FRONTLINE PHYSICIAN

A Publication of the Indiana Academy of Family Physicians • Spring 2009

IAFP Presents "**Breaking Point**" Report to Legislators

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FRONTLINE PHYSICIAN

Volume 10 • Issue 1

FrontLine Physician is the official magazine of the Indiana Academy of Family Physicians and is published quarterly.

The mission of the IAFP is to improve the health of the people of Indiana, including its families and communities, by promoting and enhancing the practice of family medicine with professionalism and foresight. The IAFP will achieve this mission while working toward the following objectives:

Advocacy and Influence
Shape health policy through interactions with government, the public, business, the health care industry and other health care professionals.

Promotion of the Value of Family Medicine
Promote the specialty of Family Medicine and its value to the public, the business community, government and the health care industry.

Practice Enhancement
Enhance members' abilities to fulfill their practice and career goals while maintaining balance in their personal and professional lives.

Membership and Leadership Development
Foster the development of leadership within IAFP and encourage Family Medicine involvement at the community, state and national levels.

Education and Research
Provide high-quality, innovative education for physicians, residents and medical students that highlights current, evidence-based practices in Family Medicine and practice management.

Workforce
Ensure a workforce of Family Medicine physicians to meet the needs of all people in Indiana.

INDIANA ACADEMY OF FAMILY PHYSICIANS

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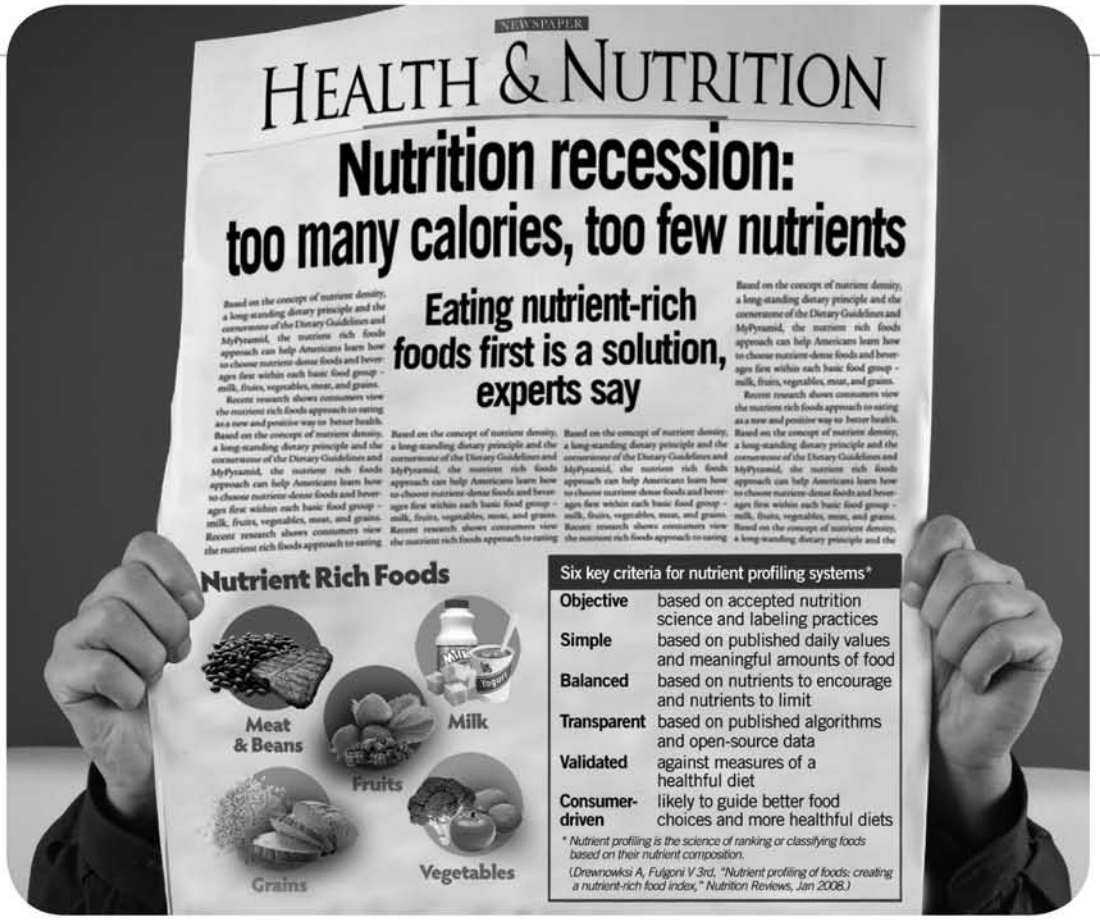

In recent years, Americans have learned *how to eat* by learning *what not to eat*. Is it working?

AMERICANS CONTINUE TO BE OVERWEIGHT AND UNDERNOURISHED.

Now a shift in thinking is under way to help Americans "get more nutrition from their calories," as recommended by the 2005 Dietary Guidelines for Americans.

As health professionals, you can play a pivotal role in educating your patients on how to base their food decisions on a food's total nutrient package rather than solely on what to avoid, such as calories or fat.

The nutrient rich foods approach is a fresh, realistic solution to help people evaluate food and beverage choices and get more nutrition per calorie, build healthier diets and achieve better health. Based on the concept of nutrient density, a long-standing dietary principle and the cornerstone of the Dietary Guidelines and MyPyramid, the nutrient rich foods approach can help Americans learn how to choose nutrient-dense foods and beverages first within each basic food group – milk, fruits, vegetables, meat & beans, and grains. Recent research shows consumers view the nutrient rich foods approach to eating as a new and positive way to think about making healthy choices – they like that it shifts their thinking from how not to eat to ***what to eat***.

Help your patients embrace the nutrient rich foods approach. Show them that nutrient-rich foods are familiar and easy to find, so healthy eating doesn't have to be difficult, stressful, or negative. Visit **www.3aday.org** for more information, including science-based resources, recipes, meal ideas and a supermarket shopping list to help your patients build and enjoy a nutrient-rich lifestyle.

MyPyramid.gov
STEPS TO A HEALTHIER YOU

3-A-Day Milk Cheese Yogurt

These health and nutrition organizations support 3-A-Day™ of Dairy, a science-based nutrition education program encouraging Americans to consume the recommended three daily servings of nutrient-rich low-fat or fat-free milk and milk products to improve overall health.

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American Academy of Pediatrics
DEDICATED TO THE HEALTH OF ALL CHILDREN™

eat right. American Dietetic Association

NHMA National Hispanic Medical Association

NMA Since 1895

SCHOOL NUTRITION ASSOCIATION

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President's Message

Teresa Lovins, MD

Your Academy at the State and National Levels

Well, the American Recovery and Reinvestment Act of 2009 is finished. There are many aspects of the package that can be beneficial to family physicians, and each of us should learn about the details as they become available. In general terms, there is more money for health information technology used by physicians, more money for training primary care providers through Title VII, more money for research into "comparative effectiveness of treatment" options (conducted by the NIH), more financial coverage of the uninsured through support for COBRA coverage and support for the state Medicaid budgets. The AAFP is promoting these benefits as a significant victory for family medicine. The provisions will make the reality of a primary-care-based medical home a possibility. The AAFP has been active on the national front, promoting what we do every day. As I see it, there is a HUGE benefit from my membership in this Academy. The AAFP really promotes "Strong Medicine for America."

On the local front, your Academy has been active at the Statehouse, supporting and opposing several health care-related bills. We have an active lobbyist team in Doug Kinser and Meredith Edwards. They are at the Statehouse to hear any potential changes to the current bills and are vocal when needed. I have personally testified before different committees to discuss several aspects of medicine and how the bill will affect each and every one of us. Family Medicine Day at the Statehouse brings many family physicians together as a force to get state support for training more family physicians for the state of Indiana. We hope to have many family physicians present to speak one-on-one with their legislators about how the state can help promote family medicine and the PCMH concept in Indiana.

It is projected that there will be a shortage of nearly 1,000 family physicians in Indiana by 2020. We need to be working toward more students at Indiana University School of Medicine going into primary care, especially family medicine. Out of the most recent graduating class, only 9 percent are going into family medicine. We are hoping that the medical school's commitment to the new Rural Medicine Program will dispel the negative myths about being a family physician in rural Indiana. When students are exposed to primary care at its best (and family physicians do it best), they see what satisfaction there is in primary care medicine and more often decide that primary care is the right career for them. As an Academy, we are also looking at ways that we can be involved at the medical school more to promote family medicine. I created an Ad Hoc Task Force for Student Interest and have been excited by the input by the team members to try and make a difference in Indiana and at the medical school. Hopefully, we can turn around the low graduation rate into primary care and fill our projected shortage. Everyone needs a family physician.

Again, this is just a little bit of what your Academy is doing for you at the national and state levels. Have you thought about what you are doing for your Academy? We welcome any interested members to become involved. You can start by attending the regional meetings being planned for this spring. You can also attend the Annual All Member Congress in July at French Lick, Indiana. I hope to see more of you there, and, as always, I am ready to answer any questions at tlovins@northsidefamilymed.com.

Mark Your Calendar

April 24-25	October 9-11 and 17	October 14-18
AAFP Annual Leadership Forum (ALF)	AAFP Board of Directors Meeting	AAFP Scientific Assembly
Kansas City, Missouri, Hyatt Regency	Boston, Massachusetts, Westin Boston Waterfront	Boston, Massachusetts, Boston Convention & Expo Center
July 23-26, 2009	**October 12-14**	
IAFP Annual Meeting	AAFP Congress of Delegates	
French Lick, Indiana, French Lick Resort	Boston, Massachusetts, Westin Boston Waterfront/Boston Convention & Expo Center	

Membership Update

Active	1,659
Supporting (Non-FP)	7
Supporting (FP)	3
Inactive	16
Life	191
Student	156
Resident	240
Total	2,266

Keep Us Informed

Please remember to keep all of your contact information up-to-date with IAFP. If you have any changes in your address (home or office), phone number, fax number and/or e-mail address, please call (317.237.4237) or e-mail (iafp@in-afp.org) the IAFP headquarters with your updated information.

If we don't have your current e-mail address on file, you are missing out on the IAFP's e-FrontLine electronic newsletter. This vital source of information for family physicians is published about once a week and contains timely information on coding and payment issues, meeting notices and reminders and legislative alerts, as well as breaking news items. To be added to the mailing list, please contact Christie Sutton at the IAFP office with your current e-mail address.

Join Us for Your Upcoming Region Meeting

Join your colleagues for dinner, education and your region meeting this spring. To find out which region you belong to, please review the map.

South East Region
Smith's Row
Columbus, Indiana
April 14, 6 p.m.

Central Region
Smee's Place
Indianapolis, Indiana
May 6, 6 p.m.

East Region
Something Different
Anderson, Indiana
April 6, 6 p.m.

