacked on its merits and faults. This law is making its way through the federal court system and eventually will be presented to the Supreme Court to determine its true constitutionality. Whether or not you support this rendition of health care reform, there are definite merits that help all of us. And there are certain aspects we feel needed to be part of health care reform were not. The Congress continues to be involved with the debate and will keep you updated as it relates to our jobs in caring for the women of Georgia. There are nine benefits that have arisen out of the ACA. These are:

1. Medicaid payment for smoking cessation counseling or treatment.
2. National direct access to obgyn care.
3. Easier Medicaid coverage for family planning.
4. Maternity and women’s preventive care mandated in all health plans.
5. Continued use of ultrasound without out-cuts.
6. Standardized HIT.
8. Research into post-partum depression.

There are three major problems for obstetricians and gynecologists you need to be aware of:

1. The bill perhaps promotes increased integration, hospital employment and large practices. (Presently 24% of ob practices are solo).
2. Abortion coverage in Exchanges is excluded. (Health plans have to inform enrollees of abortion option plans and enrollees have to write two checks. States can ban abortion coverage in the state’s Exchange).
3. Increased inclusion of lay midwives: In freestanding birth centers. In addition to these issues, there are nine problems all physicians are subject to:

1. IPAB, the 15 member Medicare cost-cutting board (appointed with minimal over-site) with the blanket authority to recommend these.
2. Mandatory participation in PQRS (CMS program).
4. Medical homes and accountable care organizations: pro and con.
5. Value based payment model that will reduce payments for low quality physicians and raise payments for high quality. Who determines who is high or low quality?
6. Public physician comparison website, already up and running based on PQRS data.
7. No tort reform.
8. No SGR repeal.

These are the issues, the answers are still forthcoming. Presently the court system, as mentioned above, is reviewing this law and it may be found unconstitutional. Whether the Supreme Court will rule on this before the next election is undecided. In spite of whatever happens, the ACA will be a huge topic of debate in the next presidential election. We will keep you informed of any major changes as they arise.
It’s that time of the year again... flu season! Although flu vaccination efforts should continue year-round, flu season has arrived and provided an excellent reminder of the importance of ensuring all of their pregnant moms are aware of the benefits of getting the flu vaccine.

The flu is a serious disease that can lead to hospitalization and even death. Among our most vulnerable groups are pregnant women. It is especially important to vaccinate pregnant women because of their increased risk for influenza-related complications. An increased risk of severe influenza infection was also observed in postpartum women (those delivered within the previous 6 weeks) during the 2009-2010 H1N1 pandemic. Vaccination can occur in any trimester, including the first trimester. Currently, there is no live-virus or TV vaccine should be given to pregnant women. The benefits of getting vaccinated go far beyond just pregnant women but the benefits to babies cannot be ignored. A study, which appeared in the June issue of the American Journal of Obstetrics & Gynecology, analyzed data from flu seasons between 2002 and 2009 and was collected by the New Vaccine Surveillance Network, which is associated with the U.S. Centers for Disease Control and Prevention. Within that data, researchers learned of 1,510 babies who had been hospitalized and had been tested for influenza infection. They concluded that babies born to moms who were vaccine naïve were up to 48 times more likely to be hospitalized for influenza.

If the study results sound familiar, it is because similar studies have been published in pediatric journals. Poonhlee notes that pediatricians only need to vaccinate their patients if they have been born; obstetricians, on the other hand, have the potential to influence women’s vaccination decisions during the course of their pregnancies by educating them and offering flu vaccines on site. Pediatricians have been vaccinating children for a long time, but vaccine recommendations for OB/Gyn’s have changed over the last decade, so everyone is having to learn new recommendations and adjust.

An article in the American Journal of Preventive Medicine concludes, “Immunization is an important part of women’s health care and has been, at least partially, incorporated into obstetric-gynecologic practice.” However, it also recognized that in regards to OB/Gyn’s, “Financial burdens and knowledge regarding vaccine recommendations remain barriers to vaccine administration.” Additionally, the article cited a majority of OB/Gyn’s agreed that financial factors, such as inadequate reimbursement, were barriers to vaccine administration. Others believed their immunization training was less than adequate and felt their practice would benefit from continuing medical education courses. In conclusion, while the obstetricians and gynecologists see the obvious benefit of vaccinations, there are a myriad of challenges presented in making vaccination administration a part of routine practice.

