FRONTLINE PHYSICIAN

A Publication of the Indiana Academy of Family Physicians • Fall 2007

2007 IAFP Annual Meeting

Elegance and Excellence PG. 14

Plan Now to Serve as Physician of the Day PG. 30

All Insurance is the Same. . . Right?

As the professional liability insurance environment has changed, so have your coverage options. In addition to familiar companies, you are now confronted with an array of non-traditional and start-up insurers who offer surprisingly low rates and other promises to gain new policyholders. But what is the truth about these coverage options?

Bargain Rate & Start-up Companies

Be careful. These insurers may:

- Maintain inadequate reserves to pay claims
- Keep reserves in high-risk investments
- Receive no oversight or licensing from regulatory agencies
- Provide limited or sub-standard claims service
- Be unable or unwilling to fulfill their promises

American Physicians

We've kept our promises to doctors for three decades:

- Financially stable with a high rating from A.M. Best
- Maintains or exceeds reserve levels set by regulators
- Selects only the safest investments for reserves
- Licensed, reviewed and regulated by government agencies
- Industry leader in claims service, underwriting and support

For three decades American Physicians has been offering rates that are both competitive and responsible, as well as providing exceptional service and industry-leading value. Our physician focus, impeccable standards and financial stability continue to attract the best practices, year after year.

If you would like more information about insurance options, please contact American Physicians at 1-800-748-0465.

American Physicians . . . Coverage Doctors Trust

American Physicians®
ASSURANCE CORPORATION

Practices That Set The Standard

www.apassurance.com

Highly Rated by A.M. Best, Endorsed by Medical Societies

Printed September 2007

Indiana Academy of Family Physicians

55 Monument Circle, Suite 400 Indianapolis, Indiana 46204
317.237.4237 • 888.422.4237
Fax 317.237.4006
E-mail: iafp@in-afp.org
Web site: www.in-afp.org

Printed September 2007

FRONTLINE PHYSICIAN

Volume 8 • Issue 3

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

The MISSION of the Indiana Academy of Family Physicians is to promote excellence in health care and the betterment of the health of the American people. Purposes in support of this mission are:

- To provide responsible advocacy for and education of patients and the public in all health-related matters;
- To preserve and promote quality cost-effective health care;
- To promote the science and art of family medicine and to ensure an optimal supply of well-trained family physicians;
- To promote and maintain high standards among physicians who practice family medicine;
- To preserve the right of family physicians to engage in medical and surgical procedures for which they are qualified by training and experience;
- To provide advocacy, representation and leadership for the specialty of family medicine;
- To maintain and provide an organization with high standards to fulfill the above purposes and to represent the needs of its members.

INDIANA ACADEMY OF FAMILY PHYSICIANS

innovativepublishingink

FrontLine Physician is published by Innovative Publishing Ink.
10629 Henning Way, Suite 8 • Louisville, Kentucky 40241
502.423.7272
www.ipipublishing.com

Innovative Publishing Ink specializes in creating custom magazines for associations.
Please direct all inquiries to Aran Jackson, ajackson@ipipublishing.com.

Medically speaking, IMACS OneCall℠ is the smartest way to connect doctors to the Clarian specialists and services they need. One number puts you in touch with a knowledgeable – and persistent – representative who will track down whatever doctor or service you're after. To connect to this and other PhysicianLink℠ services from Clarian hospitals (Indiana University Hospital, Methodist Hospital, Riley Hospital for Children, Clarian West Medical Center & Clarian North Medical Center), call **800-622-4989 or visit clarian.org/connect.**

We connect the docs.℠

Clarian Health



Contents

Features

Extras

In Every Issue

Advertisers

The strength, defense and century-long solutions of Medical Protective.

The security and resources of Berkshire Hathaway.

...On June 20, 2005 we bought Medical Protective, a 107 year-old medical malpractice insurer based in Fort Wayne. Malpractice insurance is tough to underwrite and has proved to be a graveyard for many insurers. As part of Berkshire, Medical Protective has financial strength far exceeding that of its competitors, a quality assuring healthcare providers that long-to-settle claims will not end up back on their doorstep because their insurer failed....

– from Warren Buffett's Letter to Shareholders, February 28, 2006

...We want Medical Protective to continue to be the company that thinks like a doctor and behaves with the same integrity and individual care as a doctor....

– from Warren Buffett, April 26, 2006

...We're proud to have Medical Protective as part of the Berkshire family....

– from Warren Buffett, May 30, 2006

Now is the time for you to consider joining the tens of thousands who enjoy the unmatched protection that only Medical Protective can provide.

- Best financial **strength**
- Most winning **defense**
- Smartest **solutions**
- Committed **since 1899**

MEDICAL PROTECTIVE

Strength. Defense. Solutions. Since 1899.

a Berkshire Hathaway Company

Call for a FREE Indiana medmal buyer's guide.

Defend your reputation and assets. ■ Visit medpro.com ■ Call 800-4MEDPRO ■ Contact your independent agent

Children aren't concerned about osteoporosis.

But their physicians should be.

As a physician, you know that if kids eat three daily servings of dairy, it can help reduce their risk of osteoporosis years from now. But some parents don't know; so you can help by informing them that dairy foods supply key nutrients necessary for better bone health.

The U.S. Surgeon General's report on Bone Health and Osteoporosis recognizes the role that nutrients in dairy foods – including calcium, magnesium, phosphorus, potassium, protein, and vitamin D – play in helping to build and protect bones.

In fact, a report from the American Academy of Pediatrics states that eating calcium-rich foods such as milk, cheese and yogurt during childhood and adolescence will help build strong bones, which may reduce the risk of fractures and osteoporosis later in life.

Helping patients can be easy. Just remind them to get three servings of low-fat or fat-free milk, cheese or yogurt every day, as recommended by the U.S. Dietary Guidelines for Americans. Or, direct them to MyPyramid.gov to learn more.

And remind parents that it's never too late for them to take care of their own bone health too. By getting three daily servings of dairy and participating in weight-bearing exercise, adults can help protect their bones while setting a good example for their children. To learn more, visit nationaldairycouncil.org.

Sponsored by the National Dairy Council and supported by leading health professional organizations.

NMA

American Academy of Family Physicians

American Academy of Pediatrics

American Dietetic Association

3-A-Day of Calcium for Stronger Bones

HAVE YOU HAD YOUR 3 TODAY?

3aday.org

Brought to you by:

Dairy & Nutrition Council, Inc.

Your Indiana Dairy Farmers
9360 Castlegate Drive, Indianapolis, IN 46256 • **800.225.6455** • indianadairycouncil.org

Larry Allen, MD

It's Time to Tell Your Story

"Family physician supply at critical shortage level," reads a recent headline from the Massachusetts Medical Society. In a state where legislation has mandated health insurance for everyone, the obvious question of where the insured will be cared for is coming to the forefront. I also read recently that, after a short period of time, family physicians are once again the most commonly recruited specialty by hospitals and health systems. As the "medical home" concept (a new phrase for a well established tenet of family medicine) gains momentum among payors and policymakers, the demand for family medicine will rise and pressure on the recruitment of family docs will dramatically increase.

I state this not just based on national information and trends, but on personal experience here in Indiana.

- We all receive the daily recruitment pleas, offering countless opportunities for the near-perfect practice location and setting.
- Many of my local colleagues fit the profile of older than 50, wanting to cut back on workload and considering more time in non-clinical positions and pursuits.
- In my independent group practice of three physicians, we recently nearly landed an excellent new partner from a nearby residency, only to miss out at the last minute. We realized that it could be several years before we find another candidate looking to practice in our rural location.
- Finding a family doctor who is taking new patients within a three-county, 20-mile radius is a rarity.
- The percentage of IU Medical School seniors choosing family medicine residencies continues to fall well below the targets that will meet our workforce projections.

Providing Indiana with the family physicians needed to serve the next generation will be a daunting task and will take a united effort from all of us. As professionals, part of our accepted role (in the spirit of Hippocrates) is to help train and encourage those who are stepping in behind and beside us.

The IAFP and our Foundation continue to be involved in many ways to develop family medicine students and residents. These efforts include Research Day, participation in family medicine interest groups and the Barnett Adopt-A-Student program, where students between their first two years of medical school are sponsored to work in a family doctor's office for the summer.

During this past year, a new effort has begun by meeting with members of the Department of Family Medicine at IU to share strategic plans in order to enhance collaboration on advocacy and legislative issues that affect the supply and practice environment of family physicians. At our annual meeting in French Lick, Doug McKeag, chair of the department, moderated a well attended and received "town hall" meeting, where an effort was made to build consensus and identify ways to positively influence the health care delivery system in our state.

In addition to these efforts, there are things we can all do. Last week a patient of mine who is now a sophomore pre-med student was in for an appointment, and I made sure to schedule a day for him to shadow me in the near future. He jumped at the chance. A Tar Wars presentation goes a long way toward introducing students to family medicine (see the in-afp.org Web site for details). Residencies are always looking for half-day preceptors for their clinics, and both residents and third-year students need clerkship sites. *Let us all be aware of opportunities to testify that despite the challenges, the rewards of a career in family medicine are great and unique.* In the July 1 issue of *AFP*, Marguerite Duane, MD, from Georgetown University School of Medicine, editorializes on the need to inspire future family physicians by writing: "Now, as we prepare for the future, family medicine is again at the forefront. Our greatest challenge will be to urge the best and the brightest of our medical students to join us in family medicine. We can do that only by committing to telling our stories and showing who we are. We must each identify and refute the myths about our specialty. We must answer our students' questions through our words and through our actions. We have a new generation to inspire to join us in the specialty we love. It is time to tell students your story."

Mark Your Calendar

October 3-7, 2007
AAFP Annual Meeting
Chicago

October 28, 2007
IAFP Board/Cluster Meeting
Indianapolis

November 6, 2007
Family Interest Reception
Indianapolis

November 9, 2007
IAFP Foundation Board Retreat
Indianapolis

November 16-17, 2007
AAFP State Legislative Conference
Memphis, Tennessee

January 17-20, 2008
IAFP Family Medicine Update
Indianapolis

March 5, 2008
IAFP Faculty Development Day
Indianapolis

March 6, 2008
IAFP Residents' Day/Research Forum
Indianapolis

July 23-27, 2008
IAFP Annual Meeting
Fort Wayne

IAFP Membership Update

KEEP US INFORMED

Please remember to keep all of your contact information up-to-date with the AAFP and the IAFP.

This includes: your address (home and office), phone number, fax number and e-mail address.

To update your information, call the IAFP Headquarters at 317.237.4237 or e-mail iafp@in-afp.org.

Membership Status Totals as of July 31, 2007

Active	**1,721**
Supporting (non-FP)	**6**
Supporting CME (FP)	**3**
Inactive	**12**
Life	**195**
Resident	**115**
Student	**213**
Total	**2,266**

The pill is little. But it can make a difference on your patients' heartburn and other symptoms of acid reflux disease.

Call **1-800-969-8526** today to get free patient education materials about ACIPHEX for your practice!

