# FRONTLINE PHYSICIAN

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

## Fasten Your Seat Belt
2009 IAFP Annual Meeting

PG 10

## Red Flag Rules

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INDIANA ACADEMY OF FAMILY PHYSICIANS

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Printed June 2009



# FRONTLINE PHYSICIAN

Volume 10 • Issue 2

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




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

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

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

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

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

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

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

INDIANA ACADEMY OF FAMILY PHYSICIANS


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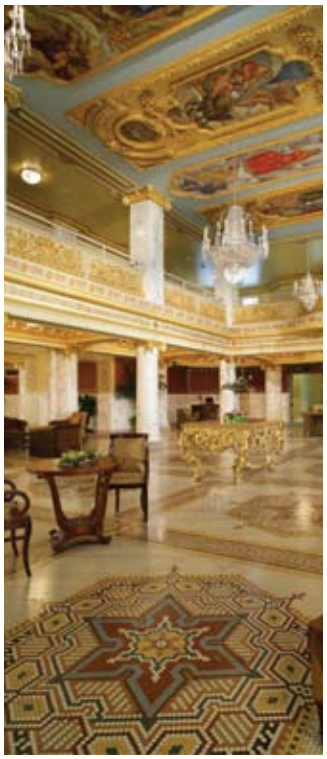


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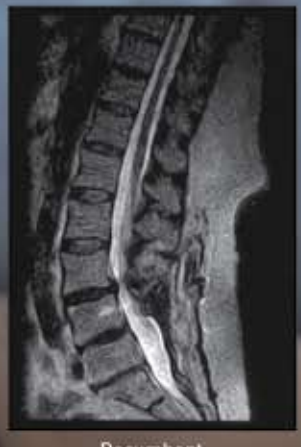

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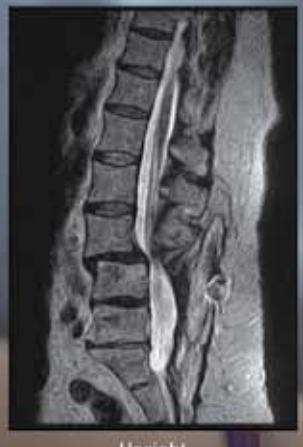

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Teresa Lovins, MD

# Thank You for Letting Me Represent You

The beginning of summer has come, and my presidency has nearly come to an end. I have had a wonderful time representing the family physicians of Indiana in the events that I have been involved with. At this time, I would like to thank the staff at the Indiana Academy of Family Physicians for the support and encouragement they have shown to me during this year. I hope that they will be as energetic for Dr. Ash Hanna as he takes the reins as your next president.

Dr. Hanna will be installed during our Annual Scientific Meeting and Congress of Delegates, to be held in French Lick from July 23 to 25. This year's Scientific Meeting will be more consolidated and more streamlined across the days to allow less time away from your office and more "bang" of CME for the money. Because of the changes to this year's Scientific Meeting, the Congress of Delegates will also be changing to be more succinct. We will not have an "All Member Party" but will combine this with the installation banquet and have a dance after that event. The dance will be family-friendly, so the children can also have a great time. I look forward to the new agenda and the time shared with my fellow family physicians.

During the last year, I have had multiple goals but the most important goal for me was to try and get more members involved. I have encouraged the IAFP to look at the student and resident interest in our academy. Hopefully, some of the information that we have uncovered will help direct the Academy to improve the student interest at Indiana University School of Medicine and keep family physicians involved in the Family Medicine Department there. I hope that we can work to improve the number of students who are interested in our exciting field and help them stay in Indiana.

In a few years, the state is projected to have a shortage of family physicians. We need to work on improving patient access to us, improving our offices to accommodate the growing numbers of patients who need medical homes and improving patient care within that medical home. I expect the AAFP to help design several different projects that will help us down this path, and, hopefully, the IAFP will help train us in some new models of care. I hope that the federal government gets this health care reform done right to focus on effective, quality health care done by family physicians.

I am always proud to say, "I am a family physician from Indiana." Thank you for letting me represent you.