It is not a widespread practice that we have seen among OB/Gyn practices in Georgia, but is a practice that the Society supports. According to Dr. Robbins, of Atlanta Women’s Health Group, “It just makes good practice sense to provide vaccines to your patients.” Their practice embarked on adult vaccinations after conducting vaccinations during the H1N1 outbreak of 2009. This experience served as the springboard to expand their vaccination program. Georgia OB’s can start this flu season to starting vaccinating their patients and see the benefits to their clients, families and their practice. For more information pertaining to implementing a vaccination program in your practice, please email kwelsh@georgiaobgyn.org.

• The Georgia Department of Public Health (GA DH) has two links on their website regarding vaccination information on location for flu vaccines in your area. http://www.lungusa.org/lung-disease/influenza/flu-vaccine-finder
• GA Immunization Coalition: http://www.immaginega.org
• Additionally, if you are interested in receiving weekly emails from flu reporting on flu activity in your state, contact delitlee@dhc.state.ga.us

References

Interesting Factoid: Infant Mortality

In 2007, Georgia had the 8th greatest infant mortality rate among all states. Infant mortality had little correlation between the years 2007 and 2008. The infant mortality rate in Georgia is significantly lower than the Healthy People 2010 objective of 4.5 infant deaths per 1,000 live births. Among African-American, black, non-Hispanic infants, the infant mortality rate was nearly 14 percent over 1,000 live births. 191 percent higher than the Healthy People 2010 objective.

Text4baby provides timely pregnancy and health tips sent directly to participants’ cell phones in the text format. While 90 percent of people in the U.S. have cell phones, text4baby is the first free pre-med education program to harness the popularity of texting as a mode of communication. Pregnant women and new mothers who text “BABY” or “BEBE” for Spanish to 51188 receive weekly text messages, timed to their due date or their baby’s birth date through the baby’s first year. The messages, which have been vetted by government and nonprofit health experts like the Centers for Disease Control and Prevention, American Academy of Pediatrics, and March of Dimes, deal with nutrition, immunization and birth defect prevention, among other topics. Sample text4baby messages include:

• Need free or low-cost health care for you & your baby? Your state has programs to help. Call 877-543-7669 to find out if you qualify.
• Talk to your Dr. about getting a flu shot. Pregnant moms & babies can get very sick from flu. For info call CDC at 800-232-4636.
• Only 3 percent of new moms have cell phones. if you’re pregnant, urge your Dr. on new born screening tests? If not, ask for it. Your baby will have these in the tests in the first 48 hours after birth.

For more info: www.text4baby.org.

Expectant or new moms can easily get the information they need through a free service on their cell phones:

It’s the End of the World

As We Know It

Most of our specialty specific journals have articles and editorials that address the change of the current private practice model in Gynecology and Obstetrics. The national trend is the evolution of the large single specialty/multi-specialty group or the hospital owned physician practice. We are all trying to make wise decisions about our practice’s business model so we can weather the storm of changes we expect with the implementation of the Affordable Care Act (Health Care Reform).

Our AGA, pre-med student book club has influenced my opinion of these changes. These students are amazingly bright. They are refreshingly dedicated to the pursuit of a career in medicine and making the system better. They do not differ from past generations in this ideal. But in other ways, they have markedly different goals in how they wish to accomplish the success of a medical career.

These students and future doctors desire a balanced life: no long shifts, no neglected families, time for outside hobbies and interests. They are committed to hard work but want more. For most of these future doctors, the idea of an employed physician model is extremely attractive. These positions would enable them to practice in more of a work-shift model so they should be able to spend the time to rest, be part of a family, as well as pursue hobbies or service opportunities. For myself, this lifestyle and work model is tempting as well. After all: no business worries, no long hours, great compensation... What more could you want?

We need to be careful what we wish for. Autonomy as a group, as well as camaraderie with partnered physicians, is invaluable. These tangibles have not been described in the articles I have read. The model of a multi-specialist private practice has been successful in the provision of care in my community as well as others for reasons which may be lost if we abandon the concept of the private practice group.

First, practice partners are the best. They support us in our practice decisions. A consult or second opinion is just a few steps or phone call away. They provide assistance, teaching, and mentoring with surgical skills. The relief of having an expert set of hands at your shoulder as you embark on a new procedure. An modification of an old procedure allows us to be better surgeons and provides patients with treatment options outside of those we have learned in residency. Many times I have counted down the hours of my call so that I could go to bed. Being a physician, my bright-eyed rate of recovery to metaphorically sweat the swim from my brow when managing a long laboring patient that is flaring with a cesarean section.