ACIPHEX 20 mg is indicated for: treatment of daytime and nighttime heartburn and other symptoms of GERD, short-term, up to 4 weeks, treatment in the healing and symptomatic relief of duodenal ulcers; short-term, 4 to 8 weeks, treatment in the healing and symptomatic relief of erosive GERD, and maintenance of healing and reduction in relapse rates of heartburn symptoms of erosive GERD (controlled maintenance studies do not extend beyond 12 months).

Important Safety Information: In clinical trials the most common side effect assessed as possibly or probably related to ACIPHEX with a frequency greater than placebo was headache (2.4% vs 1.6% for placebo).

Symptomatic response to therapy does not preclude the presence of gastric malignancy. ACIPHEX is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles, or to any component of the formulation. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

Please see brief summary of full prescribing information on adjacent page.

Manufactured & Marketed by
Eisai
Woodcliff Lake, NJ 07677

Marketed by
PriCara
Raritan, NJ 08869-0602

AcipHex®
rabeprazole sodium
www.ACIPHEX.com

AcipHex®
rabeprazole sodium

BRIEF SUMMARY

Before prescribing ACIPHEX®, please see full prescribing information.

INDICATIONS AND USAGE

Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)

ACIPHEX® is indicated for short-term (4 to 8 weeks) treatment in the healing and symptomatic relief of erosive or ulcerative gastroesophageal reflux disease (GERD). For those patients who have not healed after 8 weeks of treatment, an additional 8-week course of ACIPHEX® may be considered.

Maintenance of Healing of Erosive or Ulcerative Gastroesophageal Reflux Disease (GERD)

ACIPHEX® is indicated for maintaining healing and reduction in relapse rates of heartburn symptoms in patients with erosive or ulcerative gastroesophageal reflux disease (GERD Maintenance). Controlled studies do not extend beyond 12 months.

Treatment of Symptomatic Gastroesophageal Reflux Disease (GERD)

ACIPHEX® is indicated for the treatment of daytime and nighttime heartburn and other symptoms associated with GERD.

Healing of Duodenal Ulcers

ACIPHEX® is indicated for short-term (up to four weeks) treatment in the healing and symptomatic relief of duodenal ulcers. Most patients heal within four weeks.

Helicobacter pylori Eradication to Reduce the Risk of Duodenal Ulcer Recurrence

ACIPHEX® in combination with amoxicillin and clarithromycin as a three drug regimen, is indicated for the treatment of patients with *H. pylori* infection and duodenal ulcer disease (active or history within the past 5 years) to eradicate *H. pylori*. Eradication of *H. pylori* has been shown to reduce the risk of duodenal ulcer recurrence. (See **CLINICAL STUDIES** and **DOSAGE AND ADMINISTRATION** in full prescribing information.)

In patients who fail therapy, susceptibility testing should be done. If resistance to clarithromycin is demonstrated or susceptibility testing is not possible, alternative antimicrobial therapy should be instituted. (See **CLINICAL PHARMACOLOGY, Microbiology** in full prescribing information and the clarithromycin package insert, **CLINICAL PHARMACOLOGY, Microbiology**.)

Treatment of Pathological Hypersecretory Conditions, Including Zollinger-Ellison Syndrome

ACIPHEX® is indicated for the long-term treatment of pathological hypersecretory conditions, including Zollinger-Ellison syndrome.

CONTRAINDICATIONS

Rabeprazole is contraindicated in patients with known hypersensitivity to rabeprazole, substituted benzimidazoles or to any component of the formulation.

Clarithromycin is contraindicated in patients with known hypersensitivity to any macrolide antibiotic.

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. There have been post-marketing reports of drug interactions when clarithromycin and/or erythromycin are co-administered with pimozide resulting in cardiac arrhythmias (QT prolongation, ventricular tachycardia, ventricular fibrillation, and torsade de pointes) most likely due to inhibition of hepatic metabolism of pimozide by erythromycin and clarithromycin. Fatalities have been reported. (Please refer to full prescribing information for clarithromycin.)

Amoxicillin is contraindicated in patients with a known hypersensitivity to any penicillin. (Please refer to full prescribing information for amoxicillin.)

WARNINGS

CLARITHROMYCIN SHOULD NOT BE USED IN PREGNANT WOMEN EXCEPT IN CLINICAL CIRCUMSTANCES WHERE NO ALTERNATIVE THERAPY IS APPROPRIATE. If pregnancy occurs while taking clarithromycin, the patient should be apprised of the potential hazard to the fetus. (See **WARNINGS** in prescribing information for clarithromycin.)

Amoxicillin: Serious and occasionally fatal hypersensitivity (anaphylactic) reactions have been reported in patients on penicillin therapy. These reactions are more likely to occur in individuals with a history of penicillin hypersensitivity and/or a history of sensitivity to multiple allergens.

There have been well-documented reports of individuals with a history of penicillin hypersensitivity reactions who have experienced severe hypersensitivity reactions when treated with a cephalosporin. Before initiating therapy with any penicillin, careful inquiry should be made concerning previous hypersensitivity reactions to penicillins, cephalosporins, and other allergens. If an allergic reaction occurs, amoxicillin should be discontinued and the appropriate therapy instituted. (See **WARNINGS** in prescribing information for amoxicillin.)

SERIOUS ANAPHYLACTIC REACTIONS REQUIRE IMMEDIATE EMERGENCY TREATMENT WITH EPINEPHRINE. OXYGEN, INTRAVENOUS STEROIDS, AND AIRWAY MANAGEMENT, INCLUDING INTUBATION, SHOULD ALSO BE ADMINISTERED AS INDICATED.

Pseudomembranous colitis has been reported with nearly all antibacterial agents, including clarithromycin and amoxicillin, and may range in severity from mild to life threatening. Therefore, it is important to consider this diagnosis in patients who present with diarrhea subsequent to the administration of antibacterial agents.

Treatment with antibacterial agents alters the normal flora of the colon and may permit overgrowth of clostridia. Studies indicate that a toxin produced by *Clostridium difficile* is a primary cause of "antibiotic-associated colitis".

After the diagnosis of pseudomembranous colitis has been established, therapeutic measures should be initiated. Mild cases of pseudomembranous colitis usually respond to discontinuation of the drug alone. In moderate to severe cases, consideration should be given to management with fluid and electrolytes, protein supplementation, and treatment with an antibacterial drug clinically effective against *Clostridium difficile* colitis.

PRECAUTIONS

General

Symptomatic response to therapy with rabeprazole does not preclude the presence of gastric malignancy.

Patients with healed GERD were treated for up to 40 months with rabeprazole and monitored with serial gastric biopsies. Patients without *H. pylori* infection (221 of 326 patients) had no clinically important pathologic changes in the gastric mucosa. Patients with *H. pylori* infection at baseline (105 of 326 patients) had mild or moderate inflammation in the gastric body or mild inflammation in the gastric antrum. Patients with mild grades of infection or inflammation in the gastric body tended to change to moderate, whereas those graded moderate at baseline tended to remain stable. Patients with mild grades of infection or inflammation in the gastric antrum tended to remain stable. At baseline 8% of patients had atrophy of glands in the gastric body and 15% had atrophy in the gastric antrum. At endpoint, 15% of patients had atrophy of glands in the gastric body and 11% had atrophy in the gastric antrum. Approximately 4% of patients had intestinal metaplasia at some point during follow-up, but no consistent changes were seen.

Steady state interactions of rabeprazole and warfarin have not been adequately evaluated in patients. There have been reports of increased INR and prothrombin time in patients receiving a proton pump inhibitor and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death. Patients treated with a proton pump inhibitor and warfarin concomitantly may need to be monitored for increases in INR and prothrombin time.

Information for Patients

Patients should be cautioned that ACIPHEX® delayed-release tablets should be swallowed whole. The tablets should not be chewed, crushed, or split. ACIPHEX® can be taken with or without food.

Please see FDA approved patient labeling in the full prescribing information.

Drug Interactions

Rabeprazole is metabolized by the cytochrome P450 (CYP450) drug metabolizing enzyme system. Studies in healthy subjects have shown that rabeprazole does not have clinically significant interactions with other drugs metabolized by the CYP450 system, such as warfarin and theophylline given as single oral doses, diazepam as a single intravenous dose, and phenytoin given as a single intravenous dose (with supplemental oral dosing). Steady state interactions of rabeprazole and other drugs metabolized by this enzyme system have not been studied in patients. There have been reports of increased INR and prothrombin time in patients receiving proton pump inhibitors, including rabeprazole, and warfarin concomitantly. Increases in INR and prothrombin time may lead to abnormal bleeding and even death.

In vitro incubations employing human liver microsomes indicated that rabeprazole inhibited cyclosporine metabolism with an IC_{50} of 62 micromolar, a concentration that is over 50 times higher than the C_{max} in healthy volunteers following 14 days of dosing with 20 mg of rabeprazole. This degree of inhibition is similar to that by omeprazole at equivalent concentrations.

Rabeprazole produces sustained inhibition of gastric acid secretion. An interaction with compounds which are dependent on gastric pH for absorption may occur due to the magnitude of acid suppression observed with rabeprazole. For example, in normal subjects, co-administration of rabeprazole 20 mg QD resulted in an approximately 30% decrease in the bioavailability of ketoconazole and increases in the AUC and C_{max} for digoxin of 19% and 29%, respectively. Therefore, patients may need to be monitored when such drugs are taken concomitantly with rabeprazole. Co-administration of rabeprazole and antacids produced no clinically relevant changes in plasma rabeprazole concentrations.

In a clinical study in Japan evaluating rabeprazole in patients categorized by CYP2C19 genotype (n=6 per genotype category), gastric acid suppression was higher in poor metabolizers as compared to extensive metabolizers. This could be due to higher rabeprazole plasma levels in poor metabolizers. Whether or not interactions of rabeprazole sodium with other drugs metabolized by CYP2C19 would be different between extensive metabolizers and poor metabolizers has not been studied.

Combined Administration with Clarithromycin

Combined administration consisting of rabeprazole, amoxicillin, and clarithromycin resulted in increases in plasma concentrations of rabeprazole and 14-hydroxyclarithromycin. (See **CLINICAL PHARMACOLOGY, Combination Therapy with Antimicrobials** in full prescribing information.)

Concomitant administration of clarithromycin with pimozide and cisapride is contraindicated. (See **PRECAUTIONS** in prescribing information for clarithromycin.) (See **PRECAUTIONS** in prescribing information for amoxicillin.)

Carcinogenesis, Mutagenesis, Impairment of Fertility

In a 88/104-week carcinogenicity study in CD-1 mice, rabeprazole at oral doses up to 100 mg/kg/day did not produce any increased tumor occurrence. The highest tested dose produced a systemic exposure to rabeprazole (AUC) of 1.40 μg•hr/mL which is 1.6 times the human exposure (plasma $AUC_{0-\infty}$ = 0.88 μg•hr/mL) at the recommended dose for GERD (20 mg/day). In a 104-week carcinogenicity study in Sprague-Dawley rats, males were treated with oral doses of 5, 15, 30 and 60 mg/kg/day and females with 5, 15, 30, 60 and 120 mg/kg/day. Rabeprazole produced gastric enterochromaffin-like (ECL) cell hyperplasia in male and female rats and ECL cell carcinoid tumors in female rats at all doses including the lowest tested dose. The lowest dose (5 mg/kg/day) produced a systemic exposure to rabeprazole (AUC) of about 0.1 μg•hr/mL which is about 0.1 times the human exposure at the recommended dose for GERD. In male rats, no treatment related tumors were observed at doses up to 60 mg/kg/day producing a rabeprazole plasma exposure (AUC) of about 0.2 μg•hr/mL (0.2 times the human exposure at the recommended dose for GERD).