West Region
Almost Home
Greencastle, Indiana
April 29, 6 p.m.

West Central Region
Pastarrific
Kokomo, Indiana
May 12, 6 p.m.

North West Region
Tippecanoe Place
South Bend, Indiana
April 1, 6 p.m.

Indiana Academy Represented at Ten-State Conference

This year's Ten-State Conference was held in Michigan at the beginning of February. The Indiana chapter has been a member of this group of state chapters for around 30 years, and this year we were represented in Michigan by Windel Stracener, MD, Larry Allen, MD, Scott Frankenfield, MD, and Teresa Lovins, MD. IAFP staff members Deeda Ferree, Meredith Edwards, Kevin Speer, JD, and Missy Lewis, MS, CHES, also attended. Sharing of ideas, trends and new projects is always a theme of this conference. Included is a copy of Indiana's recap report that was presented to all attendees of the conference.

Governmental Affairs

2008 for the Indiana General Assembly was a short session. With only three short months and a property tax crisis in the state, there was not a lot of action concerning health care. Unfortunately, a statewide smokefree air law did not make it out of committee. And, fortunately, a requirement for all physicians' offices to maintain an Electronic Medical Records system also failed to pass out of committee. Indiana's Medicaid eligibility was contracted to IBM, resulting in disruptions due to the new system. An interim study committee was legislated, and several bills came out of that study committee, which may limit FSSA's ability to use contractors.

Indiana's Family and Social Services Administration has proposed cutting physician payment by 5 percent in July for the 2010 fiscal year. The state government also has plans to take control over the MCO formularies, which will result in a single formulary but likely another cut in payment as Indiana's MCOs use the money they save from formularies to pay providers more than 100 percent of Indiana Medicaid rates. The Indiana Academy staff and physician leadership is meeting with Jeff Wells, MD, the director of Medicaid, to discuss how these payment cuts will decrease physician participation in Medicaid.

This year, we are hosting our first ever Family Medicine Day at the Legislature on March 4. We are inviting physicians and legislators to a breakfast where we plan to show a short video about the family physician shortage and provide them with a cited paper. Our paper, entitled "Breaking Point," focuses on the importance of family medicine and physician-provided primary care, the current family physician shortage crisis, why students are not choosing family medicine, why family physicians are retiring earlier and how this crisis can be amended. Our solutions include a reformed payment system, greater emphasis at the medical school for training family physicians and scholarships and loan-forgiveness options to incentivize students to become family physicians. The video we are producing was inspired by the video from the Texas academy. We are shooting on-site at a residency and a family physician office and conducting additional interviews at our headquarters office.

Legislation

This year, a statewide comprehensive smokefree air bill was introduced in both houses of the Indiana General Assembly. The House version of the bill has been assigned an unfavorable committee but is receiving a hearing. Another bill is threatening to consolidate our Indiana Tobacco Prevention and Cessation (ITPC) agency with the Department of Health. ITPC has been incredibly successful as a small operation with an independent board of oversight, and the Indiana Academy will be fighting to keep it that way. A tax on other tobacco products (OTP) has been proposed. This would begin the process of bringing the cost of cigarettes and other tobacco products to parity. Additionally, IAFP has been working with the Campaign for Tobacco-Free Kids to support the federal bill that would give the FDA the authority to regulate tobacco products.

The Indiana Academy worked hand-in-hand with nurse practitioners on a bill that would regulate retail health clinics. The bill has received one hearing in committee but has not yet been voted on. Other bills this session include an exciting state loan forgiveness program for primary care physicians, forbidding insurers to mandate out-of-country health care and stopping insurers from requiring physicians to continue to take patients of a certain insurer until their entire panel is full — so called "open access" clauses.

Region Affairs

The IAFP will be hosting dinner meetings in all eight of our regions during the months of March and April. The topic for the meeting will focus on tobacco — specifically, how to integrate tobacco cessation into your practice and positively impact income at the same time. The Foundation received two grants — one from the state tobacco prevention agency and one from the Indiana State Medical Association — as a result of the Cease Smoking 2Day collaborative. These grants will assist with costs associated with the meetings, including educational materials. This will also serve as a pilot for the Web-based CME that is planned.

Foundation

The focus of the IAFP Foundation remains to be: 1) student support and recruitment and 2) tobacco prevention and cessation. The Foundation sponsored two student externs in 2008. The Barnett Adopt-A-Student Program places students who have just completed their first year of medical school in the office of a family physician for eight weeks in the summer. Scholarships in the amount of $1,500 were available for two residents to attend the Conference on Practice Improvement in December. This amount was an increase from previous years. The scholarships were directly from IAFPF and did not pass through the AAFP.

The IAFP Foundation was offered a "Rapid Response" grant from Americans for Nonsmokers' Rights (ANR) to assist in our work with the Indiana Campaign for Smokefree Air (ICSA), a coalition of statewide organizations working toward a smokefree air law that protects ALL workers from secondhand smoke in the workplace. A key focus of the Rapid Response project was smokefree gaming, as Indiana is now the third-largest gaming state in the country, with approximately 17,000 Hoosiers employed by casinos and racinos. With the help of this grant, the Foundation was able to fund a study in which Purdue University researchers examined the air quality in all 11 Indiana casinos. News of the resulting press conference was picked up by every major media outlet in Indiana, as well as many sources outside of Indiana, including Forbes.com.

The Foundation also hosted a training for smokefree advocates in areas where gaming is present and brought in Vinny Rennich, a nonsmoker and former dealer from New Jersey who developed lung cancer as a result of exposure to secondhand smoke in the workplace. Other activities included a series of town hall meetings throughout the state, the development of two Web sites (one with a focus on gaming) and recruiting materials, a public opinion poll and a number of ads featuring successful smokefree business that are smokefree as a result of a local law.

A grant from the Anthem Foundation was awarded in the fall. The funded project will feature family physicians in a series of more than 20 ads to run in state and local publications. The ads will serve as a reminder that smokers are more likely to quit smoking with the help of a physician. There will be a press event with the release of each advertisement.

Students and Residents

Student interest and involvement remains low; however, a small group of medical students maintains commitment to IAFP and to exploring opportunities to collaborate with the organization. The IAFPF once again hosted the Student Survival Skills Survival Day in June. The project was supported by a grant from the AAFP Foundation Family Medicine Philanthropic Consortium. The event allows third-year medical students to learn skills they will need as they begin clinical rotations and is primarily hosted by the residency programs. Attendance continues to increase, but it is unclear whether there is any value for IAFP.

The annual Family Medicine Student Interest Reception was canceled at the last minute

due to the very low number of RSVPs. This was a serious concern among the staff, membership and residency programs. The cancellation of the event, along with a facilitated board discussion around the same time, led chapter leadership to assemble a task force of students, residents, physicians and faculty. The task force has met once and will continue to discuss what can be done to combat the non-financial reasons for decreasing student interest. The first conference call uncovered a need for students to gain exposure to the diverse opportunities that family medicine offers. There is also concern that students do not have role models with a passion for family medicine. Some did not experience this until interviewing for residency — obviously much too late.

Our Web site usage continues to rise each month. In 2008, more than 7,500 unique visitors resulted in more than 20,000 page views.

Staff members attended NCFMR in July and hosted a reception for the Indiana residency programs and interested students. This did not end up being a worthwhile expense. There has been discussion among the residency programs that a regional recruitment fair could be a good alternative. The staff continues to explore this opportunity.

Our popular Residents' Day/Research Forum will be held in Indianapolis on March 5, 2009. This program gives family medicine residents (and IAFP members) from across Indiana the chance to present case presentations or original research lectures to their peers, faculty members from residency programs and a panel of judges. Poster presentations are also included, and prizes are awarded at the end of the day.

CME/PEF

The IAFP just hosted its January Family Medicine Update at the Marriott North in Indianapolis. We were happy to see our attendance numbers rise this year. The theme was "Back to Basics: CME Topics Relevant to Your Everyday Practice." Topics included upper respiratory infections, preventative care in older adults, depression, reducing cardiovascular risk and taking care of returning service members.

Our Annual Meeting was in July 2008 in Fort Wayne, Indiana. Attendance was down again this year, and as a result, the staff and Board members have formulated a new, more condensed Annual Meeting schedule, which will enable members to spend less time out of their offices in order to attend the meeting. More CME credits will also be available, as we hope to exclusively offer Evidence-Based credits, which qualify for double the CME credit through the AAFP.

The Indiana Academy has also been talking with various companies about the possibilities of producing enduring CME activities, which will be available to our members via webinars later this year. We also hope to use these services to enable our members to participate in our Region Meetings online.

The IAFP hosted the AAFP's Practice Enhancement Forum in Indianapolis in November. The participants found the PEF worthwhile, and we are excited for the follow-up PEF this year.

Our Annual Faculty Development Day will be held on March 4, 2009, in Indianapolis. This year, faculty members from Indiana's Family Medicine Residency Programs (and, we hope, surrounding states too) will benefit from a two-pronged educational program: the morning will be devoted to "Residents and the ITE: Strategies and Resources," and the afternoon will be focused on "International Graduates: Intervention Strategies and Resources." Our keynote speaker will be Tom O'Neil, PhD, of the ABFM.

Communications

The Indiana Academy continues to produce our magazine, *FrontLine Physician*, on a quarterly basis. The staff considered discontinuing this service but found a way to make the printing and distribution "budget-neutral." The magazine features a message from our president, legislative and coding articles, notifications on upcoming events, membership news and much more. This publication was recently completely overhauled and is now designed in accordance with the new AAFP branding guidelines. The membership has adjusted to this change with relative ease.

We also send out our *e-FrontLine* electronic newsletter via e-mail as needed. This is a useful and effective tool to inform our members about upcoming events and meetings, legislative news, our Foundation's public health efforts, medicare changes and coding updates. Again, the *e-FrontLine* has been redesigned in accordance with the AAFP branding guidelines.

Our Web site usage continues to rise each month. In 2008, more than 7,500 unique visitors resulted in more than 20,000 page views, accessing information about our upcoming meetings, our commissions and committees, our legislative efforts and our programs for students and residents. Our Web site also now reflects the new AAFP branding.

In October, we sent out an electronic survey on the Medical Home to our members via the *e-FrontLine*. The survey received 83 responses; information on the responses was posted on the Chapters Executives Web site.

Healthcare Services Commission

The IAFP Commission on Healthcare Services has taken on the initiative of educating our members on electronic prescribing. Our survey results indicated that 37.5 percent of our members are prescribing electronically; but that number is likely artificially high because we utilized an online survey. We offered information to our members on true electronic prescribing and the Medicare 2 percent increase through a *FrontLine Physician* article this December and a speaker at our January CME event. Our next steps will be determined at our meeting in April.

Members of our Commission on Healthcare Services are scheduling a meeting with the Indiana director of Medicaid to discuss how a proposed 5 percent cut to provider payment will result in lower physician participation in Medicaid.