The importance of maintaining high standards in the care we provide and adopting new practice management recommendations is enhanced by the group mentality. You usually do not implement change quickly, but you also do not procrastinate from taking action. There is always someone watching you. The emotional support with these difficult decisions requires a comfort and mutual respect that can only be developed with many years of building these practice relationships. When you are a member of a private practice group, it is like being married. This system promotes excellent and kind patient care. As a happy member of a private practice group, I challenge these models of the future to capture the abstract qualities that enhance the quality of care. As someone who will receive care in this uncertain future, I am dependent on these systems to succeed. I have confidence these brilliant pre-med students will get the job done. It will just be different.
Obstetricians are among the medical specialists in the United States most likely to be sued for malpractice. A survey by the American Medical Association of nearly 6,000 physicians during 2007-2008 found that 42.2% had had a medical liability claims filed against them. ACOG numbers are even higher. The 2006 ACOG Survey on Professional Liability found that 89.2% of the Fellows surveyed had been sued at least once. 2
To be sure, some 80% of lawsuits generally end with no money changing hands to the plaintiff. And as many as 9 out of 10 trials result in defense verdicts. 2 But to many physicians, judicial vindication does not compensate for the emotional distress experienced during the lawsuit.
In the past two decades, a growing literature has explained the phenomenon of physicians’ litigation stress, its psychological and emotional, even physical, effects. One such researcher in this area was Sara C. Charles, MD, a Chicago psychiatrist who was sued for liability. Though she won her trial, the five-year litigation experience left her feeling that “my medicine as a career. 6
In OB/GYN, the most dramatic consequence of litigation stress is the physician’s decision to give up obstetrics. This has been happening for quite a while. A survey of Florida OB/GYNs in the early 1980s showed that fully a quarter had given up delivering babies, primarily because of the threat of liability suit. 7 Since then, recurring liability insurance crises have dramatized this trend. A survey of Georgia physicians in the fall of 2002 found that a third of OB/GYNs planned to stop performing high-risk procedures.
How we cope with them will continue to pose both challenges and opportunities for physicians, medical societies and professional liability insurance companies.

References
4. Sara C. Charles MD and Eugene Kennedy PhD, “The Experience, Determining factors, and Consequences of obstetrician-gynecologists, and underscores liability insurance concerns as potentially shortening the duration of their careers.” The 2009 ACOG Survey on Professional Liability reaffirmed that risk or fear of professional liability litigation caused from 25% to 30% of those surveyed to decrease their care of high-risk obstetric patients, to increase their number of routine vs. c-sections, or to stop performing VBACs. 8
The obvious conclusion is that litigation stress is real, and an array of manifestations and consequences. In a recent ACOG Committee Opinion, the College urged several steps in action for physicians coping with medical liability litigation.

1. Defensive physicians should in-form spouses and family members, including children about the lawsuit.
2. Professional counseling could be an additional resource, especially as the counseling/consultation services accepts confidentiality of conversation, which is traditional-ly a concern of defense attorneys.
3. Physician’s decision to give up obstetrics. Some medical societies and professional liability insurance companies sponsor support groups for physicians in litigation stress. Clearly, medical liability lawsuits are bad facts of life for OB/GYNs and physicians of all specialties.
4. Physicians who are not members of the obstetricians in litigation stress is a phy-sician’s decision to give up obstetrics. Dr. Charles surveyed physicians who had been sued and those who had not. Defensive physicians are most likely to be stop seeing patients they thought could be litigious. They were also more likely to think about retiring early, and more likely to encourage their children from pursuing medicine as a career. 9
In OB/GYN, the most dramatic conse-quences of litigation stress is the phy-sician’s decision to give up obstetrics. This has been happening for quite a while. A survey of Florida OB/GYNs in the early 1980s showed that fully a quarter had given up delivering babies, primarily because of the threat of liability suit. 7 Since then, recurring liability insurance crises have dramatized this trend. A survey of Georgia physicians in the fall of 2002 found that a third of OB/GYNs planned to stop performing high-risk procedures.
How we cope with them will continue to pose both challenges and opportunities for physicians, medical societies and professional liability insurance companies.