Rabeprazole was positive in the Ames test, the Chinese hamster ovary cell (CHO/HGPRT) forward gene mutation test and the mouse lymphoma cell (L5178Y/TK+/-) forward gene mutation test. Its demethylated-metabolite was also positive in the Ames test. Rabeprazole was negative in the *in vitro* Chinese hamster lung cell chromosome aberration test, the *in vivo* mouse micronucleus test, and the *in vivo* and *ex vivo* rat hepatocyte unscheduled DNA synthesis (UDS) tests.

Rabeprazole at intravenous doses up to 30 mg/kg/day (plasma AUC of 8.8 μg•hr/mL, about 10 times the human exposure at the recommended dose for GERD) was found to have no effect on fertility and reproductive performance of male and female rats.

Pregnancy

Teratogenic Effects. Pregnancy Category B: Teratology studies have been performed in rats at intravenous doses up to 50 mg/kg/day (plasma AUC of 11.8 μg•hr/mL, about 13 times the human exposure at the recommended dose for GERD) and rabbits at intravenous doses up to 30 mg/kg/day (plasma AUC of 7.3 μg•hr/mL, about 8 times the human exposure at the recommended dose for GERD) and have revealed no evidence of impaired fertility or harm to the fetus due to rabeprazole. There are, however, no adequate and well-controlled studies in pregnant women. Because animal reproduction studies are not always predictive of human response, this drug should be used during pregnancy only if clearly needed.

Nursing Mothers

Following intravenous administration of ^{14}C-labeled rabeprazole to lactating rats, radioactivity in milk reached levels that were 2- to 7-fold higher than levels in the blood. It is not known if unmetabolized rabeprazole is excreted in human breast milk. Administration of rabeprazole to rats in late gestation and during lactation at doses of 400 mg/kg/day (about 195-times the human dose based on mg/m²) resulted in decreases in body weight gain of the pups. Since many drugs are excreted in milk, and because of the potential for adverse reactions to nursing infants from rabeprazole, a decision should be made to discontinue nursing or discontinue the drug, taking into account the importance of the drug to the mother.

Pediatric Use

The safety and effectiveness of rabeprazole in pediatric patients have not been established.

Use in Women

Duodenal ulcer and erosive esophagitis healing rates in women are similar to those in men. Adverse events and laboratory test abnormalities in women occurred at rates similar to those in men.

Geriatric Use

Of the total number of subjects in clinical studies of ACIPHEX®, 19% were 65 years and over, while 4% were 75 years and over. No overall differences in safety or effectiveness were observed between these subjects and younger subjects, and other reported clinical experience has not identified differences in responses between the elderly and younger patients, but greater sensitivity of some older individuals cannot be ruled out.

ADVERSE REACTIONS

Worldwide, over 2900 patients have been treated with rabeprazole in Phase II-III clinical trials involving various dosages and durations of treatment. In general, rabeprazole treatment has been well-tolerated in both short-term and long-term trials. The adverse events rates were generally similar between the 10 and 20 mg doses.

Incidence in Controlled North American and European Clinical Trials

In an analysis of adverse events assessed as possibly or probably related to treatment appearing in greater than 1% of ACIPHEX® patients and appearing with greater frequency than placebo in controlled North American and European trials, the incidence of headache was 2.4% (n=1552) for ACIPHEX® versus 1.6% (n=258) for placebo.

In short and long-term studies, the following adverse events, regardless of causality, were reported in ACIPHEX®-treated patients. Rare events are those reported in ≤1/1000 patients.

Body as a Whole: asthenia, fever, allergic reaction, chills, malaise, chest pain substernal, neck rigidity, photosensitivity reaction. Rare: abdomen enlarged, face edema, hangover effect. *Cardiovascular System:* hypertension, myocardial infarct, electrocardiogram abnormal, migraine, syncope, angina pectoris, bundle branch block, palpitation, sinus bradycardia, tachycardia. Rare: bradycardia, pulmonary embolus, supraventricular tachycardia, thrombophlebitis, vasodilation, QTc prolongation and ventricular tachycardia. *Digestive System:* diarrhea, nausea, abdominal pain, vomiting, dyspepsia, flatulence, constipation, dry mouth, eructation, gastroenteritis, rectal hemorrhage, melena, anorexia, cholelithiasis, mouth ulceration, stomatitis, dysphagia, gingivitis, cholecystitis, increased appetite, abnormal stools, colitis, esophagitis, glossitis, pancreatitis, proctitis. Rare: bloody diarrhea, cholangitis, duodenitis, gastrointestinal hemorrhage, hepatic encephalopathy, hepatitis, hepatoma, liver fatty deposit, salivary gland enlargement, thirst. *Endocrine System:* hyperthyroidism, hypothyroidism. *Hemic & Lymphatic System:* anemia, ecchymosis, lymphadenopathy, hypochromic anemia. *Metabolic & Nutritional Disorders:* peripheral edema, edema, weight gain, gout, dehydration, weight loss. *Musculo-Skeletal System:* myalgia, arthritis, leg cramps, bone pain, arthrosis, bursitis. Rare: twitching. *Nervous System:* insomnia, anxiety, dizziness, depression, nervousness, somnolence, hypertonia, neuralgia, vertigo, convulsion, abnormal dreams, libido decreased, neuropathy, paresthesia, tremor. Rare: agitation, amnesia, confusion, extrapyramidal syndrome, hyperkinesia. *Respiratory System:* dyspnea, asthma, epistaxis, laryngitis, hiccup, hyperventilation. Rare: apnea, hypoventilation. *Skin and Appendages:* rash, pruritus, sweating, urticaria, alopecia. Rare: dry skin, herpes zoster, psoriasis, skin discoloration. *Special Senses:* cataract, amblyopia, glaucoma, dry eyes, abnormal vision, tinnitus, otitis media. Rare: corneal opacity, blurry vision, diplopia, deafness, eye pain, retinal degeneration, strabismus. *Urogenital System:* cystitis, urinary frequency, dysmenorrhea, dysuria, kidney calculus, metrorrhagia, polyuria. Rare: breast enlargement, hematuria, impotence, leukorrhea, menorrhagia, orchitis, urinary incontinence.

Laboratory Values: The following changes in laboratory parameters were reported as adverse events: abnormal platelets, albuminuria, creatine phosphokinase increased, erythrocytes abnormal, hypercholesteremia, hyperglycemia, hyperlipemia, hypokalemia, hyponatremia, leukocytosis, leukorrhea, liver function tests abnormal, prostatic specific antigen increase, SGPT increased, urine abnormality, WBC abnormal.

In controlled clinical studies, 3/1456 (0.2%) patients treated with rabeprazole and 2/237 (0.8%) patients treated with placebo developed treatment-emergent abnormalities (which were either new on study or present at study entry with an increase of 1.25 x baseline value) in SGOT (AST), SGPT (ALT), or both. None of the three rabeprazole patients experienced chills, fever, right upper quadrant pain, nausea or jaundice.

Combination Treatment with Amoxicillin and Clarithromycin: In clinical trials using combination therapy with rabeprazole plus amoxicillin and clarithromycin (RAC), no adverse events unique to this drug combination were observed. In the U.S. multicenter study, the most frequently reported drug related adverse events for patients who received RAC therapy for 7 or 10 days were diarrhea (8% and 7%) and taste perversion (6% and 10%), respectively.

No clinically significant laboratory abnormalities particular to the drug combinations were observed.

For more information on adverse events or laboratory changes with amoxicillin or clarithromycin, refer to their respective package prescribing information, **ADVERSE REACTIONS** section.

Post-Marketing Adverse Events: Additional adverse events reported from worldwide marketing experience with rabeprazole sodium are: sudden death, coma and hyperammonemia, jaundice, rhabdomyolysis, disorientation and delirium, anaphylaxis, angioedema, bullous and other drug eruptions of the skin, severe dermatologic reactions, including toxic epidermal necrolysis (some fatal), Stevens-Johnson syndrome, and erythema multiforme, interstitial pneumonia, interstitial nephritis, and TSH elevations. In most instances, the relationship to rabeprazole sodium was unclear. In addition, agranulocytosis, hemolytic anemia, leukopenia, pancytopenia, and thrombocytopenia have been reported. Increases in prothrombin time/INR in patients treated with concomitant warfarin have been reported.

OVERDOSAGE

Because strategies for the management of overdose are continually evolving, it is advisable to contact a Poison Control Center to determine the latest recommendations for the management of an overdose of any drug. There has been no experience with large overdoses with rabeprazole. Seven reports of accidental overdosage with rabeprazole have been received. The maximum reported overdose was 80 mg. There were no clinical signs or symptoms associated with any reported overdose. Patients with Zollinger-Ellison syndrome have been treated with up to 120 mg rabeprazole QD. No specific antidote for rabeprazole is known. Rabeprazole is extensively protein bound and is not readily dialyzable. In the event of overdosage, treatment should be symptomatic and supportive.

Single oral doses of rabeprazole at 786 mg/kg and 1024 mg/kg were lethal to mice and rats, respectively. The single oral dose of 2000 mg/kg was not lethal to dogs. The major symptoms of acute toxicity were hypoactivity, labored respiration, lateral or prone position and convulsion in mice and rats and watery diarrhea, tremor, convulsion and coma in dogs.

℞ only

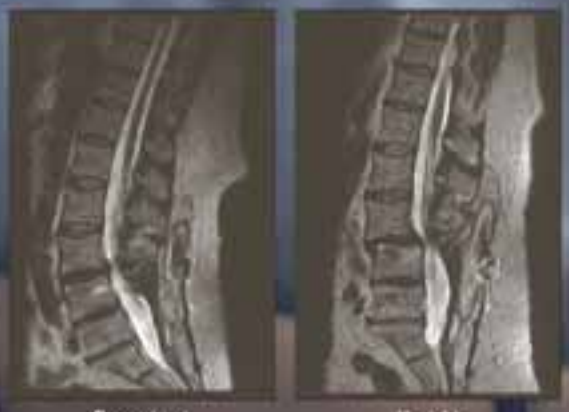
Manufactured and Marketed by Eisai Inc., Woodcliff Lake, NJ 07677
Marketed by PriCara, Unit of Ortho-McNeil, Inc., Raritan, NJ 08869

[illegible] Revised February 2007

THE SPIRIT OF CARING®

We believe superior scans lead to superior diagnoses.

Our open upright MRI means more accurate images.