Staff

The Academy continues to operate with a staff of five full-time employees, in addition to the EVP. Additionally, we contracted with the Marion County Health Department to hire a campaign coordinator for Smoke Free Indy, the Indianapolis coalition working toward a comprehensive smokefree air law in Indianapolis. This has provided an additional member of IAFP staff, who is able to assist with day-to-day operations when they do not interfere with her campaign duties. She will be on staff through June 30, 2009.

Volunteer to Serve on One of Your Academy's Commissions Today!

Dear IAFP Member:

As a valued member, the IAFP wants to provide you with the opportunity to support YOUR Academy. The IAFP cannot operate without the indispensable participation of our members, because we exist to provide the benefits, programs and information YOU need. A great way to make sure your voice is heard is by volunteering for one of our commissions. Take a look at the following list of commission descriptions, and contact us as soon as possible to let us know which one excites you the most. Let us know by phone at 317.237.4237 or e-mail at iafp@in-afp.org. We look forward to working with you soon.

Commission on Education and CME
The commission is responsible for planning the entire official educational program for the annual IAFP Scientific Assembly and the IAFP Family Medicine Update including selecting topics, developing learning objectives and selecting and inviting speakers. The commission also has the authority and oversight for the AAFP-accreditation process for Indiana programs and all IAFP-sponsored and -produced CME, including compliance with rules and regulations set by the AAFP and other CME regulatory bodies. The commission is responsible for exploring future directions and innovative concepts in CME and making recommendations regarding the future of the IAFP CME programming, and the commission will propose policies to the IAFP Board of Directors in matters of continuing medical education for submission to the AAFP.

Commission on Health Care Services
The functions of this commission are to: (1) monitor, analyze and propose policies to influence the social and economic (socioeconomic) health care environment and to determine the impact on family physicians and their patients; (2) serve as a source for gathering, evaluating and disseminating health care socioeconomics information; (3) develop appropriate responses to assist family physicians in understanding and adapting to a changing practice environment; and (4) recommend IAFP policies and public positions to the Board in the following areas of concern: (a) family physicians' reimbursement and compensation; (b) organization and management of practice; and (c) health care financing and delivery systems. The commission shall also: (1) study and develop recommendations and programs to assist family physicians in pursuing their full scope of practice in health care delivery systems, hospitals and other practice settings; (2) provide members, hospitals and other health care organizations with information and assistance regarding credentialing and privileging reappointment, quality improvement, professional relationships and departmental and other organization issues; and (3) monitor and analyze new and existing quality improvement programs for health care, and provide the family physicians' perspective to professional, private and governmental organizations concerned with such programs.

Commission on Membership and Communications
The functions of this commission shall be: (1) initiating and coordinating membership services made available through the Academy; (2) administering all awards of the IAFP; and (3) recommending communications activities that support IAFP objectives by: (a) educating the citizens of Indiana about family practice and health issues; (b) promoting family practice objectives in all policy arenas; (c) assisting members in promoting their health care services to their communities; and (d) promoting IAFP as a membership organization of value for family physicians.

Commission on Legislation and Governmental Affairs
The functions of this commission are: (1) to investigate and recommend such actions to the IAFP Board of Directors as may be necessary to assure adequate representation for the family physicians in medical and political groups; (2) to conduct such a campaign of public enlightenment or education as it may deem advisable; (3) to furnish members of the Indiana state legislature and other public officials with pertinent facts and information that they may better maintain high standards of health care; and (4) to recommend to the Board any policies or actions which the Academy may formulate or perform for the general improvement in medical care.

2009 FAMILY MEDICINE UPDATE PRIZE WINNERS

Around 100 family physicians from across Indiana and beyond gathered at the Indianapolis Marriott North in January for the 2009 IAFP Family Medicine Update. Physicians earned more than 25 CME credits and visited exhibitors, while enjoying the comfortable surroundings of the Marriott North.

Several prize drawings were held in conjunction with the Exhibit Show, and the prize winners are listed:

Jerry Wehr, MD, West Lafayette, Indiana – iPod nano

Randy Brown, MD, Seymour, Indiana – HDTV/DVD combo

Kenneth Ahler, MD, Rensselaer, Indiana – HDTV/DVD combo

Yvonne Asiimwe, MD, Seymour, Indiana – Dinner and a movie, sponsored by Suburban Health Organization

The Indiana Academy of Family Physicians gratefully acknowledges the following companies/organizations for providing education support and/or grants for the 2009 Family Medicine Update:

The France Foundation
The Indiana Spine Group
Joy Newby, Newby Consulting, Inc.
St. Vincent Health
Somerset Health Care Team
Tulane University Health Sciences Center
Uniformed Services Academy of Family Physicians

Legislative Update

by Doug Kinser, JD, and Meredith Edwards

As we go to press, the Indiana General Assembly is in the midst of its long budget-drafting session. Although the budget has certainly been at the forefront of legislators' minds, the 2009 session has not been without health-related battles.

Traditionally, the General Assembly drafts a two-year budget during the long session. The Democrats in the House of Representatives this year took a different approach, drafting a budget for one year only, citing the current economic climate and the unforeseeable economic future in the state as their reason. This version of the budget passed out of the House of Representatives on a party-line vote. The Republicans in both the House and the Senate are opposing this new format. Now that the budget bill is in the Republican-majority Senate, the budget is expected to return to its normal two-year format.

Prior to session, the former secretary of FSSA, Mitch Roob, proposed a 5 percent "holdback" on payments to Medicaid providers starting in July 2009. Anne Murphy, the new secretary of FSSA, has not echoed the same sentiments on cutting provider pay 5 percent but has mentioned a cut as a possibility. FSSA is still planning to take control of the MCO pharmaceutical formularies to take advantage of the pharmaceutical rebates. MCOs pay more than 100 percent of Medicaid fee for service with the rebates they receive from pharmaceutical companies. The prospect of physicians having their Medicaid pay cut twice is worrisome. The Democrat version of the budget does contain a provision prohibiting FSSA from taking control of the pharmaceutical formularies and also prohibiting the 5 percent provider payment holdback. House Bill 1572 originally was written to provide relief to physicians from certain MCOs' practices, but, as passed, HB 1572 would require one standard formulary for the MCOs in Indiana and one standard procedure for prior authorizations and precertifications. The bill was amended so that other concerns can be studied further by the Health Finance Commission during the interim, such as, requiring MCOs to pay for ER physician and facility fees under certain circumstances. Dr. Jeff Wells, who left as Medicaid director at the end of February, sent an e-mail to interested parties during the break that Medicaid will be monitoring the concerns and try to work out the differences.

Bills Still Alive…

Smoking Ban in Public Places, HB 1213

The IAFP has been supportive of House Bill 1213, the smokefree workplaces law. As originally written, the bill would have prohibited smoking in public places, enclosed areas of places of employment and certain state vehicles. The IAFP worked in conjunction with the Indiana Campaign for Smokefree Air (ICSA) to provide testimony in support of the bill during its hearing in the House Public Policy Committee. The bill passed through the House, but casinos, bars, nursing homes and more were exempted from the law. The IAFP is working with ICSA to ensure only a comprehensive smokefree workplaces law passes.

Primary Care Physician Loan Forgiveness Program, HB 1138 and SB 393

The IAFP government relations team worked with Sen. Simpson and Rep. Reske in the creation of a primary care physician loan forgiveness program. Primary care physicians who practice in Indiana and still have a student loan balance would be eligible to receive $5,000 a year to pay for loans. This money is not tied to practicing in an underserved area, and there is no limit on how many years a physician is eligible for the loan repayment.

Out-of-Country Health Care, HB 1084

This bill would prohibit insurers from requiring or encouraging a patient to seek health care from outside the United States.

Health Provider Patient Limits Study, HB 1300

The original version of this bill would prohibit so called "open panel" or "open access" clauses in contracts between physicians and insurers. These clauses require a physician to continue to take patients from a particular insurer until their panel is completely closed. The IAFP provided testimony on this issue, which will now be studied during the Interim.

Various Professions Matters, HB 1573

This bill as originally written changed the current supervisory agreement between physicians and physician assistants. Portions of the bill concerning physician assistants' supervision were amended out of the bill in committee.

Dead Bills…

Regulation of Retail Health Clinics, SB 216

The IAFP worked with Sen. Patricia Miller on SB 216. The bill would have put further scrutiny on retail health clinics and would have required JCHO accreditation, separate entrances from the retail stores, providing the patient's primary care provider with a clinical report and emergency-response procedures. The bill faced tough opposition and was eventually turned into a bill for the Health Finance Committee to study before it was pulled.

Midwives, SB 508

Under this legislation, certified non-nurse midwives would be allowed to practice in Indiana. This bill also requires the purchase of liability insurance, and sets the qualifications to be a certified professional midwife. The IAFP provided testimony opposing the bill. The bill was never voted out of committee.

Assignment of Benefits, HB 1086 and HB 75

Two bills contained language that would have required an insurer to comply with a patient's request to assign his or her reimbursement benefits to an out-of-network health care provider. The bills were strongly opposed by the insurance industry. The House version of the bill was not heard on the House floor, and the Senate version of the bill, in a close vote, failed to pass out of the Senate.

Breaking Point

Introduction

The Indiana Academy of Family Physicians (IAFP) is a nonprofit membership association representing more than 1,600 (nearly 80 percent) of the state's family physicians. It is the mission of the Academy to improve the health of the people of Indiana, including its families and communities, by promoting and enhancing the practice of family medicine with professionalism and foresight.