---

# IAFP Welcomes New Employee: Dawn O'Neill

This spring, the IAFP welcomed a new employee — Dawn O'Neill. Dawn will be working part-time at your Academy's headquarters as an administrative assistant. Dawn is married with four grown children. She previously worked for a hospital supply company for 27 years that moved out of state. Dawn looks forward to getting to know many new people at the IAFP and assisting the members in every way she can. This summer, Dawn will coordinate registration at the IAFP Annual Meeting in French Lick.

# Mark Your Calendar

| July 23-26 | July 30-August 1 | October 14-18 |
|---|---|---|
| IAFP Annual Scientific Assembly | AAFP National Conference of Family Medicine Residents & Medical Students | AAFP Annual Scientific Assembly |
| French Lick, Indiana | Kansas City, Missouri | Boston, Massachusetts |
| **July 24-25** | **October 12-14** | |
| IAFP All-Member Congress of Delegates | AAFP Congress of Delegates | |
| French Lick, Indiana | Boston, Massachusetts<br>Westin Boston Waterfront/<br>Boston Convention & Expo Center | |

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The program is free to your practice, and enrollment is completely voluntary. The Indiana Academy of Family Physicians is partnering with Atlantic Health Partners because Atlantic can save family physicians money, advocate for fair payment and support family medicine.

Contact Jeff Winokur at 800.741.2044 or jwinokur@atlantichealthpartners.com for more information and to register.

# Membership Update

| | |
|---|---|
| Active | 1,667 |
| Supporting (Non-FP) | 7 |
| Supporting (FP) | 3 |
| Inactive | 14 |
| Life | 192 |
| Student | 156 |
| Resident | 243 |
| Total | 2,282 |

# Keep Us Informed

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

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

# Join Us This Summer for a Leaner,

The 2009 IAFP Annual Meeting will be held in French Lick, Indiana, from Thursday, July 23, to Sunday, July 26, 2009. We have developed a new shorter schedule, which will allow members not only to spend less time away from their practice but also to reduce the number of overnight hotel stays required to fully participate in the conference. The new schedule will also combine the President's Awards Banquet and All Member Party into one exciting and fun evening for the whole family.

Make your hotel reservations today, and register now to take advantage of top-quality Evidence Based CME (more than 20 credits will be available), participate in our Congress of Delegates, visit the Exhibit Show and enjoy the beautiful surroundings of the totally transformed French Lick Hotel and Conference Center. Bring the kids or grandkids too, because the hotel's kids' program has been rebuilt and extended.

Registration information is available at our Web site, www.in-afp.org. Look under "Hot Topics." You can also register online.

Call 888.694.4332 to reserve your room at a rate of $160 for Tuesday through Friday and $205 for Saturday. Please use group code "IAFP." These room rates are available only until our group block is sold out, after which rates will increase. Act now.

## Preliminary At-a-Glance Schedule

**Thursday, July 23**

| | |
|---|---|
| 8 a.m.-7 p.m. | Registration Open |
| 10 a.m.-3 p.m. | SAM Group Session: Asthma |
| 3:15-4:30 p.m. | Executive Committee |
| 4:30-6:30 p.m. | Board of Directors |
| 7-10 p.m. | Board/VIP Dinner |