Recumbent Upright

St.Vincent Carmel Hospital has the technology to provide you with a better picture of your patients' symptoms. As pictured in the images shown here, the open upright MRI can more accurately reproduce real-life spine and orthopedic conditions than recumbent MRI scans alone. That means better-informed physicians and more comfortable patients. For more information, call 317-582-7142, or to schedule an appointment, call 317-582-7373.

THE SPIRIT OF CARING®

St.Vincent Carmel Hospital

136th & Meridian Street

Photograph by Morgan Matters

James Metzler, MD, and family, winners of the Best Family prize at the All Member Party costume contest

2007 IAFP ANNUAL MEETING

Elegance and Excellence

IN FRENCH LICK, INDIANA

The 59th IAFP Annual Meeting was held at the French Lick Hotel and Conference Center in French Lick, Indiana, on July 25-29. About 180 physicians and their families attended the meeting, which included CME sessions, Congress of Delegates, business meetings, an exhibit show and many social events.

The All Member Party had a Flappers and Gangsters theme this year, and guests were treated to delicious food and wonderful music from the Marlins.

At the President's Banquet, Larry Allen, MD, was installed as the president of the IAFP. The IAFP's new officers were also installed at this event.

2007 IAFP AWARD WINNERS

Indiana Academy of Family Physicians 2007 IAFP Family Physician of the Year

The IAFP Family Physician of the Year Award is presented annually to a member who exemplifies the tradition of the family physician and contributes to the continuing good health of the citizens of Indiana.

Dr. Alan Bercovitz graduated from the Indiana University School of Medicine and has been in a solo practice since finishing his residency in 1990. In addition to his practice, Dr. Bercovitz volunteers his time teaching at the St. Vincent Family Medicine Clinic, where he is a well-known mentor among many of the residents. He brings a great deal of knowledge and experience that only a solo-practice physician can offer them.

An award-winning teacher and role model, Dr. Bercovitz is full of compassion, always going above and beyond the call of duty for his patients. In his personal life, he has been a Cub Scout leader, coached baseball and basketball and even finds the time to speak to small groups about Jewish culture and customs. Dr. Bercovitz is a kind, modest and giving family physician. His continued dedication to the specialty of family medicine, its students and residents and, of course, his patients, make him a truly deserving recipient of the Family Physician of the Year Award.

The IAFP congratulates Dr. Bercovitz for being named 2007 IAFP Family Physician of the Year, and we thank him for the example he has set for our specialty.

Lester D. Bibler Award

The Lester D. Bibler Award is named after the first president of the IAFP (IAGP) and is presented annually to an active IAFP member who, through long-term dedication and leadership, has furthered the development of family medicine in Indiana.

Dr. Thomas Felger began his private practice in Fort Wayne in 1971, after serving as a lieutenant commander in the United States Naval Reserves, and continued in private practice until 1994. Throughout his career, Dr. Felger has held a number of valuable positions in both Fort Wayne and South Bend, serving as a consultant, administrator and teacher of students, residents and colleagues.

Dr. Felger earned his undergraduate and medical degrees from Indiana University and completed a rotating internship at St. Elizabeth's Hospital (Dayton). He has been a tremendous asset to family medicine, serving in most leadership positions within the IAFP, as president in 1995-96 and as a member of the Indiana Delegation to the AAFP Congress of Delegates since 1999. In addition to his professional activities, he has been very involved in his community, serving on boards and committees of various organizations, ranging from local health clinics and the Inter-Agency Drug Abuse Council to the Fort Wayne Chamber of Commerce and the Fort Wayne Railroad Historical Society.

Students, residents, colleagues, and his communities have all benefited from Tom Felger's commitment to family medicine. He has devoted much of his career to improving the specialty and will no doubt continue to contribute for many years to come.

The IAFP congratulates Dr. Felger for being selected to receive the 2007 Lester D. Bibler Award, and we thank him for his service in the name of family medicine.

A. Alan Fischer Award

The A. Alan Fischer Award is presented annually to recognize persons who have made outstanding contributions to education for family practice in the undergraduate, graduate and continuing education arenas.

Dr. Patrick Connerly is currently assistant director of Managed Care Services at Parkview Hospital in Fort Wayne. He has been affiliated with the Fort Wayne Medical Education Program since 1989, but began teaching 28 years ago as an assistant professor at the University of Wisconsin Medical School. An Indiana native, Dr. Connerly attended Earlham College and earned his medical degree from the Indiana University School of Medicine. He completed his term as a family practice resident at the University of Minnesota before serving several years in the United States Public Health Service.

Dr. Connerly's teaching spans a wide range of practice, including inpatient and outpatient care, obstetrics, end-of-life care and practice management. And he has committed much of his time to the Academy, particularly within the 12th District, where he served in every position available. He has been an excellent role model for family medicine residents and, having twice received the Fort Wayne Medical Education Teacher of the Year Award, is highly deserving of similar recognition from the IAFP.

The IAFP congratulates Dr. Connerly for being selected to receive the 2007 A. Alan Fischer Award, and we thank him for educating and inspiring the newest members of our specialty.

Outstanding Resident Award

The IAFP Outstanding Resident Award is presented annually to a family practice resident who demonstrates exceptional interest and involvement in family medicine and exemplifies the qualities of a family physician.

Risheet Patel, MD, came to us from New York, having earned his undergraduate degree in biology and French from Union College in Schenectady, New York, and his medical degree from Albany Medical College in Albany, New York. He returned to the Indianapolis area in 2001, when he began his residency with the Community Health Network Family Medicine Residency. A natural leader, Dr. Patel has made a lasting impression on patients, students, fellow residents and teachers in just a few short years. He has been an ambassador for the specialty and a pillar in his community.

Though cognizant of the importance of the physician-patient relationship, Dr. Patel sees beyond the walls of his residency and new practice, recognizing the responsibility that he is faced with in the greater community. He eagerly anticipates the opportunities he has to influence policies and programs that will positively impact the health of the public. He understands that, while patient care is his top priority, his role in family medicine is much larger than this. Once referred to as "a true bright star in the future of our specialty," we know that Dr. Patel will continue to do great things for family medicine.

The IAFP congratulates Dr. Patel for being named the 2007 Outstanding Resident and looks forward to working with him for many years to come.

IAFP CIRCLE OF SUPPORT

The Indiana Academy of Family Physicians would like to give special recognition to the following supporters. The companies listed below have supported special events and/or provided educational grants towards the 2007 IAFP AM in amounts that distinguish them as members of the IAFP Circle of Support.

Gold Circle
Meretek Diagnostics, Inc.

Silver Circle
Eli Lilly
Indiana Dairy and Nutrition Council
PhRMA
Indiana Spine Group
New Jersey Academy of Family Physicians
Wyeth

Bronze Circle
Novartis
St. Vincent Health
Anthem
Pfizer

SPONSORSHIPS

Anthem – Serving Hoosier Healthwise
Registration Bags

Ent & Imler CPA Group
Golf Tournament Hole Sponsor
Saturday President's AfterGlow

Hall Render
All Member Party

Indiana Dairy & Nutrition Council
Yogurt Break

Indiana Spine Group
Annual Banquet & Awards Dinner

Medical Assurance
Golf Tournament Hole Sponsor
Golf Tournament Beverage Cart
Friday Congress of Delegates Break

PhRMA
Jerry Stuckey Luncheon

St. Vincent Health
Physician/Exhibitor Luncheon

Stockyards Bank
Thursday Congress of Delegates Break

Educational Grants & In-Kind Support
American Academy of Family Physicians
American Board of Family Medicine
Blue & Company
Eli Lilly
Hoosier HealthWise
Indiana Dairy & Nutrition Council
Indiana Family and Social Services Administration Office of Medicaid Policy and Planning
Indiana Spine Group
Indiana University School of Medicine Department of Family Medicine and Bowen Research Center
Indianapolis Discovery Network for Dementia
Meretek Diagnostics, Inc.
New Jersey Academy of Family Physicians
Newby Consulting, Inc.
Novartis
Pfizer
Purdue Pharma
U.S. Centers for Disease Control and Prevention
Wyeth

2007 ANNUAL MEETING PRIZE WINNERS

LCD TV: Tom Kintanar, MD
Sony digital camera: Ted Lai, MD
Sony digital camera: Ariel Gonzalez, MD

2007 IAFP ANNUAL MEETING EXHIBITORS AND SPONSORS

The IAFP would like to extend its appreciation to the following exhibitors and sponsors. Without their help and generous support, the 2007 Annual Meeting would not have been possible.

Please thank the company's representatives when they visit your office.

AAFP Ask and Act Program
Abbott
Alcon Laboratories, Inc.
Allscripts
Assisted Living Concepts, Inc.
AstraZeneca Pharmaceuticals
Boehringer Ingelheim Pharm. Inc.
Bristol-Myers Squibb
Catalis, Inc.
Cephalon Inc.
Clarian Health
Clarian Senior Heath & Ambulatory Services
Community Physicians of Indiana
Corvasc MD's Vein Solutions
Endo Pharmaceuticals
GlaxoSmithKline Inc.
Hoffman-La Roche Inc.
Indiana Academy of Family Physicians
Indiana AHEC Program
Indiana National Guard
Indiana Spine Group
Indiana State Dept. of Health
IN Tobacco Prevention & Cessation
iSalus healthcare
MDwise
Medical Assurance
Medical Protective
MedImmune, Inc.
Merck & Co., Inc.
Meretek Diagnostics
Mid America Clinical Laboratories
Midwest Pain Institute
National Government Services, Inc.
Noteworthy Medical Systems
Novartis Pharmaceuticals
PA Labs/Midwest COAG
Premier Surgical and Institute for Pain Management/Dr. Judith Dunipace
Pricara, Unit of Ortho-McNeil, Inc.
Reckitt-Benckiser Pharmaceuticals
Reliant Pharmaceuticals, Inc.
Sanofi-Aventis Pharmaceuticals
Sanofi Pasteur
Sepracor
St. Vincent
Summit Medical Technologies
Takeda Pharmaceuticals
TAP Pharmaceuticals
UCB, Inc.
Ulrich Medical Concepts, Inc.
Verathon Medical Inc
Wyeth Pharmaceuticals

All Member Party AND President's Banquet

Photographs by Morgan Matters

Dr. Alan Bercovitz, IAFP Family Physician of the Year, and his family

Dr. Clif Knight and his wife, Shelly, with AAFP Board Member Ted Epperly, MD, of Iowa

Worthe Holt, MD, and Tom Felger, MD

Dr. and Mrs. Robert Ward, winners of the Best Couple prize at the All Member Party costume contest

The Marlins entertained guests of all ages with their infectious music.

Larry Allen, MD, and Windel Stracener, MD

Legislative Update

Interim Study Committees
The Indiana General Assembly's interim agenda began with the meeting of its annual Legislative Council meeting in July. The Health Finance Commission in particular will grapple with several important issues, including physician reimbursement rates and the efficacy of the state's Tobacco Prevention and Cessation Program. This commission will be extraordinarily busy, as it will only meet three to four times this year. For your reference, please see the committees and charges of interest below.