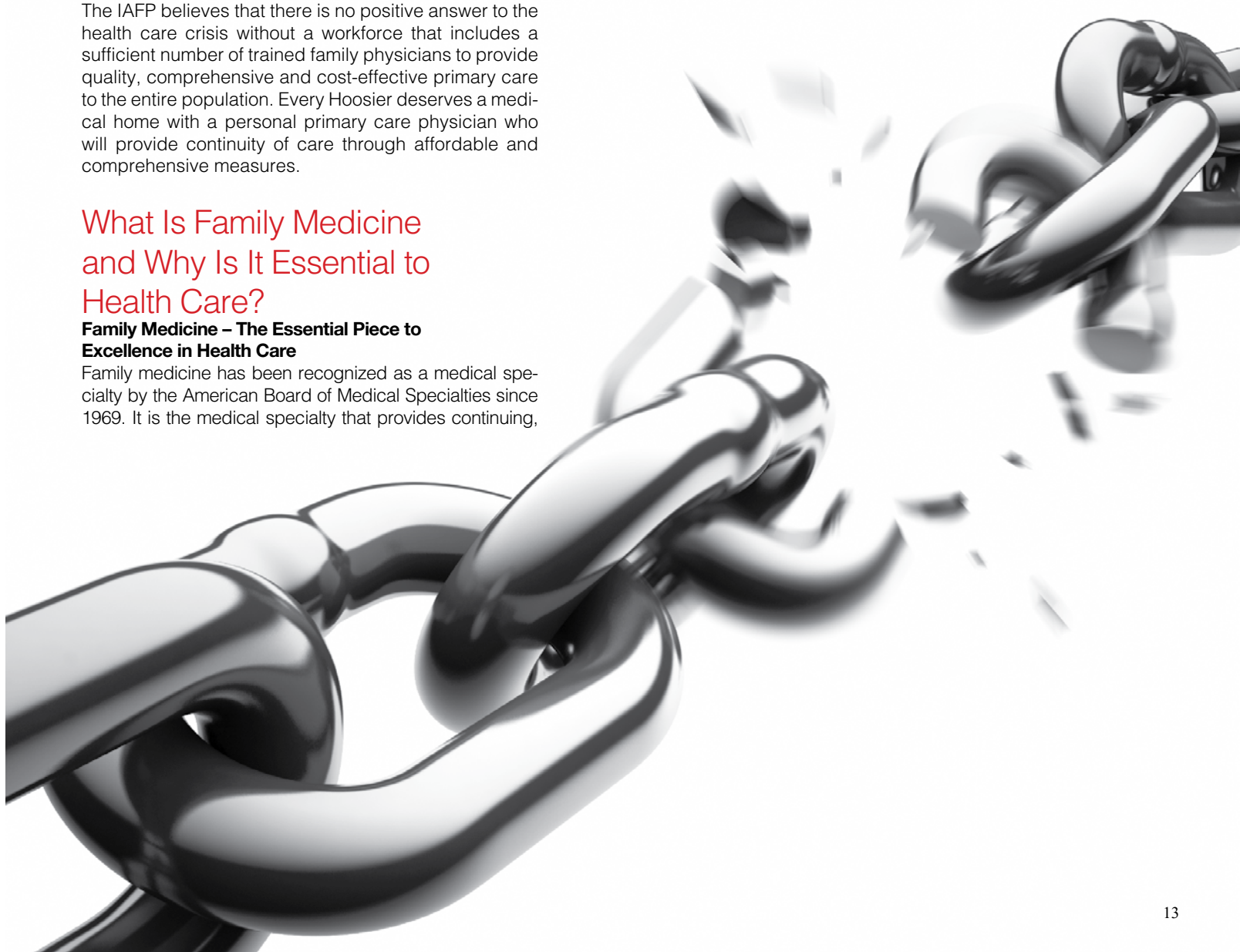
The purpose of this report is to stress to the state's policymakers, legislators and patients that the family physician workforce — in fact the entire primary care workforce — is in dire straits. Report after report indicates that comprehensive primary and preventive care results in better quality care at a lower cost to all involved. But health care in Indiana continues to reward physicians to perform procedures, many unnecessarily, and focus on episodic care, fanning the fire of piece-meal and high-priced care.

The IAFP believes that there is no positive answer to the health care crisis without a workforce that includes a sufficient number of trained family physicians to provide quality, comprehensive and cost-effective primary care to the entire population. Every Hoosier deserves a medical home with a personal primary care physician who will provide continuity of care through affordable and comprehensive measures.

What Is Family Medicine and Why Is It Essential to Health Care?

Family Medicine – The Essential Piece to Excellence in Health Care

Family medicine has been recognized as a medical specialty by the American Board of Medical Specialties since 1969. It is the medical specialty that provides continuing, comprehensive health care for the individual and family. The scope of family medicine encompasses all ages, both sexes, each organ system and every disease entity. Family physicians are trained to diagnose, treat and manage illness, provide preventive care, manage chronic disease and coordinate care with other subspecialists. From routine checkups, health risk assessments and screening tests to management of asthma, heart disease, hypertension and diabetes, family physicians are trained to provide full-service, frontline health care.



In Indiana, primary and preventive care is most likely to be provided by a family physician. This is especially true in rural areas where the population might not be large enough to support both an internal medicine physician and a pediatrician but may be able to support a single family physician.[1] Family physicians are trained to deliver babies, perform medical procedures and care for children, adults and the elderly in offices, hospitals, emergency departments or homes, distinguishing the specialty from all others.

Not only are family physicians trained to provide the most comprehensive primary care, but historically, they will also provide the most years of standard primary care service. A recent study found that during a 35-year period, physicians who specialized in family medicine, on average, provided primary care service for almost 30 years. Pediatricians and internists averaged 17 years and five years respectively, as they often leave primary care to subspecialize. Nurse practitioners and physician assistants commit even fewer years to primary care, as the general trend for these providers also is to specialize.[2]

Educating and training physicians is a rigorous, time-consuming process and expense for the state; however, family physicians are worth the investment. Arguably more so than any other primary care specialty, family physicians are the best equipped to deliver primary care to the broadest groups of people and are more likely than any other specialty to stay on the frontline to deliver primary care.

Better Quality Outcomes, Greater Access

Family physicians provide a regular and continuous source of care. Study after study shows that regular care from the same physician over time is associated with better health outcomes and lower total costs.[3] Evidence also suggests that increased use of primary care physicians results in reduced hospitalizations, reduced spending on other non-primary care specialists, and improvements in morbidity and mortality rates.[4] The inverse is true of specialists — the greater the specialist-to-population ratios, the higher the mortality rates.[5]

Economic impact

As small business owners, family physicians contribute significantly to Indiana's economy. A recent study found the positive economic impact of each family physician in Indiana to be $949,269 per year. All the family physicians in Indiana provide a total yearly economic impact of $1,723,872,029. This billion-dollar figure includes the employment family physicians provide and the goods they purchase for themselves and their practice, but it does not include the income family physicians generate for other health care organizations, such as nursing homes and hospitals.[6]

How Many Family Physicians Does Indiana Need?

Indiana's population grew 14 percent from 1980 to 2005. As a result, the state needed 1,000 additional primary care physicians to provide care for the growing population in 2006.[7] Currently, 30 percent of Indiana's 92 counties are designated primary medical care Health Professional Shortage Areas (HPSA), and 54 percent of Indiana's counties are designated as Medically Underserved Areas (MUA).[8]

By 2020, Indiana will need 2,000 additional primary care physicians to meet the health care needs of Hoosiers.[9] Reduced work hours and a retiring workforce lead us to believe that Indiana may actually need more primary care physicians than anticipated. Where are we going to find these physicians?

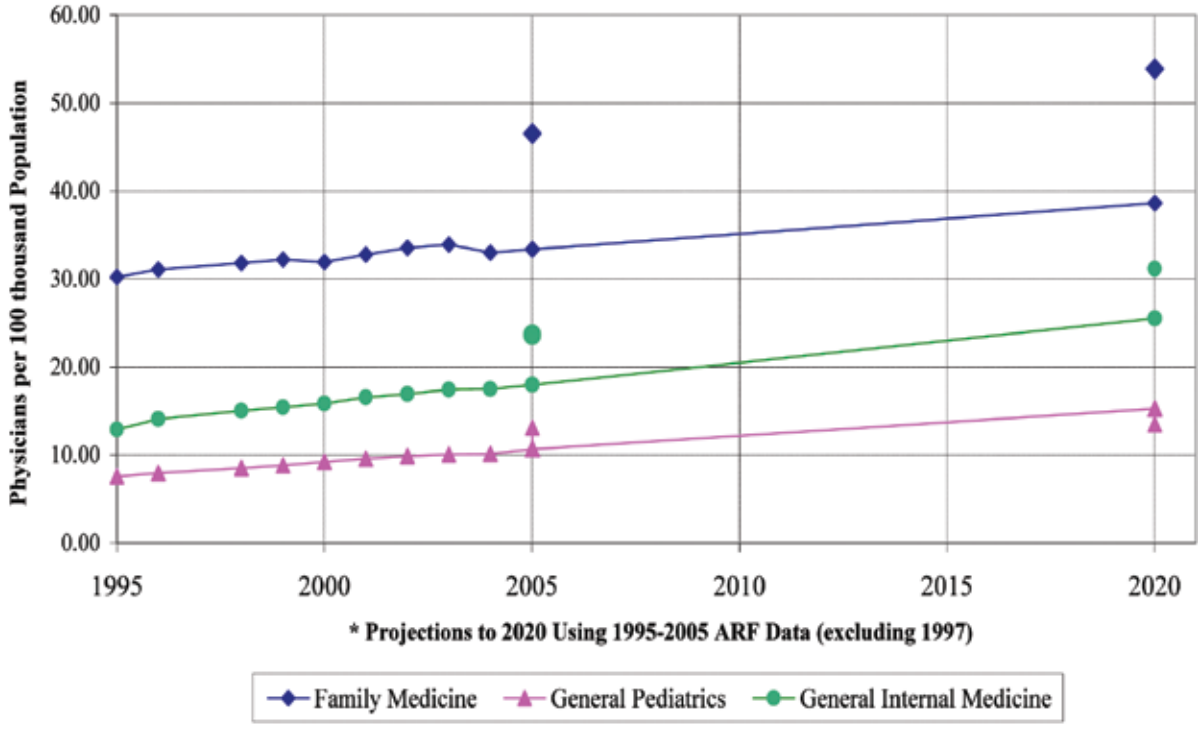
The Declining Interest Among Medical Students in Family Medicine

Supply and Demand: The Need for Primary Health Care Is Greater Than Ever; However, the Number of Primary Care Physicians in the State Is Decreasing at a Rapid Rate

In the face of this growing shortage, trend analysis of graduates from the Indiana University School of Medicine (IUSM) demonstrates an insufficient number of students choosing primary care disciplines. The number of IUSM graduates choosing postgraduate training in family medicine has dropped from 20 percent to 9 percent in the last 10 years.[10]

Because fewer students are entering family medicine, Indiana has lost three family medicine residencies in a 10-year time span. Indiana University and Methodist Family Medicine Residen-

Figure 1: Primary Care Physician Supply in Indiana Showing Physician Demand Estimates for 2005-2020*
(Demand Estimates Shown as Points Off the Lines of Supply)



cies merged, and both St. Mary's in Evansville and the Methodist program in Gary closed. This trend is also reflected at the national level as the family medicine residency positions filled by U.S. senior medical students have decreased, and some positions remain unfilled.[12]

Physician Dissatisfaction

The overall dissatisfaction with the primary care environment found in "The Physician's Foundation Survey"[13] illustrates a systematic and fatal flaw in the health care system that will undoubtedly continue to drive medical students away from considering a career in family medicine or another primary care specialty. According to the same survey, more than 75 percent of physicians surveyed said that they are either at "full capacity" or "overextended and overworked." Declining payment, demands on physician time and increased paperwork were cited as significant impediments to delivery of patient care.