**Friday, July 24**

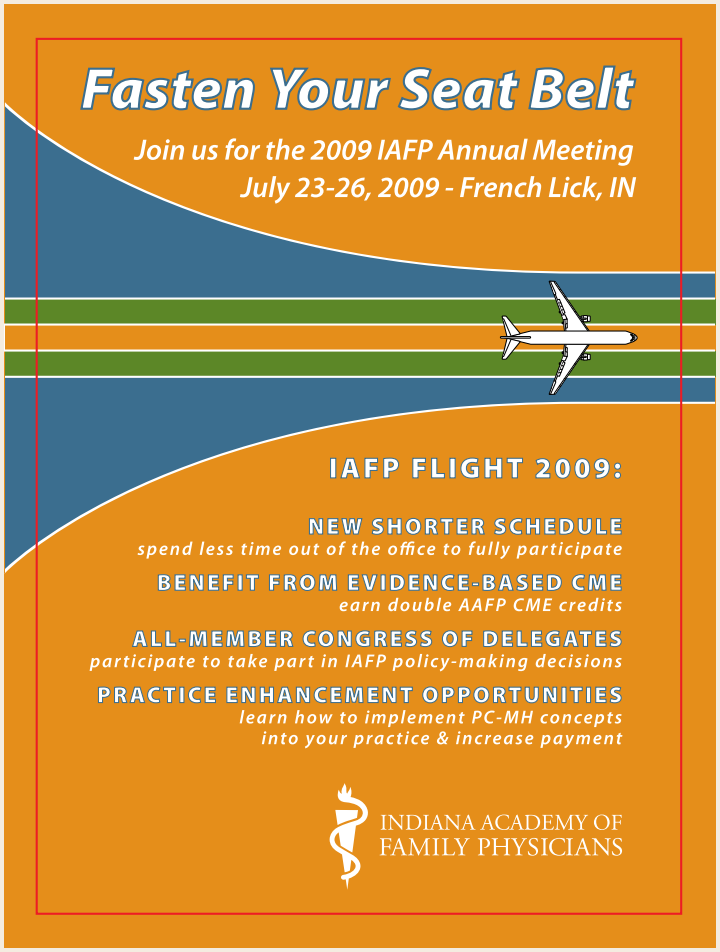
| | |
|---|---|
| 7:30-8:45 a.m. | CME Breakfast |
| 9 a.m.-4 p.m. | CME sessions |
| 10:30 a.m.-3:30 p.m. | Exhibits Open |
| 11:45 a.m.-12:45 p.m. | Foundation/CME lunch |
| 5-6:30 p.m. | Town Hall Dinner |
| 6:30 p.m. | 1st Session Congress of Delegates |
| 7:30 p.m. | Reference Committees |
| 9 p.m. | AfterGlow |

**Saturday, July 25**

| | |
|---|---|
| 8 a.m. | 2nd Session COD |
| 10 a.m-2 p.m. | Exhibits Open Lunch in Exhibit Hall |
| 10:30 a.m.-4:45 p.m. | CME sessions |
| 6 p.m. | Reception |
| 6:45 p.m. | President's Awards Banquet & Installation of Officers |
| 6:45 p.m. | Separate Dinner Party for children |
| 8 p.m. | Children join parents for dessert buffet and dancing |

**Sunday, July 26**

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



# CME Topics & Learning Objectives

## Friday, July 24

7:30-8:45 a.m. CME Breakfast
**Hypogonadism and Low Testosterone – Abraham Morgentaler, MD**

*Learning Objectives:*
*Upon completion of this activity, the participant should be able to:*

1. *Identify and diagnose male hypogonadism*
   - *Recognize clinical signs and symptoms of male hypogonadism, including special populations (adolescents, geriatrics)*
   - *Increase awareness of signs and symptoms of hypogonadism as part of standard medical assessment of the adult male*
   - *Describe the pathophysiology of primary/secondary hypogonadism and constitutional delay of growth and puberty*
   - *Utilize appropriate lab measurements of total T, free T, bio-available T to affect clinical diagnosis*
2. *Describe prevalence, association and response to treatment of male hypogonadism in presence of co-morbid conditions such as metabolic syndrome, diabetes, obesity, HIV/AIDS*
3. *Increase awareness of the prevalence of hypogonadism in men with Type 2 diabetes, recognize when to test for hypogonadism in the diabetic male population, and understand the association of the two conditions*
4. *Discuss treatment of male hypogonadism*
   - *Similarities and differences of various testosterone replacement therapy pharmaceutical delivery systems*
   - *Monitoring safety and efficacy of testosterone replacement therapy*
   - *Evaluation of risks and benefits of testosterone replacement therapy*

**Concurrent Sessions: Choose Either**

9-10 a.m. **Coding and Billing Update Part One – Joy Newby, LPN, CPC**

*Learning Objectives:*
*Upon completion of this activity, the participant should be able to:*

- *Identify how to bill for group visits*
- *Understand how Recovery Audit Contractors will use data to recoup/pay for incorrectly coded services*

**Or**

**Pain Management, Tom Kintanar, MD**

**Concurrent Sessions: Choose Either**

10:45 a.m.-11:45 a.m. **Coding and Billing Update Part Two – Joy Newby, LPN, CPC**