Health Finance Commission (IC 2-5-23)
The Commission Is Charged With Studying The Following Topics:
A. Study the survey process for long-term care facilities (SR 69)
B. Review reports requested by the Legislative Evaluation Oversight Policy Subcommittee and prepared by the Legislative Services Agency evaluation staff concerning:
(1) A survey of the status of inmate health in the state prison system; and
(2) An inventory of IDOH programs (Legislative Council)

SELECT JOINT COMMISSION ON MEDICAID OVERSIGHT (IC 2-5-26-1)
The Commission Is Charged With Studying the Following Topic:
A. Issues relating to the state's practice of buying out Medicaid-certified beds in health facilities (HB 1679)
The Commissions Were Also Charged by the 2007 Legislative Council to Study These Additional Topics:
A. Survey of long-term care facilities
B. Reimbursement rates to providers and premium costs of accident and sickness insurance policies and health maintenance organization contracts
C. Efficacy of Indiana's Tobacco Prevention and Cessation Program
D. Hospitals placed under moratorium
E. Adequacy of the regulation of methadone clinics
F. Acute-care hospitals in Gary, Indiana
G. Ways in which the state and other entities can encourage physicians to practice in rural and county hospitals
H. A prohibition against smoking in public places in Indiana
I. Mechanisms for providing programs to provide health care coverage for uninsured individuals in Indiana
J. The state department shall, in consultation with health care providers, evaluate the current immunization data registry system under IC 16-38-5 and determine ways to make the registry easier for health care providers to report to and use
K. Most Favored Nations clauses in insurance contracts

Thank you to the following IAFP members for contributing $100 or more to the 2007 IAFP PAC!

Debbie Allen, MD
Larry Allen, MD
Doug Boss, MD
Bruce Burton, MD
Brian Coppinger, MS3
Bernard Emkes, MD
Richard Feldman, MD
Tom Felger, MD
Alvin Haley, MD
Ash Hanna, MD
Shannon Joyce, MD
Clif Knight, MD
Debra McClain, MD
Bill Mohr, MD
Suzanne Montgomery, MD
Ray Nicholson, MD
Risheet Patel, MD
Melissa Pavelka, MD
David Pepple, MD
Fred Ridge, MD
Dan Walters, MD

Your contributions will allow our legislative team to continue to represent family physicians before the state's executive and legislative branches.

***If you have not yet contributed this year, *please contribute today!* Please send contributions to the IAFP headquarters.**

Indiana Academy of Family Physicians • Political Action Committee
55 Monument Circle, Ste. 400 · Indianapolis, IN 46204
Telephone: 317.237.4237; 888.422.4237 (in-state only)

2007 All Member Congress o

The 2007 All Member Congress of Delegates (COD) was a success, as members from across the state gathered in French Lick, Indiana, to vote on issues important to family medicine. Resolutions passed by 2007 COD include:

Position Statement Regarding Mid-Level Providers
The IAFP supports public policy that would generally restrict the outpatient practice of mid-level providers to situations where the supervising physician is physically present except, but not limited to: rural communities (to be defined), designated underserved areas and school-based clinics. In these situations when remote supervision is allowed, rules for more meaningful and closer supervision should be established. The IAFP does not support the autonomous practice of mid-level providers, and where physician oversight is allowed, the IAFP prefers "supervised" as opposed to "collaborative practice."

The IAFP supports policies that would limit the number of mid-level providers an individual physician/practice site can supervise.

Action Item on IAFP Positions
The IAFP should grant permission to the COL to formulate IAFP legislative positions for specific bills whenever an immediate position is required. This applies to situations when communication with the president or Executive Committee is not readily available and when IAFP and AAFP policy does not specifically address the issue. Any policy formulated by the COL shall be validated by the Executive Committee or Board of Directors at the next scheduled meeting of such organization.

"Multiple E&M Codes" #07-01
RESOLVED, that the American Academy of Family Physicians thoroughly study for its utility and possible adoption a system to modify CPT E&M codes to allow for multiple E&M codes for the same patient visit in which multiple chronic problems are addressed, modeled after the way in which multiple CPT codes are payable for multiple surgeries performed on the same patient visit, with a report back to the 2008 Congress of Delegates, and be it finally

RESOLVED, that part of the study regarding modifying CPT E&M codes to allow for multiple E&M codes for the same patient visit in which multiple chronic problems are addressed, modeled after the way in which multiple CPT codes are payable for multiple surgeries performed on the same patient visit, involve obtaining reaction, comment and support from other specialty organizations and components of organized medicine.

ss of Delegates

To Help Preserve Primary Care, Fix the Conversion Factor(s) # 07-02
RESOLVED, that the Indiana Academy of Family Physicians seek dialogue with Indiana's insurance companies to resolve the payment disparity between procedural and primary care physicians and develop possible solutions regarding this payment disparity; and be it further

RESOLVED, that the Indiana Academy of Family Physicians work with the appropriate legislative body if necessary to resolve the payment disparity between procedural and primary care physicians; and be it finally

RESOLVED, that this concern and possible solutions regarding the disparity of payment between procedural and primary care physicians be forwarded to the 2007 Indiana State Medical Association's House of Delegates and to the 2007 American Academy of Family Physicians' Congress of Delegates.

Proper Reimbursement For Vaccines # 07-03
RESOLVED, that the Indiana Academy of Family Physicians seek dialogue with payers who reimburse at less than the cost of vaccines to urge a reimbursement rate for family physicians that covers at least the cost of the vaccine, storage and handling involved in administration of the vaccine, and be it further

RESOLVED, that the Indiana Academy of Family Physicians work with the appropriate legislative body if necessary to seek a reimbursement rate for family physicians that covers at least the cost of the vaccine, storage and handling involved in administration of the vaccine and that this resolution be submitted to the Indiana State Medical Association and the American Academy of Family Physicians to continue dialogue at the state and national levels.

PAC Status
The Indiana Academy of Family Physicians' Political Action Committee (**IAFP PAC**) needs your help as it collects funds for next year's campaigns. The PAC has already made contributions to a few key members of the state's legislative health committees. However, additional contributions to other key health care leaders will be necessary to ensure that our experienced legislative team gains access to and is able to educate legislators on the issues that are important to family physicians and their patients.

Sincerely,
Allison Matters and Doug Kinser

Student Congress Report

Family Medicine Residents and Students National Conference

Barbara Mowery, Indiana University School of Medicine, MS4
Student Delegate to NCFMR/MS and Alternate Director, Student Region

The 2007 Family Medicine Residents and Students National Conference offered workshops, guest speakers, procedural skills, student and resident congress meetings, and booths and displays by more than 200 family medicine residency programs.

I was pleased to represent Indiana as our state's student representative. We elected the following officers: Student Candidate to the AAFP Board of Directors, Beth Loney; 2008 National Conference Chair, Amy McIntyre; Alternate Delegates to the AAFP Congress of Delegates, Lisa Dafuzzo and Mike Oller; National Family Medicine Interest Group Coordinator, Bob Jeske; and Representative to the Society of Teacher of Family Medicine, Erin Corriveau.

The student congress also debated and voted on 19-plus resolutions. The scope of resolutions was broad, from dealing with the drug-seeking patient to minorities in family medicine. Among those resolutions passed were the following:

1) Resolution No. S1-107, "Dual Certification and Fellowship Options in Family Medicine Residencies," Resolved, That the American Academy of Family Physicians offer a lecture on "Dual Certification and Fellowship Options in Family Medicine Residencies" in conjunction with the National Conference of Family Medicine Residents and Medical Students and include information on family medicine residency programs that offer combined certification, fellowships and additional degrees.
2) Resolution No.S1-106, "Use of Ultrasound in Family Medicine," Resolved, That the American Academy of Family Physicians investigate whether physician-performed ultrasound use in the outpatient family medicine setting is cost-effective and beneficial to patients.
3) Resolution No. S2-205, "American Academy of Family Physicians-Sponsored Medical Spanish Courses," Resolved, That the American Academy of Family Physicians investigate the potential of a live, intensive, medically-oriented language immersion course in Spanish (modeled after the Advanced Life Support in Obstetrics and Board Review courses).
4) Resolution No. S3-306, "Impact of Pharmaceutical Interactions on Patient Outcomes," Resolved, That the American Academy of Family Physicians encourage the National Research Network to assess the impact of pharmaceutical company interactions with family physicians on patient outcomes.

Thank you for allowing me to serve as Indiana's student representative at the Family Medicine Residents and Students National Conference. It was truly a fun learning experience.

Sincerely,
Barbara Mowery, MS4

Other News from the Residents and Students

The Student Region elected a new director at their May meeting, as outgoing director Andy Campbell was graduating and starting residency at St. Francis. Brian Coppinger, a new third-year student and former extern in the Barnett Adopt-A-Student Program, was elected to serve as the Student Director for the remainder of the year. Brian is eager to continue his involvement with the Academy and has already offered valuable input for both the Board of Directors and Foundation Board of Trustees.

The Student Region was able to hold a second meeting this summer at the IAFP Annual Meeting. On Friday, the Academy hosted a student luncheon for all students attending the meeting and invited AAFP board members Dr. Ted Epperly, Dr. Tom Kintanar and Dr. Clif Knight to share their words of wisdom about getting involved in the Academy and answer questions about what lies ahead for family medicine. At the conclusion of lunch, the students present elected Barbara Mowery, a fourth-year student from Linton, to serve as alternate director of the region. Barbara went on to serve as delegate to the Student Congress in Kansas City the following week.

Though small in number, the luncheon was a great opportunity to bring our leadership together with some of our most promising student members. We hope to make this an annual event and welcome all students to attend next year in Fort Wayne!

On Saturday, August 4, Roy Miner, MD, was elected to represent all residents as a delegate to the AAFP Congress of Delegates in 2008. Dr. Miner will attend the Congress in Chicago as alternate delegate. He is in his second year of residency at Ball Memorial. Congratulations, Dr. Miner!

Resident Congress Report

The 2007 National Conference for Family Medicine Residents and Medical Students was again a great success, with inspiring speakers such as AAFP President Rick Kellerman and former Surgeon General David Satcher, exciting lectures and workshops, and another fulfilling Resident Congress in which compelling and spirited debate of resolutions occurred. As the Indiana resident delegate, I thoroughly enjoyed representing Indiana this year. The Resident Congress discussed several resolutions on such topics as retail health clinics, resident participation in practice-based research networks and the development of four-year family medicine residencies. Specifically, the Resident Congress passed a resolution asking the AAFP to change the language of the AAFP's policy on retail health clinics to include a stronger stand with regard to potential fragmentation of care and conflict of interest. A resolution asking family medicine residencies to consider experimenting with four-year training models so residents could get further experience in high-risk obstetrics and procedures also passed. Furthermore, a resolution supporting potential resident involvement in practice-based research networks was adopted. The National Conference again was an outstanding meeting and I would encourage all residents and students to make an effort to attend next year in Kansas City.