Debt and Payment

In Indiana, medical students graduate with an average of $163,000 in debt while the average salary of a family physician under the age of 36 is $124,700.[14] On a national level, the average income of a family physician has increased by 20 percent during the last 10 years, while income for specialties such as diagnostic radiology and dermatology has increased by 70 percent and 97 percent respectively.[15] Family physicians and other primary care physicians continue to be paid at rates 100 percent to 200 percent below other specialties.[16]

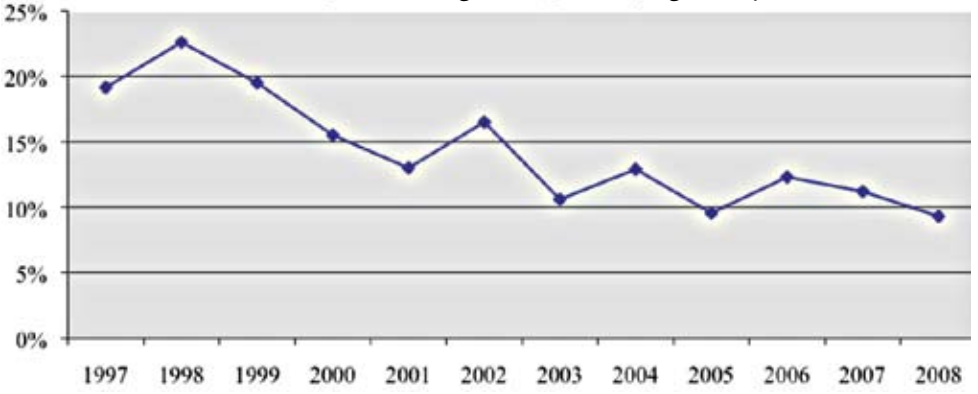
Based on these compensation trends, it is clear that the current reimbursement system places a greater value on high-priced, episodic specialty care than is placed on primary care. Health care providers and hospitals are in daily competition to offer better technology and procedures, rather than focusing on overall personal or population health outcomes.[17]

Indiana University School of Medicine (IUSM) Expansion

Indiana University School of Medicine plans a 30 percent increase in medical student enrollment (80 students) by 2012. The school has launched a primary care track focused on rural health in Terre Haute, Indiana, but few details have been made available about other primary care efforts.

The IAFP is supportive of the expansion and funding of the medical school. Legislators and policymakers should ensure that this expansion prominently includes the goal of producing more family physicians to meet the needs of the state of Indiana. Increasing the number of medical students entering family medicine residency programs in Indiana should be a high priority for the school. In order to be successful, IUSM must make culture changes within the medical school to value family physicians and not discourage students from entering family medicine.

Percent of IUSM Graduating Students Entering Family Medicine[11]



Scholarships and Loan Forgiveness

The legislature and the Indiana University School of Medicine (IUSM) need to entice students into the practice of family medicine in Indiana. This can be done by providing medical students that enter Indiana family medicine residency programs with substantial scholarship, loan forgiveness and other incentive programs. Loan forgiveness programs for family physicians currently practicing in the state will encourage physicians to continue to practice primary care and not move into more lucrative specialties or leave the field of medicine altogether.

Earlier Exposure and Selective Recruitment at IUSM

Students should be exposed to family medicine earlier and more often, beginning in the first year of medical school. This can be achieved by increasing the number of courses taught by family physicians, especially during the first two years of medical school. Students could also spend more time in primary care clinical settings.

A selective admissions policy that supports students from rural and underserved communities in Indiana should be developed at IUSM. The strongest predictor of where a physician will practice is where he or she grew up. In order to provide more primary care physicians in critical shortage areas, the medical school should actively recruit students from rural and urban inner city underserved areas.[18]

Payment

Indiana, along with the rest of the nation, needs to change the way it pays for health care. Payment should be based on *better* care rather than *more* care. Improving primary care payment should lead to improved quality and decreased cost of health care in Indiana. A new blended payment model should be based on the following framework:

- It should pay for the time spent to coordinate care with family caregivers and other health professionals, separate from — and in addition to — the work recognized in a face-to-face encounter.
- It should pay for services associated with

Family Medicine Positions Filled by U.S. Senior Medical Students

coordination of care both within a given practice and between consultants, ancillary providers and community resources.
- It should support adoption and use of health information technology for quality improvement.
- It should support the provision of enhanced communication access, such as secure e-mail and telephone consultation.
- It should allow for additional payments for achieving measurable and continuous quality improvements.[19]

Patient-Centered Medical Home

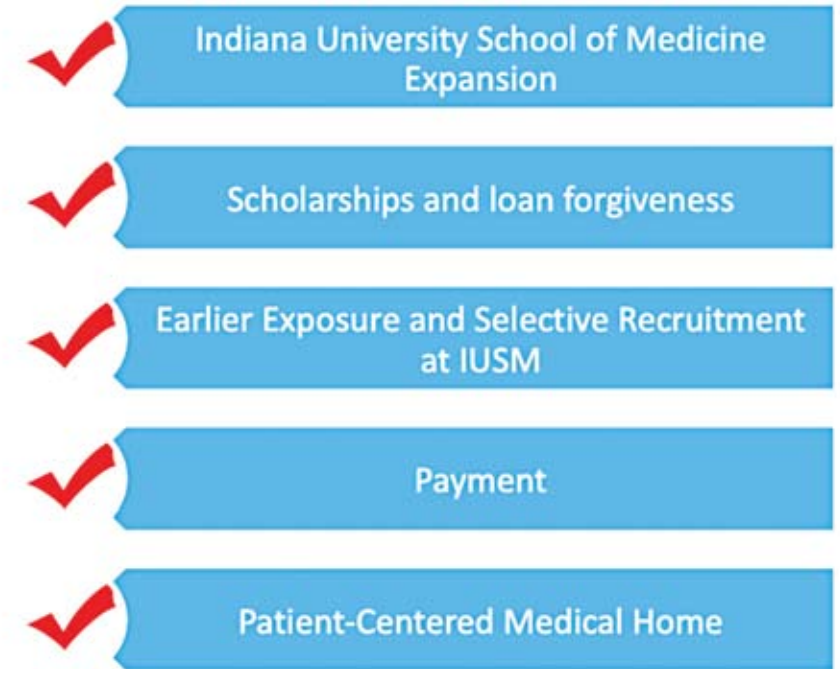
Indian's health care system should embrace the patient-centered medical home (PCMH) model. Adopted by the American Academy of Family Physicians, American Osteopathic Association, American Academy of Pediatrics and the American College of Physicians,[20] this model has proven to be a more effective and efficient model of health care delivery.[21] The IAFP believes that everyone should have a personal patient-centered medical home that serves as the focal point through which all individuals — regardless of age, sex, race or socioeconomic status — receive preventive, chronic and acute medical services. Through an ongoing relationship with a family physician, patients can be assured of care that is not only accessible but also accountable, comprehensive, integrated, patient-centered, safe, scientifically valid and satisfying to both patients and their physicians.

In a patient-centered medical home:
- Patients have a **relationship** with and **continuous** access to a personal primary care physician.
- A practice-based care team takes collective responsibility for the patient's **ongoing care**.
- The care team is responsible for providing and arranging all of the patient's health care needs.
- Patients can expect care that is **coordinated** across health care settings and disciplines.
- **Quality** is measured and improved as part of daily workflow.
- Patients experience **enhanced access** and communication.
- Physicians receive appropriate payment for being a medical home.[22]

A study by the Commonwealth Fund found that when adults have access to a medical home, racial and ethnic disparities in access and quality are reduced or even eliminated.[23]

The purpose of this report is to stress to the state's policymakers, legislators and patients alike that the family physician workforce — in fact the entire primary care workforce — in Indiana is in dire straits. Report after report indicates that comprehensive primary and preventive care results in better quality care at lower costs to all involved. But Indiana continues to see a decline in the number of medical students choosing family medicine as their career choice. The Indiana Academy of Family Physicians believes the health of Indiana's people depends on the state's quick response to this crisis and outlines our concerns and recommendations for solutions in this report.

The Solutions



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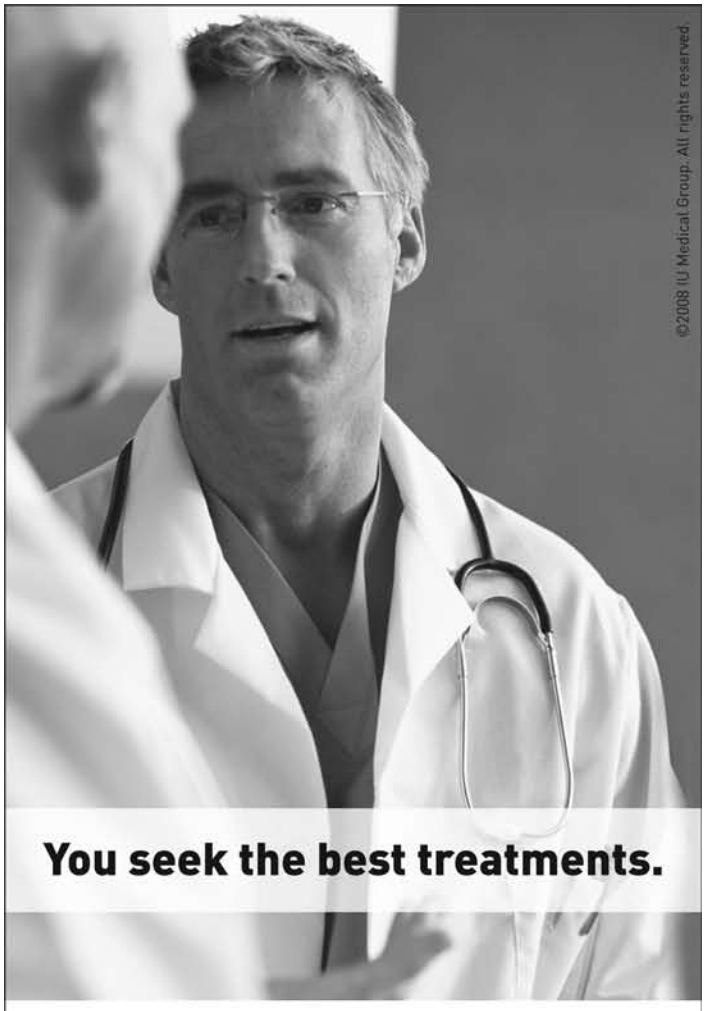