**Or**

10:45 a.m.-11:45 a.m. **Concepts in Weight Management, Meena Garg, MD**

11:45 a.m.-12:45 p.m. **Understanding the Failed Back – Jonathan Gentile, MD**

11:45 a.m.-12:45 p.m. CME lunch

12:45-1:45 p.m. **Tobacco Cessation Group Visits**

1:45-2:15 p.m. Break to view exhibits

2:15-3 p.m. **Management of Depression by Nonprescriptive Means – Jeffrey Gladd, MD**

3-4 p.m. **Getting Serious About Gout and Hyperuricemia: Improving Understanding of Clinical Approaches to Diagnosis and Management – Joseph D. Croft Jr., MD**

*Learning Objectives:*
*Upon completion of this activity, the participant should be able to:*

- *Identify the four stages in the clinical progression of gout and hyperuricemia and recognize the differing clinical manifestations among the stages*

## Complete the Knowledge Assessment Portion of Your Asthma SAM at Our Group Session

Thursday, July 23, 2009 • 10 a.m.-3 p.m.
French Lick Hotel and Conference Center • Facilitator: Fred Ridge, MD, Linton, Indiana

Do you still need to complete Self-Assessment Modules (SAMs) for your MC-FP Part II? Your Academy is offering a great way to help you do this: our SAM Working Group Session on Asthma, being offered in conjunction with this year's Annual Meeting in French Lick, Indiana.

- Complete your SAM knowledge questions on-site
- Explore the topic via interactive discussions
- Earn 15 CME credits by completing the Clinical Simulation after this event

This workshop takes you through the 60 core competency questions to determine the correct answers. After the session, the IAFP reports your answers to the ABFM.

Download a registration form for this SAM session at the IAFP's Web site: www.in-afp.org.

- *Confirm a diagnosis of gout employing joint aspiration and synovial fluid analysis, and distinguish an acute flare from advanced disease*
- *Utilize a comprehensive physical examination and other indicated diagnostic testing to distinguish gout and hyperuricemia from common differential diagnoses including rheumatoid arthritis, pseudogout and septic arthritis*
- *Devise an appropriate treatment plan for patients with gout and hyperuricemia, utilizing anti-inflammatory agents for acute attacks and serum urate-lowering therapy for advanced disease, and assess the importance of comorbid conditions when devising this strategy*

4 p.m. CME adjourns

## Saturday, July 25

7 a.m. Breakfast – Product Theater – Managing Bacterial Respiratory Tract Infections (RTIs) – Staying a Step Ahead of Common Respiratory Pathogens
*Sponsor: PriCara division of Ortho-McNeil-Janssen Pharmaceuticals, Inc.*
*Facilitated by: PRI Healthcare Solutions*

10:30 a.m. CME sessions begin

10:30 a.m.-Noon **Getting the Jump on Type 2 Diabetes: The Pivotal Roles of Early Dx and Individualized Management – Silvio E. Inzucchi, MD**

*Learning Objectives:*
*Upon completion of this activity, the participant should be able to:*
- *Provide patients with an evidence-based treatment plan that sets an appropriate A1C goal and employs an individualized assessment of the advantages and disadvantages of ADA/EASD-recommended glycemic agents*
- *Promptly intensify glycemic therapy when A1C is ≥ 70 percent by employing combinations of glycemic agents that are appropriate to the individual needs of the patient*
- *Utilize individualized, comprehensive type 2 diabetes regimens that minimize cardiovascular risk while concurrently targeting appropriate goals for A1C, blood pressure and serum cholesterol*

Noon-1 p.m Lunch in Exhibit Hall

1-1:45 p.m. **The Subtle and Not-So-Subtle Side Effects of ADHD Medications in Children – Edward Aull, MD**

1:45-2:45 p.m. **A Case-Based Analysis of the Management of Fibromyalgia in Primary Care**

*Learning Objectives:*
*Upon completion of this activity, the participant should be able to:*
- *Take a detailed patient history as part of the fibromyalgia diagnostic process*
- *Practice manual tender point exams for the diagnosis of fibromyalgia*
- *Apply American Pain Society guidelines for the use of diagnostic laboratory testing for patients with fewer than 11 tender points*
- *Employ evidence-based treatment strategies for the treatment of fibromyalgia*