Roy Miner, MD
2007-08 Indiana Chapter Delegate
2007-08 Alternate Resident Delegate to AAFP Congress of Delegates

New Residents at Indiana's Family Medicine R

St. Francis Family Medicine Residency

Adam Trammel
Chatham, IL
Graduated from: Southern Illinois University School of Medicine

Alexander Molina
Indianapolis
Graduated from: Indiana University School of Medicine

Andrew Campbell
Plainfield
Graduated from: Indiana University School of Medicine

Asoka Ratnayake
Indianapolis
Graduated from: Indiana University School of Medicine

Krista O'Neal
Indianapolis
Graduated from: Indiana University School of Medicine

Ryan White
Brownsburg
Graduated from: American University of the Caribbean

Scott Bilyeu
Rockford, IL
Graduated from: University of Illinois School of Medicine

e Residency Programs

The IAFP wishes the very best of luck to all new family medicine residents who have chosen to complete their residencies in Indiana.

Memorial Hospital Family Medicine Residency Program

Kirk Bodach, MD
Indiana University

Travis Casper, MD
Medical University of Ohio

Megan Johnston, MD
University of North Dakota

Anne Harris (Koontz), MD
Medical College of Wisconsin

Tricia Kurtz, MD
Indiana University

Emily McDevitt, DO
Nova Southeastern University

Mandy Sorlie, MD
University of North Dakota

Bethany Wait (Milton), DO
Michigan State University

Dr. Craig Brater Receives Lifetime Achievement Award for Distinguished Service in Years of Health Advancement

Craig Brater, MD, dean of the Indiana University School of Medicine, will receive the Indiana Public Health Foundation's 2007 Lifetime Achievement Award for Distinguished Service in Years of Health Advancement. In making the announcement, dinner chairman Daniel Evans, CEO of Clarian Health, stated that the award will be presented on October 11, 2007, at the Hulman Health Achievement Awards Dinner in the Westin Hotel downtown Indianapolis. Ticket information for the reception at 6 p.m. and the dinner at 7 p.m., followed by the awards presentation, is available from elenscheibner@sbcglobal.net or by phone at 317.244.2145.

Dr. Jason Marker Elected to AAFP's Board of Directors

At the May meeting of the American Academy of Family Physicians (AAFP), Dr. Jason Marker was elected to serve on the organization's Board of Directors. Dr. Marker has been a member of the Indiana Academy of Family Physicians Board of Directors as a student, resident and physician, and has been in private practice in Wyatt, Indiana, for five years. In his new role with the AAFP, he will represent the interests of family physicians at the national level, both in policy-making and in legislative advocacy. His installation in this position will come at the Annual Meeting of the AAFP to be held in Chicago this October.

THE IAFP NEEDS YOUR HELP!

Plan Now to Serve as Physician of the Day in January and March 2008

The Indiana Academy of Family Physicians (IAFP) and the Indiana State Medical Association (ISMA) will once again sponsor the Physician of the Day program at the 2008 General Assembly. Your assistance is needed! In this session, it is most important that family medicine make an impression on our legislators. This im-portant program allows you to observe the legislative process firsthand and to meet with your area representatives.

The Physician of the Day program is one in which IAFP members volunteer to spend one or more days at the Statehouse during the legislative session. The purpose of the Physician of the Day Program is to provide episodic primary care services, as a con-venience, for the governor, legislators and their staffs during the time the state Legislature is in session. The Physician of the Day will be introduced at the beginning of the day. Your day at the Statehouse will be from 8:30 a.m. to 4:30 p.m.

Read an account of Jason Marker, MD's, time as Physician of the Day in April of this year to give you a better idea of what you can expect, should you decide to serve in 2008.

Physician of the Day Journal

On April 25, as the 2007 Indiana General Assembly rolled to a close, I took the plunge and volunteered for my first IAFP State Legislature Physician of the Day shift. I want to tell you about my day because, like many of you, I was nervous about this opportunity and the responsibility it holds. I had considered volunteering in the past but finally found some courage and signed up. I hope this brief journal entry motivates some of you to volunteer next session for what, for me, turned out to be an exciting, educational and fulfilling day.

6 a.m.: On the road early for Indianapolis. Living in extreme northern Indiana means I needed to get going early to be to the Statehouse on time.

8:30 a.m.: After checking in at the legislators' guard station a few steps from the Statehouse, I was startled to see that I was parking next to a spot labeled, "Governor." I found my way to the Senate Republican secretary's office and was given a pager, key to the physician's office and numerous offers of donuts and coffee. A Senate doorman gave me a thorough tour of the House and Senate chambers and introduced me to innumerable staff members as he led me to the physician office in an out-of-the-way corner of the basement.

10 a.m.: Back at the House of Representatives chamber, I am escorted by the House secretary to a seat embarrassingly close to the Speaker of the House's platform. Soon, my own district representative came by to say good morning and have a picture taken and I was introduced before the House as the Physician of the Day. They, and I, got to work: a cold, a sore shoulder, follow-up on a sprained ankle. In between "office visits" I enjoyed watching the House debate the issues of the day and had several members step over to my area just to say hello and thanks for being available.

Noon: I walked the three blocks from the Statehouse to the IAFP Headquarters on Monument circle and got a tour and said hello. Upon returning and grabbing a quick lunch at the Statehouse snack shop, I met up with the IAFP lobbyist, Allison Matters, who gave me an excellent overview of the legislative process from the standpoint of a professional lobbyist. For a guy who hasn't thought much about government since high school, it was fascinating.

2 p.m.: I returned to the Senate chambers where my state senator was located and came over to see how my day was going. We talked a bit and I asked about the tobacco tax and other legislation I knew was being discussed. He commented that he hadn't heard of a physician coming from so far away to take part in the Physician of the Day program and how pleased he was to get a chance to talk to me. Shortly after being introduced on the floor of the Senate, my pager went off and I returned to the office to check on the progress of a Chalazion and to dispense some generic Claritin for a staff member's allergies. I returned to the floor of the Senate and watched the rest of their session.

4:30 p.m.: I turned in my pager and office key, was wished off with a hearty "thank you" by the pleasant doorman who had helped me start my day and set off for home, arriving in time to spend an hour with my wife and daughters before their bedtime. They wanted to know whom I had seen who was "famous" and hugged me proudly, even though I said I had only parked next to the governor, not actually seen him.

Please fill out and mail to: IAFP, 55 Monument Circle, Suite 400, Indianapolis, IN 46204

Name: _____

Phone Number: _____

Malpractice Insurance Carrier: _____

Day(s) Requested: _____

Being Physician of the Day was not only unbelievably straight-forward, but incredibly rewarding and educational. Though it did not strain my clinical skills, the value that it held for our legislators was obvious and happily expressed by them. The value that our involvement holds for the specialty of family medicine is immeasurable and made even more important when you consider the incredible access we have to legislators while serving.

I would encourage each of you to consider volunteering for the Physician of the Day Program in the next legislative session. I cannot express enough how well organized the program is and how excited you will feel when you are done to have been part of our democracy at work.

We are in the process of scheduling physician volunteers for the months of January and March. If you are interested in serving as the Physician of the Day, please fill out the information on page 30 and return it to the IAFP office no later than November 12, or feel free to call the IAFP office at 888.422.4237 (toll-free, in-state only) or 317.237.4237 to schedule your Physician of the Day shift. Thank you in advance for your assistance with this important program.

Please note: Only the shaded dates are available. Physician of the Day does not operate Friday-Sunday.

January 2008

Sun	Mon	Tues	Wed	Thur	Fri	Sat
		1	2	3	4	5
6	7	8	9	10	11	12
13	14	15	16	17	18	19
20	21	22	23	24	25	26
27	28	29	30	31		

March 2008

Sun	Mon	Tues	Wed	Thur	Fri	Sat
						1
2	3	4	5	6	7	8
9	10	11	12	13	14	15
16	17	18	19	20	21	22
23	24	25	26	27	28	29
30	31					

Foundation Update

2007 Student Procedure Day

I'm excited to share with you the success of the recent IAFP Foundation-sponsored Annual Procedure Workshop. This is an experience offered to incoming third-year medical students in an effort to prepare them for their clinical training. While previous workshops have been well received, attendance this year was by far the best yet. The event was held on Saturday, June 9, at the IU Family Medicine Center. We had a record number of RSVPs and a total of 87 participants, up from 47 the previous year. This means approximately one-third of the medical students at IU took part, soaking up the practical knowledge being handed out by our family medicine residents. Several programs were present and included Community Health Network, Indiana University, St. Francis and St. Vincent. Multiple topics were covered such as: basic lab interpretation, pocket reference books, the musculoskeletal exam, joint injections, scrubbing in, how to write admission orders and SOAP notes, and how to effectively learn during rounds. Surveys were completed by the students at the end of the day and the responses were overwhelmingly positive, certainly directing us to expect an even larger number of attendees at next year's event.

I'd like to take this opportunity to thank the IAFP Foundation for its support and sponsorship of this vital instrument of outreach and education. It's an exceptional opportunity to showcase the talents of family medicine residents and initiate interest in our specialty among medical students.

Shelley Stiner, DO
IAFP Resident Director

Barnett Adopt-A-Student

Michael O'Connor, a new second-year medical student from the Indianapolis area, was selected as the Barnett Adopt-A-Student extern for 2007. Michael had a range of experiences this summer, spending two days a week with Dr. Bob Clutter and colleagues, and two days a week with Dr. Mark Fakhoury and Dr. Martha Yoder at the People's Health Center. Michael found this to be especially rewarding, as it gave him the opportunity to see patients from very different backgrounds, but found that, although there were many differences, much of the issues remained the same. Additionally, Michael spent time each week volunteering at a variety of community agencies, with particular focus on care of the homeless. The lessons learned this summer were many, but Michael noted that one of the greatest lessons he has taken away from this experience is the continuity of care that family medicine offers and the critical role that it plays in the lives of all patients.

Please help us thank our volunteer preceptors this summer, and keep an eye out for Michael as he continues his journey through medical school!

Clinton Student Places Third in Tar Wars National Poster Contest

Megan McCoy, a fifth-grade student at Central Elementary in Clinton, Indiana, threw out the first pitch at the July 8 Indianapolis Indians baseball game, when the IAFP Foundation hosted the Fourth Annual Tar Wars Celebration at Victory Field. One thousand Tar Wars student artists, presenters and tobacco-free friends attended the game and watched Megan's pitch travel right across home plate.

In July, Megan traveled to Washington, D.C., for the Tar Wars National Poster Contest, where she was honored as the third-place winner in the national contest! While there, Megan and her family visited with Rep. Brad Ellsworth and thanked him for co-sponsoring HR 1108, a bill that would give the FDA effective authority to regulate the production and sales of tobacco and would return control of tobacco advertising to the states. They also spent the afternoon touring the Capitol with staff from Sen. Lugar's office, and even had an opportunity to meet him between votes. On the day that began the "slumber party" heard around the country, we were especially appreciative of the time that Megan's representatives were able to take out of their busy days to spend with her.

This was the first trip that Megan and her mother have ever taken on an airplane, but Megan certainly has her sights set on another trip soon! In fact, she's already prepping younger family members for their entries into the state poster contest in the future. We look forward to another entry from the family!