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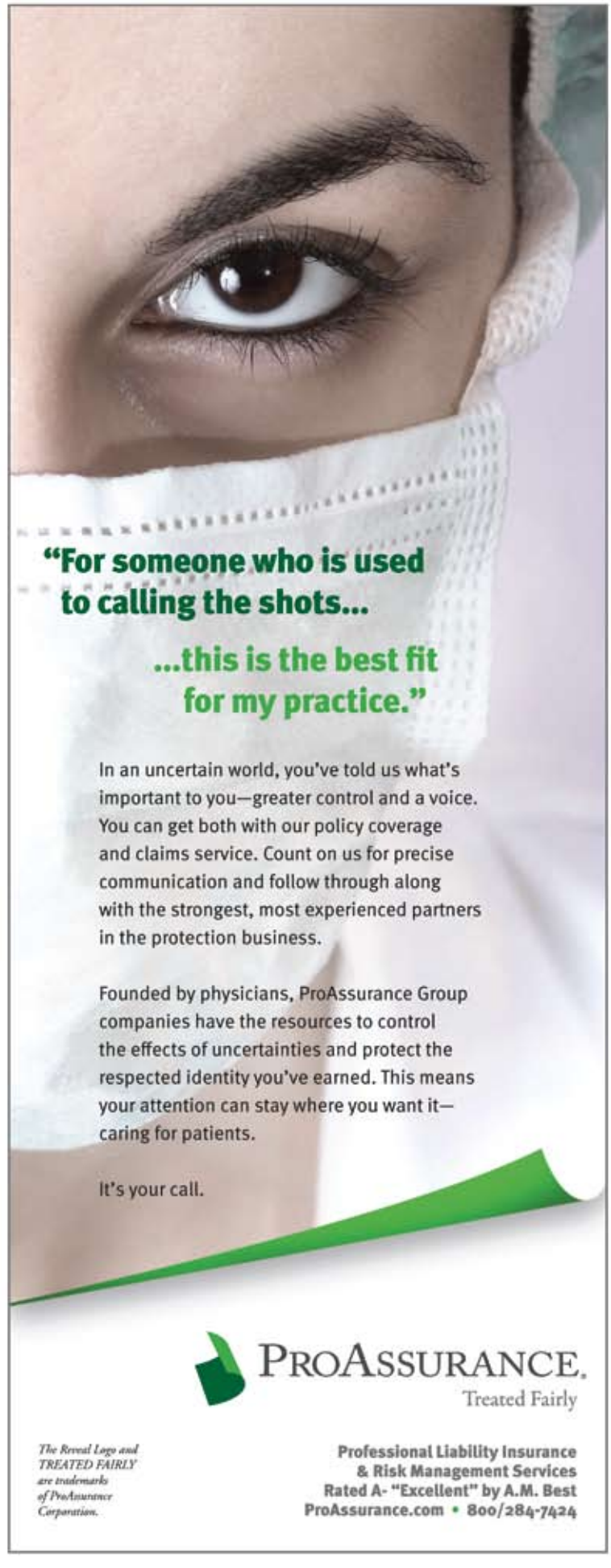

Join Us This Summer for a Leaner, Meaner Annual Meeting

The 2009 IAFP Annual Meeting will be held in French Lick, Indiana, from Thursday, July 23, to Sunday, July 26, 2009. We have developed a new shorter schedule, which allows time to travel from northern Indiana on Thursday morning, thus cutting costs of one overnight stay at the hotel and allowing you to spend less time out of your office. The new schedule also combines past activities associated with the Presidents' Banquet and All Member Party into one evening. Mark your calendars now, and take advantage of top-quality Evidence-Based CME, participate in our Congress of Delegates, visit the Exhibit Show, and enjoy the beautiful surroundings of the totally transformed French Lick Hotel and Conference Center. Bring the kids or grandkids too, because the hotel's kids' program has been rebuilt and extended. Call 888.694.4332 to reserve your room at a rate of $160 Tuesday to Friday and $205 Saturday. Please use group code "IAFP." These room rates are available only until our group block is sold out, after which, rates will increase. Act now.

CME topics will include:

- Getting Serious About Gout and Hyperuricemia: Improving Understanding of Clinical Approaches to Diagnosis and Management
- Getting the Jump on Type 2 Diabetes: The Pivotal Roles of Early Dx and Individualized Management
- No Referral Needed: Primary Care Management of IBS and Chronic Constipation

Our schedule is as follows:

Thursday, July 23

8 a.m.-7 p.m.	Registration Open
8 a.m.-9 p.m.	Exhibit Setup
10 a.m.-3 p.m.	Special Educational Session
4-4:30 p.m.	Executive Committee
4:30-6:30 p.m.	Board of Directors
7-10 p.m.	Board/VIP Dinner

Friday, July 24

7:30 a.m.-4 p.m.	CME
10:30 a.m.-3:30	Exhibits Open
5 p.m.	Town Hall Dinner
6:30 p.m.	First Session of Congress of Delegates
7:30 p.m.	Reference Committees
9 p.m.	AfterGlow

Saturday, July 25

8 a.m.	Second Session of Congress of Delegates
10 a.m.-2 p.m.	Exhibits Open
10:30 a.m.-5 p.m.	CME
6 p.m.	Reception
6:45 p.m.	President's Banquet (awards and installations) *Separate Dinner for children*
8 p.m.	Children join parents for dessert buffet and dancing

Sunday, July 26

8-10 a.m.	CME Breakfast/Session
10 a.m.	Board of Directors

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B. Matthew Hicks, M.D.
Barry W. Liechty, M.D.
Jerry L. Mackel, M.D.
Michael L. McArdle, M.D.
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Gregory M. Sassmannshausen, M.D.
Niles D. Schwartz, M.D.
Robert M. Shugart, M.D.

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EMTALA
On-Call Physicians Liable for Violations

Hospitals that participate in the Medicare and Medicaid programs must comply with various state and federal laws, including the Emergency Medical Treatment and Active Labor Act (EMTALA). Hospitals subject to EMTALA may incur liability for violations under its enforcement provisions. But did you know that on-call physicians at hospitals subject to EMTALA must also comply with the act to avoid liability?

EMTALA and On-Call Lists

EMTALA governs how and when a hospital can refuse to treat a patient and transfer unstable patients to another hospital. It requires hospitals to "maintain a list of physicians who are on call for duty after the initial examination to provide treatment necessary to stabilize an individual with an emergency medical condition." The purpose of the on-call list is to identify and ensure that emergency departments are prospectively aware of those physicians, including specialists and subspecialists, who are available to provide care.

The law applies to both emergency department physicians and those on-call physicians required to assist in the medical screening examination and, if necessary, the stabilization and appropriate transfer of a patient.

Hospital and Staff

As stated above, the Medicare and EMTALA laws directly govern the actions of a hospital. Therefore, a hospital can be liable for EMTALA violations.

A hospital's governing board is responsible for the hospital's control and operation. This includes approving the hospital's medical staff bylaws, rules and regulations that govern its physicians' responsibilities and duties, including on-call physicians. In addition, the governing board must ensure that the medical staff is accountable to the board.

By virtue of a hospital governing board's assignment of responsibilities, the hospital itself may be directly responsible for the actions of its medical staff, including on-call physicians. Moreover, EMTALA expressly holds hospitals liable for certain actions of on-call physicians. For example, a hospital may be held liable for an on-call physician's refusal or failure to come to the hospital when his or her services are necessary to assess and possibly stabilize or assist in the transfer of a patient.

On-Call Liability

Physicians are agents of a hospital. As such, under EMTALA, physicians, including on-call emergency physicians, may — in addition to the hospital — be held liable for violating the statute and its accompanying regulations.

For example, suppose that, after an initial examination, an emergency department physician determines a patient's condition requires the services of a physician on the hospital's on-call list. The emergency physician notifies the on-call physician, but the on-call physician fails or refuses to appear within a reasonable time. After making the determination that, without the services of the on-call physician, the benefits of transfer outweigh the risks, the emergency physician orders the transfer of the individual.

In this scenario, the physician who authorized the transfer will not be subject to any EMTALA penalty, but a penalty may apply to the on-call physician who failed or refused to appear. Hospitals should track these events. In fact, the act requires hospitals to record the name and address of any on-call physician who has refused or failed to appear within a reasonable time to provide the level of treatment required to satisfy his or her EMTALA obligations.

Courts and CMS

Courts have concluded that EMTALA applies to the actions of on-call physicians. In *Burditt v. U.S. Dept. of Health and Human Services*, the 5th Circuit Court of Appeals held that, because a physician agreed to be bound by the hospital's bylaws in an application for medical staff privileges, he was subject to EMTALA. The court also found that hospital physicians who treat hospital patients are the hospital's agents for purposes of such treatment. It reasoned that, because hospitals can act and become aware of information only through certain individuals, including physicians, any EMTALA violation by the physician is also an EMTALA violation by the hospital.

The Centers for Medicare and Medicaid Services (CMS) also has addressed the issue of EMTALA and on-call physicians. In commentary and proposed rules the agency has published in the Federal Register and in interpretive guidelines it has issued, CMS has specifically included on-call physicians as part of the ancillary services used to provide an appropriate screening exam to the patient as required by EMTALA.

Be in the Know

EMTALA affects both hospitals that employ on-call physicians and physician groups that have employees on a hospital's on-call list. If you're in either of these situations, familiarize yourself with the EMTALA regulations that apply to on-call situations. Violations of these obligations could result in large financial sanctions and revocation of participation in federal health care programs.

EMTALA Penalties for On-Call Physicians

Like hospitals, on-call physicians who violate their EMTALA obligations face a number of enforcement provisions. A failure to comply with federal and state laws and their accompanying regulations — including EMTALA — may result in termination from the Medicare and Medicaid programs.

The Office of Inspector General (OIG) may issue civil monetary penalties (CMPs) and exclude physicians from federal health care programs as well. CMPs range from up to $25,000 per violation for hospitals with fewer than 100 beds to $50,000 per violation for hospitals with 100 beds or more. Penalties are based on the size of the facility. The OIG can also assess up to $50,000 per violation for physicians who commit gross and flagrant violations.

Courts have concluded that EMTALA applies to the actions of on-call physicians.