2:45-3 p.m. Break

3-4:15 p.m. **No Referral Needed: Primary Care Management of IBS and Chronic Constipation – David A. Peura, MD**

*Learning Objectives:*
*Upon completion of this activity, the participant should be able to:*
- *Describe barriers that might hinder communication between the patient and clinician and implement approaches that can be used to overcome them*
- *Accurately diagnose patients by recognizing key symptoms and utilizing the Rome III criteria and ACG guidelines for irritable bowel syndrome and chronic constipation*
- *Implement an individualized approach to managing patients with irritable bowel syndrome and chronic constipation that incorporates realistic patient-treatment goals*
- *Formulate an appropriate treatment strategy for patients with IBS or patients with chronic constipation, based on the latest evidence on both nonpharmacologic and pharmacologic therapeutic options*

4:15-4:45 p.m. **Vaccines Update – Charlene Graves, MD**

4:45 p.m. CME adjourns

## Sunday, July 26

7:30 a.m. Breakfast available

**CME: Practice Enhancement Morning**

8 a.m.-9 a.m. **Setting a Course Toward Prostate Cancer Prevention: Communicating the Evidence to our Patients – Louis Kuritzky, MD**

9-10 a.m. **Maximizing Profits in the Family Physician's Office – Jason Marker, MD**

More objectives can be found at www.in-afp.org.

## IAFP Town Hall Forum: The Patient Centered Medical Home

July 24, 2009
French Lick Hotel and Conference Center • Held in conjunction with IAFP Annual Meeting

**Are you new to the Patient Centered Medical Home and are you…**
- Confused as to what PCMH, NCQA and TransforMED are?
- Wondering how the medical home can help your practice?
- Curious as to whether you are already a medical home?
- Wanting to learn more from family physicians in Indiana like you?
- In need of a place to have your questions answered?

Then the **IAFP Town Hall Forum: The Patient Centered Medical Home** is right for you!
- Hear speakers from Indiana explain the PCMH movement and the current demonstration projects
- Enjoy a free dinner with your physician colleagues
- And have a chance to ask questions and hear immediate answers

For planning purposes, it is extremely important that we have an accurate count of the number of members planning to attend. Please show your intention to attend the COD and Family Medicine Town Hall by e-mailing medwards@in-afp.org. We hope that you will also register for the full 2009 IAFP Annual Meeting. Find out more at www.in-afp.org.

# Have a Voice in **Academy Policy**

Interested in shaping your Academy? Our governing body, the Congress of Delegates, meets during the Annual Meeting in French Lick, Indiana. All IAFP members are welcome to attend and have a vote. Come and help set the IAFP's legislative and action policies.

- First Session of 2009 Congress of Delegates: Friday, July 24, 6:30 p.m.
- Second Session of 2009 Congress of Delegates: Saturday, July 25, 8 a.m.

The IAFP accepts suggestions for policy through the resolution process. If you would like assistance in writing a resolution, please e-mail or call Meredith Edwards. Resolutions are due June 22. Resolutions will then be voted on at the Congress of Delegates. See the example below.

WHEREAS, it is well documented that American society spends far more on its health care system, with much poorer results, than any other industrialized nation; and

WHEREAS, multiple studies have shown that nations with strong primary care have less costly health care and better health outcomes; and

WHEREAS, in the United States, primary care; pediatrics, internal medicine and family medicine have seen significant reductions in their relative income; and

WHEREAS, many insurance companies pay significantly higher values for procedures than they do for cognitive services; therefore be it

RESOLVED, that the Indiana Academy of Family Physicians seek dialogue with Indiana's insurance companies to resolve 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.

Questions? Contact Meredith Edwards, director of legislative and region affairs, at 317.237.4237 or medwards@in-afp.org.

# Legislative Update

by Doug Kinser, JD, and Meredith Edwards

On April 29, the General Assembly held its last day of the 2009 long session. During a long session, the General Assembly has one constitutional requirement: to draft a budget. The IAFP has been tracking the Budget Committee's actions and drafts since fall 2008. By late in the session, even with the usual politics, it appeared the budget could be voted through without much controversy, especially with the influx of stimulus dollars to help fill funding gaps.