Cystic Fibrosis (CF)

• Is the most common lethal autosomal recessive disease in the U.S.
• In every 25 Caucasians with no family history of CF is a carrier. The carrier frequency is lowest in other ethnic groups, but carriers are still detected.
• In every 46 Hispanics
• In every 45 Black Americans
• In every 90 Asians
• In every 46 Hispanics
• In every 46 Asians
• In every 90 Asians

Affects the respiratory, digestive and reproductive systems. Symptoms include pneumonia, diarrhea, poor growth and infertility. With treatment mortality and morbidity can improve, though 30% of those who live into their 20’s and 30’s, though the more severely affected may die in childhood. CF does not affect intelligence.

The American Congress of Obstet-rics and Gynecology (ACOG) and the American College of Obstetricians and Ge-netists (ACMG) endorse population screening for CF in patients who are planning pregnancy or considering pregnancy. Different labs offer testing for differing numbers of CF mutations, typically ranging from 32 to nearly 100 mutations. Fragile X syndrome provides a good check with their individual lab to determine detection rates for each ethnic group and number of mutations evaluated.

Screening for SMA

• Is the second most common lethal autosomal recessive disease in the U.S. after CF.
• In every 46 people over all racial and ethnic backgrounds. (1 in every 35 Caucasians).
• Is characterized by the progres-sive degeneration of lower motor neu-rons that results in worsening muscle weakness and, with the most common type, respiratory failure and death by age two. SMA does affect intelligence.
• ACMG endorses population screening for SMA. ACOG has not yet recommended population screening for SMA, but does recommend appropriate counseling to those undergoing screening.

Fragile X

• Is the most common inherited form of intellectual disability. It is found in all racial and ethnic groups resulting from excessive CGG repeats or the FMR 1 gene found on the X chromosome.
• Fragile X syndrome is a disorder that causes mental retardation, autism, and hyperactivity.
• Fragile X syndrome affects primarily boys. Women who are carriers are at risk to have a child with mental retardation.
• In every 260 women is a carrier for Fragile X, if they have no fam-i-ly history of mental retardation or autism. A family history of MR or autism would lead to an increased risk. The American Congress of Obstetricians and Gynecologists (ACOG) and the American College of Obstetricians and Ge-netists (ACMG) endorse population screening for CF in patients who are planning pregnancy or considering pregnancy. Different labs offer testing for differing numbers of CF mutations, typically ranging from 32 to nearly 100 mutations. Fragile X syndrome provides a good check with their individual lab to determine detection rates for each ethnic group and number of mutations evaluated.

Recommended Criteria for Population Screening (ACOG)

Generally accepted criteria that a carrier screening should meet before widespread screening is instituted include the following:
• Disease significantly impacts health and well-being in affected offspring.
• High frequency of carriers in the population to be screened.
• Technically and clinically valid screening methods are available to the population, and screening is cost-effective.
• Testing is voluntary, and informed consent and pretest and posttest counseling are available and effective.
• Prenatal testing is available for couples whose screening results are positive and reproductive options are readily available in a time-sensitive manner.

The Obstetrician-Gynecologist’s Role in Prenatal Carrier Screening

Prenatal carrier testing for cystic fibrosis (CF) and Fragile X syndrome is an integral part of obstetrician-gynecologist’s routine obstetric and gynecologic care. Obstetrician-gynecologists perform about 80% of all obstetric ultrasounds, which are sensitive to detecting fetal abnormalities. Obstetrician-gynecologists, therefore, are in a unique position to promote and perform carrier screening.

• Prenatal carrier testing for SMA: SMA is a common autosomal recessive disorder of motor neurons resulting in muscle weakness and fatal respiratory failure, typically by age 2 years. The frequency of SMA alleles among various racial and ethnic groups varies widely: 1 in every 90 Asians, 1 in every 46 Hispanics, 1 in every 45 Black Americans, and 1 in every 90 Asians. SMA is the most common lethal autosomal recessive disease in the United States. In every 25 Caucasians with no family history of CF is a carrier. The carrier frequency is lowest in other ethnic groups, but carriers are still detected.
• Prenatal carrier testing for Fragile X syndrome: Fragile X syndrome is an X-linked disorder caused by an unstable CGG repeat expansion on the X chromosome. Carriers may be identified as a part of routine prenatal screening, or by requesting testing for genetic counseling. It is the most common inherited form of intellectual disability in the U.S. and affects at least 1 in 38,000 males and 1 in 500 females. Affected males have autism, intellectual disability (ID), and characteristic facial features, while affected females are at risk for autism and may also experience a variety of other symptoms, including attention deficit hyperactivity disorder (ADHD) and learning disabilities. There is no cure for Fragile X syndrome, but treatments and support can help individuals lead fulfilling lives.