Article reprinted from Practical Health Law, *January/February 2009, courtesy of Hall Render Killian Heath & Lyman.*

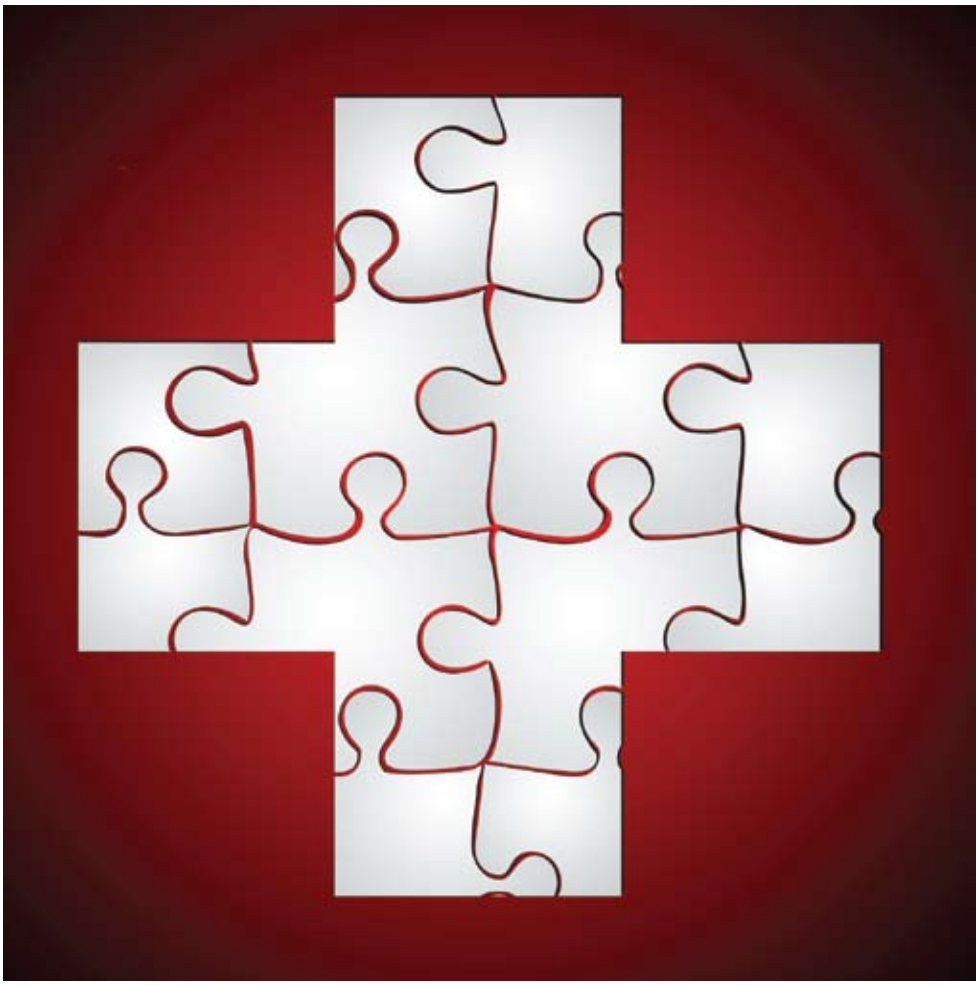
CPT Coding Changes, Implementation of ICD-10 and Medicare Coverage, and Fee Schedule Changes for 2009

by Joy Newby, LPN, CPC, PCS
Newby Consulting, Inc.

CPT Changes for 2009 – Not All-Inclusive

One of the changes we can always count on are the updates to the Current Procedure Terminology (CPT) codes. Coding changes pertinent to primary care physicians include:

New/Revised Vaccines, Toxoid Codes
When FDA-approved, use the following codes to report:



- 90650 Human papilloma virus (HPV) vaccine, types 16, 18, bivalent, three-dose schedule
- 90738 Japanese encephalitis virus vaccine, inactivated

Not to be confused with the existing code 90680, rotavirus vaccine, pentavalent, three-dose schedule, live for oral use. CPT 2009 includes a new code: 90681, rotavirus vaccine, human, attenuated, two-dose schedule, live, for oral use.

More choices to report combination vaccines:

- 90696 Diphtheria, tetanus toxoids, acellular pertussis vaccine and polio virus vaccine, inactivated (DTaP-IPV), when administered to children 4 through 6 years of age
- 90698 Diphtheria, tetanus toxoids, acellular pertussis vaccine, haemophilus influenza Type B and polio virus vaccine, inactivated (DTaP-Hib-IPV)

New Hydration and Injection Administration Codes Excludes Chemotherapy Administration

Just as you were becoming comfortable with the revisions made to the hydration, infusion and injection administration codes that changed in CPT 2007, the codes (90760-90779) have been deleted and renumbered to be in the 963XX series of codes. Hydration is now reported using 96360 and 96361.

The greatest impact for primary care physicians is the renumbering of 90772, therapeutic, prophylactic or diagnostic injection (specify substance or drug), subcutaneous or intramuscular, to 96372. This code is effective with dates of service on and after January 1, 2009.

During the past year, Newby Consulting, Inc (NCI) has noted that, when billing Medicare and most other insurers, many primary care physicians are failing to append the -25 modifier to the evaluation and management (E/M) code when also reporting the injection administration code. This results in payment denial for the E/M service. When these E/M services are denied, some practices simply stop reporting the administration code instead of investigating the reason for the denial. Physicians can typically append the -25 modifier and refile the claim, but some

Medicare contractors are requiring practices to perform a telephone reopening requesting the addition of the -25 modifier in order to be paid for the visit.

Newborn Care Services

Also affecting primary care physicians is the renumbering of newborn care services. Codes 99431-99440 have been deleted. To report normal newborn services, physicians should report the following codes:

- 99460 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant
- 99461 Initial care, per day, for evaluation and management of normal newborn infant seen in other than hospital or birthing center
- 99462 Subsequent hospital care, per day, for evaluation and management of normal newborn
- 99463 Initial hospital or birthing center care, per day, for evaluation and management of normal newborn infant admitted and discharged on the same date
- 99464 Attendance at delivery (when requested by the delivering physician) and initial stabilization of newborn
- 99465 Delivery/birthing room resuscitation, provision of positive pressure ventilation and/or chest compressions in the presence of acute inadequate ventilation and/or cardiac output

Continue to report 99238 or 99239 for newborn hospital discharge services provided on a date subsequent to the admission date. Remember, these are time-based codes, and time must be documented in the patient's medical record.

Neonatal and Pediatric Inpatient Services

New sections have been created in CPT 2009 to report:

- Critical care services for pediatric patient (24 months of age or less) during interfacility transport
- Inpatient neonatal critical care (28 days of age or less)
- Inpatient pediatric critical care (29 days to 24 months of age)
- Inpatient pediatric critical care (2 through 5 years of age)
- Hospital care for neonate (28 days or less) requiring intensive observation, frequent interventions and other intensive-care services

Table 1

	ICD-9-CM	ICD-10-CM
# of Characters	3-5 Numeric (+V and E codes)	3-7 Alphanumeric
# of Codes	~13,500	~68,000

Table 2

ICD 9-CM	Mechanical complication of other vascular device, implant, and graft – one code
996.1	Mechanical complication of other vascular device, inpatient and graft

ICD-10-CM	Mechanical complication of other vascular grafts – 156 codes, including
T82.310	Breakdown (mechanical) of aortic (bifurcation) graft (replacement)
T82.311	Breakdown (mechanical) of carotid arterial graft (bypass)
T82.312	Breakdown (mechanical of femoral arterial graft (bypass)
T82.318	Breakdown (mechanical) of other vascular grafts
T82.319	Breakdown (mechanical) of unspecified vascular grafts
T82.320	Displacement of aortic (bifurcation) graft (replacement)
T82.321	Displacement of femoral arterial graft (bypass)
T82.322	Displacement of femoral arterial graft bypass
T82.328	Displacement of other vascular grafts

ICD-9-CM	Pressure ulcer codes – total of nine location codes – shows broad location but not depth (stage)
707.00	Pressure ulcer, unspecified site
707.01	Pressure ulcer, elbow
707.02	Pressure ulcer, upper back (shoulder blades)
707.03	Pressure ulcer, lower back (Sacrum)
707.04	Pressure ulcer, hip
707.05	Pressure ulcer, buttock
707.06	Pressure ulcer, ankle
707.07	Pressure ulcer, heel
707.09	Pressure ulcer, other site (e.g., head)

ICD-10-CM	Pressure ulcer codes – 125 codes – shows more specific location as well as depth, including
L89131	Pressure ulcer of right lower back, stage I
L89132	Pressure ulcer of right lower back, stage II
L89133	Pressure ulcer of right lower back, stage III
L89134	Pressure ulcer of right lower back, stage IV
L89139	Pressure ulcer of right lower back, unspecified stage
L89141	Pressure ulcer of left lower back, stage I
L89142	Pressure ulcer of left lower back, stage II
L89143	Pressure ulcer of left lower back, stage III
L89144	Pressure ulcer of left lower back, stage IV
L89149	Pressure ulcer of left lower back, unspecified stage
L89151	Pressure ulcer of sacral region, stage I
L89152	Pressure ulcer of sacral region, stage II

Table 3

Calculation of the CY 2009 PFS CF	
CY 2008 Conversion Factor	$38.0870
CY 2009 CF Update 1.1 percent	(1.011)
CY 2009 CF Budget Neutrality Adjustment	0.08 percent (1.0008)
5-Year Review Budget Neutrality Adjustment	-6.41 percent (0.9359)
CY 2009 Conversion Factor	**$36.0666**

ICD-10 – Implementation Date October 1, 2013

After years of discussion, in the January 15, 2009, *Federal Register*, CMS published the final rule modifying the standard medical data code sets. Physicians will transition from ICD-9-CM to ICD-10-CM on October 1, 2013. Although hospitals will transition both their diagnosis and inpatient hospital procedures from ICD-9 to ICD-10, physicians are only changing diagnosis codes. Physicians will continue to use CPT and HCPCS codes to report services rendered.

CMS believes this transition:

- Incorporates much greater specificity and clinical information, which results in:
  - Improved ability to measure health care services
  - Increased sensitivity when refining grouping and reimbursement methodologies
  - Enhanced ability to conduct public health surveillance
  - Decreased need to include supporting documentation with claims
- Includes updated medical terminology and classification of diseases
- Provides codes to allow comparison of mortality and morbidity data
- Provides better data for:
- Measuring care furnished to patients
- Designing payment systems
- Processing claim
- Making clinical decisions
- Tracking public health
- Identifying fraud and abuse
- Conducting research

CMS provides the following comparison between ICD-9-CM and ICD-10-CM in the MLN Matters Number SE0832 (revised October 9, 2008), available on the CMS Web site at http://www.cms.hhs.gov/MLNMattersArticles/downloads/SE0832.pdf. (Table 1)

As shown in Table 2, ICD-10 codes may be longer, and there are about five times as many of them. Consequently, in an unabridged ICD-9 to ICD-10 mapping, each ICD-9 code is typically linked to more than one ICD-10 code, because each ICD-10 code is more specific. Below are examples that show where ICD-10-CM codes are more precise and provide better information.

Although 2013 is almost five years from now, physicians should begin to think about this transition. NCI recommends starting to think about this transition now. If you are still using paper superbills/charge tickets/fee slips, using the examples above, you can see how there will be changes in the specificity of your frequent diagnoses. Review the diagnosis codes currently on your superbill.

- Are there diagnostic statements infrequently used?
- How many unspecified diagnosis codes are you currently reporting?
- Determine your most frequently reported diagnosis codes.

Starting with the diagnosis codes most frequently reported, identify the specificity required for ICD-10. These codes are available on the CMS Web site at http://www.cms.hhs.gov/ICD10/02m_2009_ICD_10_CM.asp#TopOfPage

Compare the specificity of the information to the diagnostic statements on your superbill and, even more importantly, in your progress notes. Coding is the easy part of transitioning to ICD-10. We will still use the index, looking up the main term and then verifying that the code selected in the index is the correct code by looking in the tabular list. The fact we may be reporting seven alphanumeric digits versus numeric/alphanumeric digits is irrelevant. The problem will be having a complete diagnostic statement to code as well as how to modify the superbill to allow for the specificity.