The reality was different. In the last week before the end of session, the governor wanted to see the budget cut another $100 million, and House Republicans disliked how gaps in the budget were being filled with stimulus money — wondering what will happen when the federal money disappears.

At 11:50 p.m. on April 29, the Senate Republican version of the budget was voted on in the House. The vote was surprising — 71 representatives voted against the budget, and with only 27 votes in favor, the budget failed to pass. A few minutes later, the Senate voted and passed that same bill the House disapproved. At midnight, both houses adjourned, failing to meet the requirement to pass a budget before April 30.

Now Gov. Mitch Daniels will have to call the legislature into a special session explicitly for the writing of a budget. Another deadline is looming: June 30, the end of the Indiana fiscal year. A new budget will be needed before the new fiscal year begins on July 1. Gov. Daniels will call the special session for the purpose of passing a budget, but once the governor calls the legislators back, other issues could re-surface. It is likely that only issues with a fiscal impact on the budget will be considered.

Although the theater of budget drafting has taken the spotlight during the final weeks of the General Assembly, the 2009 legislative session was not without health-related controversies.

An amendment in the House caused Senate Bill 89 to require all physicians performing surgical procedures to have hospital admitting privileges. What would be classified as a surgical procedure was left undefined, causing the IAFP and the medical community to fear hundreds of physicians in Indiana would have their scope of practice reduced. After some quick action, the IAFP was reassured that the amendment would be removed. The problematic portions of the bill were removed in conference committee, where members of the House and Senate work out differences of opinion on bills that have passed through both houses but with different language. But because of other controversial issues within the bill, including abortion and a breast and cervical screening program with a $26 million appropriation, Senate Bill 89 failed to receive the signatures needed to proceed onto the House and Senate floors once more. This bill should not re-surface, although the underlying substance of the bill was supported overwhelmingly by legislators.

Throughout the session, the IAFP was looking out for certifying the practice of lay midwifery for home births in Indiana to be amended into legislation after it failed to pass early in the session. Lay or direct-entry midwives would gain certification to provide home births after an 18-month post-high school training and watching and performing 60 deliveries. Briefly, the lay midwifery language was revived again in an amendment, but the bill failed to pass out of the House. In the 2010 session, the IAFP

fully expects for the certification of lay midwives and the expansion of scope for physician assistants to be introduced again.

The Smokefree Workplaces bill faced tough opposition throughout the 2009 session. The bill was revived in the last days but failed to receive enough signatures to be sent to the floor of either house. The IAFP will seek another Smokefree Workplaces bill in the 2010 or 2011 session. Rep. Charlie Brown has already said he will introduce a bill next year to ban smoking.

We saw several health-related issues be relegated to summer study committees, including the study of automatic assignment of benefits to an out-of-network provider. Also placed in a summer study is the use of open-panel/open-access clauses in insurance contracts, which require physicians to continue to take patients from a particular insurer until the physician's panel closes to all patients. Health summer study committees will tackle the issue of the Medicaid eligibility modernization once more. This year, the contractor for Medicaid eligibility is being required to provide reports on their intake procedures and problems.

In addition to summer study committees, a new taskforce on Medicaid was created to bring together the OMPP, providers and MCOs to enable the resolution of problems in a timely manner without turning to legislation.

Besides assigning and creating study committees, there were pieces of legislation that made it through the process that are beneficial to physicians. Legislation eliminating the liability for the destruction of medical records by a natural disaster passed both houses. And the framework for a primary care physician loan-forgiveness program was created. The IAFP will return to the legislature in 2011 to discuss the full funding of the loan-forgiveness program.

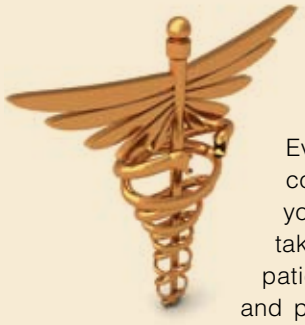
Senate Bill 219 passed both houses, and once it is signed by the governor, physicians will be legally allowed to assign a designee to enter immunization data into CHIRP. But if you are interested in direct data uploading from your EMR to CHIRP, you should contact Cameron Minich at the state Department of Health (phone number: 317.234.2484), who can assist you.