ACMG recommends population screening for SMA. ACOG has not yet recommended population screening for SMA, but does recommend appropriate counseling to those undergoing screening.

Case Presenting

Fragile X syndrome presents with a variety of symptoms, including:
• Cognitive impairment
• Autism spectrum disorder
• Attention deficit hyperactivity disorder
• Sleep disorders
• Depression
• Social skill challenges
• Learning disabilities
• Poor motor coordination
• Behavioral problems

ACMG endorses population screening for SMA. ACOG has not yet recommended population screening for SMA, but does recommend appropriate counseling to those undergoing screening.
The ABCs of Medicare and Medicaid Audits

The Medicaid Fraud Control Unit

Another way to fight waste in the Medicaid program is through the Medicaid Fraud Control Unit (MFCU). It is a single identifiable entity of state government, annually certified by the Secretary of the U.S. Department of Health and Human Services (HHS). The Unit has either statewide criminal prosecution authority or formal procedures for referring cases to local prosecutorial authorities with respect to the detection, investigation and prosecution of suspected criminal violations of the Medicaid program. You can find out more about MFCU here: www.namfco.us/about-us/about-mfcu

What to Do?

I think the best piece of advice I can give you is to not take inquiries from these agencies lightly.

• Visit the above web sites and stay abreast on all approved audit issues.
• Make sure you have the telephone number/e-mail/fax of your consultant and/or practice attorney in the event you are audited by any of these agencies lightly.
• Always be confirmed with a second source.
• Consider having a prospective review of the services you provide to see if you have any potential audit liabilities that need to be addressed.
• Make sure your staff reviews all requests for your records carefully to ensure nothing goes out without being first reviewed by the provider and/or your practice consultant/attorney.
• If you receive a letter from a MAC, RAC, ZPIC, MIP, MCFU, MIS or any other entity with Medicare or Medicaid on the letterhead, header or footer and you don’t already have a consultant or practice attorney in the event they roll out their enforcement and recoup potential overpayments, fraud, waste, and abuse.
• Hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
• Provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse.
• Along with these responsibilities, the Act also requires that CMS develop a five-year Comprehensive Medicaid Integrity Program (CIMP) in consultation with internal and external partners to outline the efforts to reduce overpayments, fraud and waste.

For more information on the MIP: www.cms.gov/ProviderAudits/

MAC - The Medicare Area Contractor

The first major step Medicare took to help reduce the amount of fraud and abuse in their system was to consolidate their Fiscal Intermediaries (FI) and Carriers into Medicare Administrative Contractors (MACs). In the past, Part A claims and Part B claims were processed by separate entities. Now, each jurisdiction has one MAC that processes both Part A and Part B claims. Georgia is in jurisdiction 10 and our MAC is Cahaba GBA. Their web site is: www.cahabaga.com

RAC - Recovery Audit Contractor

To further the recoupment activity of the federal government, Recovery Audit Contractors (RACs) were put into place in order to re-search and recoup potential over-payments for both Part A and Part B services. Georgia is in Region C and our RAC auditor is known as Connolly Healthcare. Their web site is: www.connolly.com/healthcare/Pages/CMSRAPRO-

The Medicaid Integrity Program (MIP)

In February 2006, the Deficit Reduction Act (DRA) of 2005 was signed into law and created the Medicaid Integrity Program (MIP) under section 1936 of the Social Security Act (the Act). The MIP is the first comprehensive Federal strategy to prevent and reduce provider fraud, waste and abuse in the $300 billion per year Medicare program.

CMS has two broad responsibilities under the MIP:

• Hire contractors to review Medicaid provider activities, audit claims, identify overpayments, and educate providers and others on Medicaid program integrity issues.
• Provide effective support and assistance to States in their efforts to combat Medicaid provider fraud and abuse.

Along with these responsibilities, the Act also requires that CMS develop a five-year Comprehensive Medicaid Integrity Program (CIMP) in consultation with internal and external partners to outline the efforts to reduce overpayments, fraud and waste.

For more information on the MIP: www.cms.gov/ProviderAudits/

Syphilis Rates in Georgia

The South was the only region that did not reach the health objective for the year 2000 of a reduction to 4 cases per 100,000 people, reporting 19.3 cases per 100,000 persons, a 192.4% increase from three years prior. Women’s health, as it relates to syphilis, can be directly correlated to the rate of congenital syphilis in a population. The rate of primary and secondary syphilis in the female population directly correlates to the rate of congenital syphilis, usually lagging by 1-2 years. Syphilis can be transmitted from mother to fetus during pregnancy causing stillbirths or congenital syphilis, with sequelae that include skeletal deformities, developmental delays, rash, hepato- splenomegaly, seizures.