Scholarships Available for Residents to Attend the Conference on Practice Improvement

We are pleased to announce that the IAFP Foundation will once again be offering three $1,200 scholarships for the Conference on Practice Improvement. The 2007 conference is being held November 8-11 in Newport Beach, California. This unique meeting proves to be a favorite among all who attend. For more information about the conference or to learn about scholarship opportunities, visit: www.aafp.org/pec.xml.

Family Practice Stories Book Selected as the New IAFP Foundation Priority Program

At the July board meeting the Foundation officially selected the Family Practice Stories Book as its priority program for the next two years. This book has been a work in progress for more than five years but has seen much activity in the last six months after Andy Campbell, MD, took an interest in the project. As a student, Dr. Campbell offered to help with the interview process, and he has now completed interviews with some of our most beloved members.

With a goal of $10,000 in contributions and nearly 50 stories, this is a project members of all ages can contribute to. If you know of a member you'd like to see featured in the

book, please let us know! We will also be arranging some interviews with select wives, nurses and office staff when appropriate. Every story is important to us — please don't pass up this opportunity to give YOUR story its place in history!

New Physician Risheet Patel, MD, Welcomed to IAFP Foundation Board of Trustees

With the Annual Meeting comes the transition of officers and board members. Completing their terms this year were Clif Knight, MD, Teresa Lovins, MD, and Alan Sidel, MD. Dr. Knight and Dr. Lovins were elected to serve another term and Dr. Risheet Patel was elected to fill the spot vacated by Dr. Sidel, who will be stepping down after two terms. Dr. Patel most recently served on the Board of Trustees as resident director and was responsible for the 2006 Student Procedure Day and much of the early plans for 2007.

Dr. Richard Feldman was elected to serve as chairman of the board for 2007-08, Dr. Lovins was elected to serve as vice chairman, and Dr. Knight was re-elected as board treasurer. Please join the board in thanking Dr. Sidel for his years of service on the Board of Trustees and Dr. Debra McClain for her years as chairman of the board. The Foundation has benefited greatly from their support and appreciates all of the time they have put into furthering the mission of the organization. Dr. McClain will remain on the board.

Coding and Billing Update

Billing Services Performed by Nurse Pra

Many physicians believe the correct way to report services rendered by physician extenders is to bill the encounters as if the physician personally examined the patient. Unfortunately, billing for these extenders is much more complicated. Physician extenders are also called nonphysician practitioners (NPP). For purposes of this article NPPs include nurse practitioners (NP), physician assistants (PA), clinical nurse specialists (CNS), and certified nurse midwives (CNM).

In my experience, the confusion actually begins with the distinction between what services NPPs can provide under their scope of practice versus how to bill the services. Adding to the confusion is Medicare's payment policy on "incident to" billing, not understanding "incident to" billing requirements can generate Medicare overpayments. Billing is further complicated by commercial insurers' coverage and billing guidelines for NPP services.

Medicare "Incident to" Requirements

"Incident to" is actually a Medicare phrase and does not necessarily apply to any other third-party payer. A commercial insurer may not be familiar with this phrase or may have a different definition of "incident to" billing. This section explains Medicare's definition of "incident to." The bottom line is if the NPP's service meets the "incident to" requirements, the supervising physician may be reported as the "rendering provider" on the claim.

An NPP may be licensed under state law to perform a specific medical procedure and may be able to perform the procedure without physician supervision and have the service separately covered and paid for by Medicare as an NPP's service. However, in order to have that same service covered as "incident to" the physician's services, it must be performed under the direct supervision of the physician as an integral part of the physician's personal in-office service.

To be considered "incident to," the NPP's service must be provided during a course of treatment where **the physician performs an initial service** *[Emphasis added]* for the patient's diagnosis/problem and subsequent services of a frequency, which reflect his or her active participation in and management of the course of treatment. Furthermore, the physician must provide direct supervision of the NPP's service.

Direct supervision in the office setting does not mean the physician must be present in the same room with the NPP. However, the physician must be present in the office suite and immediately available to provide assistance and direction throughout the time the NPP is performing services.

For NPP services outside the office setting, (e.g., in a patient's home or in an institution other than hospital or SNF), the NPP's services are covered incident to a physician's service only if there is direct supervision by the physician. For example, if an NPP accompanies the physician on a house call and evaluates a patient, the NPP's services are covered "incident to." This means the service can be reported using the supervising physician's national provider identification number (NPI). This service will be paid as if the physician personally performed the service.

If the NPP made the house call alone, the services are not billable "incident to" the physician. In this situation, the service must be reported using the NPP's NPI. The service may not be reported with a physician's NPI because the physician is not providing direct supervision.

Services provided by auxiliary personnel in an institution (e.g., nursing or convalescent home) present a special problem in determining whether direct physician supervision exists. The availability of the physician by telephone and the presence of the physician somewhere in the institution do not constitute direct supervision and cannot be reported "incident to."

In the office setting, to be considered "incident to," the NPP's service must meet all of the following criteria:

- The patient must be an established patient to the practice;
- The patient's condition must have previously been diagnosed by the physician (or a physician in the group practice) and a treatment plan already established; and
- The billing physician must be physically present in the office suite.

If all of the above criteria are not met, the service must be reported using the NPP's NPI.

Incident-To Services on Form CMS-1500

For Medicare patients, use the following billing guidelines when billing "incident to" services.

Item 17	When a service is incident to the service of a physician or nonphysician practitioner, the name of the physician who performed the initial service and orders the NPP's service must appear in item 17.
Item 17a	Enter the ID qualifier 1G, followed by the CMS assigned UPIN of the referring/ordering physician listed in item 17. Under Medicare's NPI contingency plan, the UPIN may be reported on the Form CMS-1500 and MUST be reported if an NPI is not available.
Item 17b	Enter the NPI of the referring/ordering physician listed in item 17 as soon as it is available.
Item 24J	During Medicare's NPI contingency plan, enter the rendering provider's PIN in the shaded portion. In the case of a service provided incident to the service of a physician, enter the rendering provider number of the supervising physician (physician physically present in the office suite) in the shaded portion. Enter the supervising physician's NPI number in the lower portion. In the case of a service provided incident to the service of a physician or nonphysician practitioner, when the person who ordered the service is not supervising, enter the NPI of the supervisor in the lower portion.

In a group practice, there may be situations when the physician who diagnosed the patient's problem and initiated the treatment plan is not the physician physically present in the office suite when the patient is seen in follow-up. In this situation, the physician physically present in the office suite must be shown as the "rendering physician" on the claim form in Item 24J.

Split/Shared E/M Service

A split/shared E/M visit is defined by Medicare Part B payment policy as a medically necessary encounter with a patient where the physician and a qualified NPP each personally perform a substantive portion of

Practitioners and Physician Assistants

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

an E/M visit face-to-face with the same patient on the same date of service. A substantive portion of an E/M visit involves all or some portion of the history, exam or medical decision-making key components of an E/M service. The physician and the qualified NPP must be in the same group practice or be employed by the same employer. The split/shared E/M visit applies only to selected E/M visits and settings (i.e., hospital inpatient, hospital outpatient, hospital observation, emergency department, hospital discharge, office and non-facility clinic visits, and prolonged visits associated with these E/M visit codes).

The split/shared E/M policy does not apply to consultation services, critical care services or procedures.

Nursing Facility Services

- A split/shared E/M visit cannot be reported in the SNF/NF setting.

Office/Clinic Setting

- In the office/clinic setting when the physician performs the E/M service, the service must be reported using the physician's NPI.
- When an E/M service is a shared/split encounter between a physician and a non-physician practitioner (NP, PA, CNS, or CNM), the service is considered to have been performed "incident to" if the requirements for "incident to" are met and the patient is an established patient.
- If "incident to" requirements are not met for the shared/split E/M service, the service must be billed under the NPP's NPI and payment will be made at the appropriate physician fee schedule payment. For example, the service must be reported using the NPP's NPI if the NPP sees a new patient, an established patient for a new problem, or the physician (or a physician in the same group) is not physically present in the office when the NPP renders the service.

Hospital Inpatient/Outpatient/Emergency Department Setting

- When a hospital inpatient, hospital outpatient, or emergency department E/M is shared between a physician and an NPP from the same group practice and the physician provides any face-to-face portion of the E/M encounter with the patient, the service may be billed under either the physician's or the NPP's NPI.
- If there was no face-to-face encounter between the patient and the physician (e.g., even if the physician participated in the service by reviewing the patient's medical record), then the service may only be billed under the NPP's NPI. Payment will be made at the appropriate physician fee schedule rate based on the NPI entered on the claim.

Examples of Shared Visits

- If the NPP sees a hospital inpatient in the morning and the physician follows with a later face-to-face visit with the patient on the same day, the physician or the NPP may report the service.
- In an office setting the NPP performs a portion of an E/M encounter and the physician completes the E/M service. If the "incident to" requirements are met, the physician reports the service. If the "incident to" requirements are not met, the service must be reported using the NPP's NPI.

Medicare Payment for "Incident to" Services

Medicare payment for professional services provided by a physician is based on the current Medicare Physician Fee Schedule. Medicare payment for professional services meeting the "incident to" requirements and billed by the supervising physician is based on the current Medicare Physician Fee Schedule as if the physician personally performed the service.

Medicare payment for NPP professional services not meeting the "incident to" guidelines will be based on the lower of the actual charge billed on the claim or the following percentage of the current Medicare Physician Fee Schedule:

- An NP (and a CNS) is paid for covered services at 85 percent of the Medicare Physician Fee Schedule.
- PA services are paid at 85 percent of the Medicare Physician Fee Schedule, except services performed in a hospital.
- For services performed in a hospital, carriers limit the payment for PA services to 75 percent of the Medicare Physician Fee Schedule amount.
- Payment for most nurse-midwife services is equal to 65 percent of the Medicare Physician Fee Schedule.
- Payment for NP, CNS, or PA assisting in surgery is based on 85 percent of the 16 percent of the Medicare Physician Fee Schedule amount (i.e., 10.4 percent).

Billing NPP Services to Commercial Insurers

Not all commercial insurers follow Medicare "incident to" guidelines. Physicians should not automatically assume services rendered by nonphysician practitioners can be reported using the supervising/collaborating physician's NPI.

More and more insurers are credentialing NPPs. Physicians should contact all contracted insurers about credentialing their NPP(s). The next step is to ask the insurer their coverage and billing requirements for services performed by NPPs. It is possible insurers who do not credential NPPs will follow Medicare "incident to" guidelines. Others may simply allow physicians to report NPP services using the supervising/collaborating physician's NPI.

There are insurers and member plans that do not cover services rendered by NPPs. These insurers and member plans only cover services performed by a physician. Typically, these insurers and member plans do not allow the NPP's services to be billed using the supervising/collaborating physician's NPI.

ALLERGY CASE STUDY

The following case studies by Dr. Leonard Fromer, allergy specialist and member of the AAFP, are to educate family physicians about advances in diagnosing allergies early on before more serious complications develop. These diagnostic options allow physicians to effectively manage allergy and asthma patients at the primary care level.