House Bill 1300 applies when patients see an out-of-network provider and payment is sent to the patient instead of the provider. If the governor signs House Bill 1300, insurers will be mandated to send with the check a statement that explains the claims covered by the payment, the name and address of the provider submitting the claim and that the check is to be used to pay the provider unless the provider has already been paid.

The IAFP government relations team will be working through the special budget session to ensure the family medicine residencies continue to receive their funding through the Medical Education Board. After the budget is finalized, the General Assembly's interim study committees begin in late summer and early fall. The IAFP expects to provide testimony on issues ranging from the primary care physician shortage to insurance contracts. Various parties, including IAFP, encouraged Rep. Charlie Brown to add the primary care shortage to the list of summer study topics, and Rep. Brown agreed.

Questions about IAFP government relations? Contact Meredith Edwards or Doug Kinser at the IAFP office 317.237.4237.

# The Indiana Academy of Family Physicians Political Action Committee (IAFP PAC) Needs Your Help!



Many issues that family physicians care about promoting are advanced with the help of a strong IAFP PAC. Every year, the General Assembly considers legislation that will affect your practice — mandates that take more time away from your patients, scope-of-practice issues and public health initiatives. A strong PAC will allow family physicians to build relationships and gives us a seat at the table when these important issues are hammered out.

With increased giving by political action committees for non-physician providers, trial lawyers, tobacco and insurance companies every year, it is essential for family medicine to keep our voice strong. When Indiana state legislators think health, we want the IAFP to be on the front of their minds. One of the easiest ways to do this is with campaign contributions through the Indiana Academy of Family Physicians PAC.

If you have not given to the IAFP PAC this year, please consider doing so. The Indiana General Assembly can affect your practice. Financial participation in the political process is another step the IAFP must take in order to build strong relationships with the legislature. Donate today!

For questions about the PAC or other legislative activities, please contact Meredith Edwards or Doug Kinser at 317.237.4237.

Help make the IAFP's legislative work stronger with a donation. Checks should be made out to **IAFP PAC** and sent to the IAFP downtown office, **55 Monument Circle, Suite 400, Indianapolis, IN 46204.**

# Red Flag Rules

by Gail Jones, AAFP

Many have already heard, but the FTC has announced that the Red Flags Rule that was to go into effect May 1 has been delayed until August 1, 2009. Originally, the ruling was to begin November 1, 2008, but due to the objections of many medical associations and other organizations, the FTC had agreed to delay until May 1. Then, on May 1, the FTC announced this new delay with the statement "to give creditors and financial institutions more time to develop and implement written identity theft prevention programs." The FTC has further agreed to provide a template to assist entities with a low risk of identity theft to comply with the law.

## But What Is the Red Flag, and How Does This Apply to Me?

The Identity Theft Red Flags and Address Discrepancies under the Fair and Accurate Credit Transactions Act of 2003 require that physician offices who accept payments be compliant. These final rules and guidelines implementing section 114 of the Fair and Accurate Credit Transactions Act of 2003 (FACT Act) and final rules implementing section 315 of the FACT Act were originally posted with a compliance date of November 1, 2008. Many physicians and associations have argued that practices are not creditors. **However, in a letter dated February 1, 2009, the FTC indicated that physicians may be creditors if they accept payment after the time of service.**

## What Is the Purpose of the Red Flags Rule?

The FTC has been working for many years on ways to reduce identify theft and became increasingly aware that medical identify theft was a large problem. In an effect to protect consumers, this rule was developed to eliminate medical identify theft. Medical identity theft sometimes has serious consequences caused by incorrect information included in a patient's history, including diagnoses and treatments that the patient never had, wrong blood type or incorrect allergy information, and it also can lead to exhaustion of medical benefits by the imposter(s). It is often an onerous task for the patient, physicians and other providers and health benefit plans to untangle correct patient medical and financial history from that added by an imposter. Implementation would protect not only the patients but also the providers by making it difficult for insider identify theft to occur.