Medicare Conversion Factor

Under the Medicare Improvements for Patients and Providers Act of 2008 (MIPPA), the Centers for Medicare & Medicaid Services (CMS) is required to apply a 1.1 percent update to the 2009 Physician Payment System. Physicians may be confused about how CMS applied a positive update when the 2009 conversion factor (CF) ($36.0666) is significantly lower than the 2008 conversion factor ($38.087).

§1848(c)(2)(B)(ii)(II) of the Social Security Act requires that increases or decreases in relative value units (RVUs) for a year may not cause the amount of expenditures for the year to differ by more than $20 million from what expenditures would have been in the absence of these changes. If this threshold is exceeded, CMS must make adjustments to preserve budget neutrality (BN).

In CY 2008 (table 3), CMS met the BN requirement by applying a separate BN adjustment factor (-11.94 percent) to the work RVUs. This is why many services had a lower fee schedule in 2008, even though Congress required a positive 0.5 percent increase. Beginning in CY 2009, §133(b) of the MIPPA requires CMS to apply the required BN adjustment to the conversion factor.

All of these calculations do result in a positive Medicare fee schedule update, but that does not mean that physicians will see a 1.1 percent increase for all services when comparing the 2009 fee schedule with the 2008 fee schedule. For example, the 2008 Arizona Medicare fee schedule allowance for 99213 ($59.03) increases to $59.96 for 2009; 99214's 2008 value of $88.75 increases to $90.32 for 2009.

Other services that are more heavily weighted to practice expense are expected to decrease due to this calculation. For example, the code for electrocardiogram 93000 will decrease to $20.14, down from $22.38 for 2009. The code for chest X-ray AP/lateral views (71020) is reduced from $32.41 to $30.47 for 2009.

If §131 of the MIPPA had not been enacted, the CY 2009 conversion factor update would have been -15.1 percent. Congress needs to act in 2009 to prevent the more than 21 percent negative conversion factor update for calendar year 2010.

Revisions to the Medicare Initial Preventive Physical Examination

§101(b) of the MIPPA amended the requirements for the Initial Preventive Physical Examination (IPPE), also known as the "Welcome to Medicare Physical." Beginning January 1, 2009, the Medicare deductible no longer applies to the IPPE. Although patients are still responsible for the 20 percent coinsurance amount, it should help alleviate patients' misconceptions that they were to receive a "free physical."

MIPPA also expands the eligibility period from the first six months to a full year (first 12 months) after the effective date of the patient's first Part B enrollment period. Medicare still will only pay for one IPPE per beneficiary lifetime, and those Medicare patients who are no longer in the first 12 months of their first Part B enrollment period are not entitled to payment for a screening physical exam.

There are three significant changes in IPPE required services. Effective January 1, 2009, physicians must include the measurement of an individual's body mass index as part of the IPPE. Physicians must also include end-of-life planning during the encounter.

MIPPA removes the electrocardiogram (ECG) from the list of mandated services that must be included in the IPPE benefit and makes the ECG an educational, counseling and referral service to be discussed with the patient and, if necessary, ordered by the physician. This change alleviates physician frustration of having to perform a screening ECG when the patient just had a diagnostic ECG. Medicare will cover the screening

ECG when the physician deems the screening is appropriate for the individual patient.

To meet these changes CMS, effective **January 1, 2009**, the following codes have been deleted:

~~G0344~~ Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first six months of Medicare enrollment

~~G0366~~ Electrocardiogram, routine ECG with 12 leads; performed as a component of the initial preventive examination with interpretation and report

~~G0367~~ Tracing only, without interpretation and report, performed as a component of the initial preventive examination

~~G0368~~ Interpretation and report only, performed as a component of the initial preventive examination

Effective with IPPE services rendered on or after January 1, 2009, physicians will use the following codes to report the service(s):

G0402 Initial preventive physical examination; face-to-face visit, services limited to new beneficiary during the first 12 months of Medicare enrollment

G0403 Electrocardiogram, routine ECG with at least 12 leads; performed as a screening test for the initial preventive examination with interpretation and report

G0404 Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report, performed as a screening for the initial preventive examination

G0405 Electrocardiogram, routine ECG with at least 12 leads; interpretation and report only, performed as a screening for the initial preventive examination

Smoking and Tobacco-Use Cessation Counseling Services

Medicare has been covering counseling services for smoking and tobacco-use cessation since March 22, 2005.

Smoking and tobacco-use cessation counseling is considered reasonable and necessary for a patient with a disease or an adverse health effect that has been found by the U.S. Surgeon General to be linked to tobacco use or who is taking a therapeutic agent whose metabolism or dosing is affected by tobacco use as based on FDA-approved information.

CMS specifically states that patients must be competent and alert at the time that services are provided. Minimal counseling of three minutes or less is included in the payment for the evaluation and management (E/M) visit and is not separately reported.

Although most family physicians provide smoking and tobacco-use cessation counseling that lasts more than three minutes in duration, this service is frequently not reported. Medicare covers two cessation attempts per year. Each attempt may include a maximum of four intermediate or intensive sessions, with the total annual benefit covering up to eight sessions in a 12-month period. Physicians and patients have the flexibility to choose between intermediate or intensive cessation strategies for each attempt.

Further, intermediate and intensive smoking-cessation counseling services are also covered for outpatient and hospitalized patients who are smokers and who qualify as above, as long as those services are furnished by qualified physicians and other Medicare-recognized practitioners (e.g., nurse practitioner, physician assistant, etc).

The following CPT codes should be reported when billing for smoking and tobacco-use cessation counseling services:

99406 Smoking and tobacco-use cessation counseling visit; intermediate, greater than three minutes and up to 10 minutes

99407 Smoking and tobacco-use cessation counseling visit; intensive, greater than 10 minutes

Physicians should also remember that Medicare allows payment for a medically necessary E/M service on the same day as the smoking and tobacco-use cessation counseling service when it is clinically appropriate. Physicians and qualified non-physician practitioners should report the appropriate CPT code, e.g., 99201-99215, for the visit and must append the -25 modifier to the E/M code to indicate that the visit is a separately identifiable service from 99406 or 99407.

Claims for smoking and tobacco-use cessation counseling services should be submitted with an appropriate diagnosis code. Due to coverage requirements, diagnosis codes should reflect the condition the patient has that is adversely affected by tobacco use, e.g., diabetes mellitus, chronic obstructive pulmonary disease, etc., or the condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use.

CMS has an excellent brochure explaining coverage and coding for smoking and tobacco-use cessation counseling services. This brochure, ICN 006767, dated August 2007, is available on the CMS Web site at http://www.cms.hhs.gov/MLNproducts/downloads/smoking.pdf. The brochure includes the following information.

Cessation Counseling Attempt: A cessation counseling attempt occurs when a qualified physician or other Medicare-recognized practitioner determines that a beneficiary meets the eligibility requirements and initiates treatment with a cessation counseling attempt. A cessation counseling attempt includes the following:

- Up to four cessation counseling sessions (one attempt = up to four sessions)
- Two cessation counseling attempts (or up to eight cessation counseling sessions) are allowed every 12 months

Cessation Counseling Session: A cessation counseling session refers to face-to-face patient contact at one of two levels:

- Intermediate (greater than three minutes and up to 10 minutes)
- Intensive (greater than 10 minutes)

Documentation: Keep patient record information on file for each Medicare patient for whom a smoking and tobacco-use cessation counseling claim is made. Medical record documentation must include standard information along with sufficient patient history to adequately demonstrate that Medicare coverage conditions were met. Diagnosis codes should reflect the following:

- The condition the patient has that is adversely affected by tobacco use
- The condition the patient is being treated for with a therapeutic agent whose metabolism or dosing is affected by tobacco use

The CMS brochure also clarifies that cessation counseling sessions may be performed "incident to" the services of a qualified practitioner. This means the initial session must be performed by a physician/nonphysician provider. At the physician/nonphysician practitioner's discretion, follow-up sessions may be performed and documented by ancillary personnel. In this scenario, the billing physician/practitioner must be physically present in the office suite when the counseling services are performed by ancillary personnel.

Physicians have access to smoking and tobacco-use cessation counseling services eligibility data to determine the patient's remaining smoking and tobacco-use cessation counseling sessions and, when appropriate, the next eligible date when the patient has reached his or her maximum eight sessions, through the 270/271 eligibility inquiry and response transaction. Typically, this information is also available through the Medicare Contractor's Interactive Voice Response (IVR) system.

2009 Call for Nominations for Officers

At least 90 days prior to the IAFP Annual Assembly each year, the Nominating Committee shall announce nominations as required by the Bylaws. These nominations shall be formally presented at the first meeting of the Congress of Delegates, which this year will be July 24 and 25 in French Lick. At the time of the meeting, additional nominations from the floor may be made. The said election of officers shall be the first order of business at the second session of the Congress of Delegates on July 25.

Offices to be filled for 2009-2010 are: president-elect, second vice president, speaker of the Congress of Delegates, vice speaker of the Congress of Delegates, one AAFP delegate (two-year term) and one AAFP alternate delegate (two-year term).

The Nominating Committee's objective is to select the most knowledgeable and capable candidates available. The committee is also responsible for determining the availability of those candidates to serve, should they be selected.

If you are an active member of the IAFP and are interested in submitting your name as a candidate, you must submit a letter of intent, a glossy black-and-white photo and a curriculum vitae. This information must be received prior to April 25. If you have questions, please contact Kevin Speer or Deeda Ferree at 317.237.4237.

Casino Air Monitoring Study Gains Extensive Media Coverage for IAFP Foundation

On January 13, 2009, the IAFP Foundation held a press conference to release its "Indiana Casino Air Monitoring Study, April 2008-May 2008." The event was covered by media outlets throughout the Midwest, including the Louisville *Courier-Journal*, the Evansville *Courier-Press*, the *Indianapolis Star*, the *Lafayette Journal & Courier*, Fox news, NBC news and many others.

This study was conducted by Purdue University and funded by the Indiana Academy of Family Physicians Foundation (IAFPF) with a grant from the Americans for Nonsmokers' Rights Foundation and the Robert Wood Johnson Foundation.

This "Rapid Response" grant was offered to assist IAFPF and the Indiana Campaign for Smokefree Air (ICSA) in their efforts to educate employees of gaming venues about the serious dangers of the secondhand smoke that they are exposed to on the job every day. In addition to the Purdue study, IAFPF and ICSA hosted a one-day training for tobacco-control advocates in communities with gaming facilities, produced two Web sites, hosted six regional town-hall forums and placed a series of ads featuring business owners sharing the benefits of their smokefree workplaces.

A special thanks goes out to Dr. Christopher Doehring for speaking at the press conference! Find more info on the study at our Web site, www.in-afp.org.

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