Specific IgE Blood Test Reveals Avoidance Measures Unnecessary in Certain Patients with Allergy-Like Symptoms

Allergy symptoms often mimic symptoms caused by other conditions, so an accurate diagnosis is necessary to properly manage a patient. In fact, a negative allergy blood test result can be just as valuable as a positive one in making an accurate diagnosis in patients with these symptoms. For instance, nasal congestion does not necessarily stem from allergic rhinitis, but because allergies seem to be ubiquitous, parents of a child with a chronic, stuffy nose might assume that their child has allergies.

Whether a child's parents need to implement avoidance strategies, reducing the child's exposure to known allergens, depends on if the child is truly allergic. These avoidance strategies can be extremely disruptive. Parents who think that their child has allergies might think that they have to get rid of the family dog or eliminate favorite foods in the house. However, before a family parts with their dog or stops serving foods they love, they should identify the precise cause of their child's symptoms. A simple blood test can tell them all they need to know about managing their child's condition.

A specific IgE blood test works by measuring the levels of allergen-specific IgE antibodies in a small sample of blood. The blood sample is then sent to a reference lab where IgE levels are tested. Immunoglobulin E (IgE) is produced as a result of sensitization to an allergen and increases with exposure to that substance, causing symptoms. The following case demonstrates the value that specific IgE blood testing can have in the primary care setting to help you determine the cause of your patients' allergy-like symptoms.

A 3-year-old male was diagnosed with eczema at six months of age by a primary care physician. He experienced recurrent ear infections, fluid in the middle ear and a chronic cough. As an infant, he had projectile reflux of formula. Additionally, his maternal family has a strong history of allergies. One aunt suffered from allergies to foods, animal dander, insect bites, molds and pollens. Another aunt went through a course of immunotherapy shots and carried an epinephrine pen.

Previous treatments had been largely ineffective. His parents had worked to eliminate his exposure to allergens by encasing his pillows and mattress, washing his bedding and stuffed animals weekly in hot water and replacing the curtains in his bedroom with PVC blinds, which were cleaned regularly. Additionally, they placed a HEPA filter in his bedroom.

A specific IgE blood test was administered to determine the precise cause of his symptoms. However, the results came back negative. In this case, the results indicated no atopy and disruptive avoidance strategies ended. The patient began treatment with nasal anti-inflammatory steroids and, but for an occasional morning cough, his symptoms disappeared.

This example shows that through specific IgE blood testing, the patient was accurately diagnosed, allowing inconvenient avoidance measures to be discontinued.

The Value of the Negative Specific IgE Blood Test Results

Many of us treat patients with allergy-like symptoms nearly every day. However, it often is difficult to accurately diagnose this chronic condition. According to one study, medical history and physical examination are accurate in diagnosing allergic disease only 50 percent of the time. This explains why another study found that two-thirds of patients taking non-sedating antihistamines for allergies were not allergic. These findings are concerning given that the majority of patients taking NSAs are doing so unnecessarily and the underlying cause of these symptoms is not being addressed.

When used in combination with family history and medical evaluation, diagnostic blood tests for specific IgE are approximately 95 percent accurate. Immunoglobulin E (IgE) is produced as a result of sensitization to an allergen, increases with exposure to that substance, and is the cause of the most severe allergic reactions. Specific IgE blood tests work by measuring the levels of allergen-specific IgE antibodies in a small sample of blood. The blood sample is sent to a reference lab where IgE levels are tested.

These tests provide objective, quantifiable evidence about the presence or absence of allergies. Thus, the use of diagnostic blood tests by primary care physicians makes it possible to improve the management of allergies and allergy-like symptoms.

The following case demonstrates the value that specific IgE blood testing can have in the primary care setting to help you determine the cause of your patients' allergy-like symptoms.

A 47-year-old male had, until recently, been leading an active life. He had been an avid outdoorsman and traveled frequently for his job. Four years ago, he moved into a 50-year-old house and completed multiple remodeling projects. Unfortunately, for more than two years he had experienced severe fatigue, despite getting 10 to 12 hours of sleep each night. Although his overall health was good, he complained of a lack of focus and loss of interest in many pastimes. A complete physical examination only revealed arthritis associated with an old knee surgery and mouth breathing resulting from chronic nasal congestion.

Fatigue is a well characterized consequence of chronic nasal congestion. Since chronic nasal congestion often is the result of allergic rhinitis, it appeared that this patient suffered from allergic rhinitis. Non-sedating antihistamines were prescribed, but the treatment was ineffective.

A complete blood count and chemistry panel, including thyroid function tests, proved to be normal. Furthermore, a specific IgE blood test returned negative. Although symptom presentation, history and physical exam findings led to a presumptive diagnosis of allergic rhinitis, laboratory data suggested that this patient was experiencing non-allergic rhinitis. The patient was prescribed a long-acting pseudoephedrine product and an intranasal nasal anti-inflammatory steroid. Within days, his rhinitis cleared up and his severe fatigue resolved.

Specific IgE blood testing allowed this health care provider to discard the presumption of atopy, cease ineffective treatments, and effectively manage this patient's symptoms.

Early Food Allergy Diagnosis and Intervention May Curb a Child's Risk for Asthma

A baby's first nourishment is milk, and this may be the very thing that also can make an infant sick. Rashes, upset stomachs and a cough may be dismissed by doctors and parents as ordinary childhood ailments, when the true underlying cause could be food allergies. According to The Food Allergy and Anaphylaxis Network, approximately 12 million Americans have food allergies. An estimated 2 million of these are school-age children and one in every 20 children under 3 also suffers from food allergies. Eight foods account for 90 percent of all food-allergic reactions. These include: milk, egg, peanut, tree nut (walnut, cashew, etc.), fish, shellfish, soy and wheat. If misdiagnosed or left untreated, allergic reactions to food can be deadly.

As a primary care physician, you are the first line of defense in recognizing allergies. By identifying food and other allergies early on, you can effectively treat or recommend avoidance strategies to separate children from their triggers. This can help to prevent an allergic reaction as well as the development of other serious and related complications of allergies like asthma.

Before a family stops serving their favorite foods, they should get tested for allergies. A simple blood test can tell them all they need to know about managing their child's allergies. This blood test — also known as a specific IgE blood test — works by measuring IgE antibodies to specific allergens in a small sample of blood. The blood sample is then sent to a reference lab where specific IgE levels are tested. IgE is produced as a result of sensitization to an allergen and increases with exposure to that substance. Allergy blood testing is now recognized by the National Institutes of Health for asthma patients.

Diagnostic blood tests for specific IgE, when used in combination with family history and medical evaluation, are approximately 95 percent accurate. As a result, these tests allow health care providers to accurately diagnose these conditions, which in theory, improves care for patients. The following case demonstrates the value that specific IgE blood testing can have in the primary care setting.

A 20-month-old boy had eczema beginning at four months of age. Despite steroid creams, oral antihistamines, dermatology consultation and appropriate skin care, he suffered from frequent recurrences and exacerbations. He had no family history of allergies or asthma. He had no pets in the household. Examination revealed severely cracked skin and scratches on his hands and feet and thickened, red patches of skin on the backs of his knees. Specific IgE blood testing indicated that the child had food allergies and the beginning of allergies to inhaled triggers. This patient's health care provider recommended avoidance of the foods to which he was sensitized and antihistamine treatment. Within a short time, the eczema cleared completely.

Four years later, follow-up specific IgE blood test results confirmed that intervention had successfully altered the progression of this patient's allergies. This interruption prevented the development of more serious allergies like asthma.

Despite this success story, this march from allergies to asthma appears to be increasing in children. Nationally, nearly one in 13 school-age children has asthma, and that rate is rising more rapidly in preschool-aged children and those living in urban inner cities than in any other group. In fact, the first quantitative research to find that allergies and asthma are on the rise in younger generations was recently presented by P. Brock Williams, PhD, at the 2005 American Academy of Family Physicians' Annual Scientific Assembly. This research supports the crucial role that specific IgE blood testing can play in managing the evolution of a child's food allergies.

THANK YOU!

The Board of Trustees of the Indiana Academy of Family Physicians Foundation would like to thank the individuals and organizations that have donated to the Foundation in 2007. Your generosity has provided the Foundation with critical resources needed to fulfill its mission:

> *"…to enhance the health care delivered to the people of Indiana by developing and providing research, education and charitable resources for the promotion and support of the specialty of family practice in Indiana."*

FOUNDERS CLUB MEMBERS

Founder's Club members have committed to giving $2,500 to the IAFP Foundation during a five-year period. Members noted with a check mark (✓) have completed their commitment. The Board would also like to acknowledge that most of these individuals continue to give after completing their commitment.

Deborah I. Allen, MD ✓
Dr. Jennifer and Lee Bigelow
Kenneth Bobb, MD ✓
Douglas Boss, MD
Bruce Burton, MD ✓
Kalen A. Carty, MD
Clarence G. Clarkson, MD ✓
Dr. Robert and Donna Clutter ✓
Dianna L. Dowdy, MD
Bernard Emkes, MD ✓
Richard D. Feldman, MD ✓
Thomas A. Felger, MD ✓
Eugene Gillum, MD ✓
Fred Haggerty, MD ✓
Alvin J. Haley, MD ✓
John L. Haste, MD ✓
Jack W. Higgins, MD ✓
Worthe S. Holt, MD ✓
Richard Juergens, MD ✓
Thomas Kintanar, MD ✓
H. Clifton Knight, MD ✓
Edward L. Langston, MD ✓
Teresa Lovins, MD ✓
Jason Marker, MD
Debra R. McClain, MD ✓
Robert Mouser, MD ✓
Raymond W. Nicholson, MD ✓
Frederick Ridge, MD ✓
Jackie Schilling ✓
Paul Siebenmorgen, MD ✓
Kevin Speer, JD (IAFP EVP)
Daniel A. Walters, MD ✓
Deanna R. Willis, MD, MBA

PLANNED GIVING CONTRIBUTORS

Ralph E. Barnett, MD
Deeda Ferree
Raymond W. Nicholson, MD

2007 CONTRIBUTORS

Gold Level ($1,000+)

Campaign for Tobacco-Free Kids
Bernard Emkes, MD
Eugene Gillum, MD
Raymond W. Nicholson, MD
St. Joseph Regional Memorial Hospital
Union Hospital

Silver Level ($100-$999)

Ball Memorial Hospital Family Medicine Residency
Douglas Boss, MD
Cathy Bryant, MD
Bruce Burton, MD
Ken Elek, MD
Al Haley, MD, in memory of A. Alan Fischer, MD
Al Haley, MD, in memory of Wilson Dalton, MD
James and Joyce Kinsey
Ilya Schwartzman, MD
Alan Sidel, MD, in memory of Wayne & Gladys Sidel
Daniel A. Walters, MD
Deanna Willis, MD

Bronze Level ($1-$99)

Melissa Lewis
John Linson, MD
Allison Matters

IAFP
55 Monument Circle, Suite 400
Indianapolis, IN 46204

PRESORTED STANDARD
U.S. POSTAGE PAID
LOUISVILLE, KY
PERMIT NO. 1477