In 2010 the CDC updated STD treatment guidelines. Few changes were made in regards to syphilis. It is important to note that false- positive can result from nontreponemal testing should always be confirmed with a treponemal test. CDC recommends using the same testing method (e.g., VDLR or RPR), preferably by the same laboratory. During pregnancy, it is mandated for screening to occur at the first prenatal visit. In high risk populations, serologic testing should be performed two additional times: between 28-32 weeks’ gestation and at the time of Continued on Page 10

Sexually Transmitted Disease Surveillance 2009. Division of STD Prevention. CDC 2009

CDC: http://www.cdc.gov/nchhstp/
Syphilis Rates in Georgia

Continued from page 9

delivery. Furthermore, any woman who delivers a stillborn infant after 20 weeks’ gestation should be tested for syphilis. All patients who have syphilis should also be screened for other STDs, including HIV.

Since 1947, Penicillin G is the drug of choice for the treatment of syphilis. Pregnant women who are allergic to penicillin should undergo desensitization, as there is no acceptable alternative therapy in pregnancy. Further information can be found in the 2010 guidelines at http://www.cdc.gov/std/treatment/2010/.

Medicaid System Changes

Your Comments Are Needed

Catherine Bonk, MD

The Georgia Department of Community Health is currently in the process of evaluating the Medicaid delivery system. To this end, they have hired the consulting firm, Navigant, to conduct interviews with and collect data from affected stakeholders. Some OBGyns from across the state have been invited to in-person group interviews along with other providers (Pediatrics, Adult Primary Care and Hospital representatives). GOGS thanks those who have participated so far. For those who have not attended a focus group, there is a way to express your opinion regarding issues with Medicaid and the CMOs (for example: the struggles with prior authorizations, ultrasounds and low payment rates) without leaving the privacy of your own office, home or laptop. Anyone can log on to a questionnaire by Navigant through the Georgia Department of Community Health website and type in the word “navigant” in the search box at the upper right corner of the screen. The questionnaire will pop up and should be available through early November.
Alternatively, you can email Navigant directly with your free form comments at navigant@ dch.ga.gov. GOGS urges you to make your voice heard during this crucial fact finding process. Navigant wants to be ready to present a report to the Commissioner of Community Health, David Cook. This report will help shape changes to the Medicaid system for the future and is a watershed opportunity. No such survey took place when the CMO plan was being implemented over five years ago. Please take the survey or email Navigant today as a voting and participating member of GOGS.

As over 50 percent of the deliveries in Georgia are Medicaid funded, this decision process is crucial to our specialty in a unique way. Pediatricians and Adult Primary Care Providers, while being our colleagues, are not acquainted with the issues that we as OBGyns face. Please respond to the survey today and if you happen to miss the deadline (as sometimes we do), email Navigant directly with your comments.

Volunteer Specialist Needed

The Good Samaritan Health Center (GSHC), founded in 1998 by Atlanta pediatrician Dr. Bill Warren, is a comprehensive healthcare ministry to uninsured, low-income families in greater Atlanta. GSHC needs volunteer physicians to see patients. Our services include but are not limited to: General Obstetrics and Gynecology, nutritional health, and mental health. We provide referral services as needed.

*Georgia doctors can earn up to 10 continuing education hours by providing uncompensated care at The Center.*

Please contact Crystal Harris (678) 553-4937 or specialtycare@goodsamatlanta.org for more information on how to get involved. Visit us at www.goodsamatlanta.org

November 2011
There’s a guiding philosophy to Mag Mutual’s efforts to defend your reputation: Whatever it takes. Claims committees staffed 100% by physicians. An exhaustive review and medical opinion for every claim filed. Outside help, when needed, to prepare a physician for deposition. Deep exploration of the best available expert witnesses. A detailed game plan weeks before trial. Testing the defense with focus groups. Mock trials. Continuous involvement of MAG Mutual’s claims specialists.

Much of the above represents an “expense” to other carriers – an expense they often don’t want to pay. So, they’re often inclined to settle. But settling just to avoid cost isn’t in the best interest of the physician, whose reputation, life and livelihood are at stake.

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