Identify theft can occur in several ways. It may be as innocent as a family member or friend offering to allow someone to assume their identify and insurance when they do not have health insurance themselves. In many cases, the sources of medical identify theft is from an insider who either purposefully or inadvertently releases information that is then used in fraudulent activities, such as seeking care under another person's name and insurance plan or, in the case of a physician's identity, to order services or drugs that are not appropriate or necessary. Without evaluating areas of risk and incorporating policies and procedures to safeguard against improper disclosures and/or provision of treatment to a person using a false identity, a practice may unwittingly become entangled in a criminal case or, worse, inadvertently treat a patient based on inaccurate information. Many have questioned whether or not HIPAA addresses this issue and if the Red Flag is overkill. HIPAA does address some of the issues, but not all.

## Am I Subject to the Identity Theft Red Flags Rule?

It depends. If you are a cash-at-the-time-of-service-every-time practice, than the rules do not apply to you. However, most physicians bill the patient after the claim for service has been processed by a payer and/or accept partial payments on patient balances and will then be subject to the rules. Physicians are subject to the Red Flag rule if they meet the definition of a creditor under the rule. Under the rule, a physician or practice is a creditor if it extends "credit," which means it regularly defers payment for goods or services and have covered accounts. A covered account is (1) an account primarily for personal, family or household purposes that involves or is designed to permit multiple payments or transactions, or (2) any other account for which there is a reasonably foreseeable risk to customers or the safety and soundness of the financial institution or creditor from identity theft.

## What Is Considered a Red Flag?

"Red Flag" is defined as a pattern, practice or specific activity that could indicate identity theft. For instance, if a new patient completes the date of birth on a registration form with different information than that on his or her driver's license, it may be appropriate to request

further proof of identity. Many practices already ask for a copy of the patient's ID for checks but do not verify identification for every patient. By obtaining an ID on every patient, you can reduce the chances of identify theft

Some examples from the Red Flag rule that may apply to physician practices:

- Documents provided for identification appear to have been altered or forged
- The photograph or physical description on the identification is not consistent with the appearance of the applicant or customer presenting the identification
- Other information on the identification is not consistent with information provided by the person opening a new covered account or customer presenting the identification
- Other information on the identification is not consistent with readily accessible information that is on file with the financial institution or creditor, such as a signature previously obtained
- Personal identifying information provided by the customer is not consistent with other personal identifying information provided by the customer. For example, there is a lack of correlation between the SSN range and date of birth.
- Personal identifying information provided is of a type commonly associated with fraudulent activity as indicated by internal or third-party sources used by the financial institution or creditor. For example:
  - The address on an application is fictitious, a mail drop or a prison
  - The phone number is invalid or is associated with a pager or answering service
  - The SSN provided is the same as that submitted by other persons opening an account or other customers
  - The address or telephone number provided is the same as or similar to the account number or telephone number submitted by an unusually large number of other persons opening accounts or other customers
- The patient/guardian fails to provide all required personal identifying information at registration or in response to notification that the registration is incomplete
- Personal identifying information provided is not consistent with personal identifying information that is on file
- Mail sent to the patient/guarantor is returned repeatedly as undeliverable, although the patient has current activity and has confirmed the accuracy of the information
- The billing office is notified that the customer is not receiving statements and did not provide the address of record in the patient account
- The beneficiary of a health plan contacts the practice after receiving an explanation of benefits for a service they did not receive
- The practice is notified by a patient, a victim of identity theft, a law enforcement authority or any other person that it has opened a fraudulent account for a person engaged in identity theft (e.g., a health plan notifies the practice that claims for a patient will not be paid because the plan has determined the patient's identity was used by another party)
- An employee makes duplicate copies of forms or reports containing identifying information of patients or practice staff without known cause

***"Red Flag" is defined as a pattern, practice or specific activity that could indicate identity theft.***

- Electronic systems security logs indicate the transfer of information to an unknown source
- A pharmacy requests confirmation or refills of a prescription that the physician did not order
- A request for patient information or physician authorization is received from an outside vendor for supplies or services not ordered by a physician in the practice
- Medical records that are inconsistent with the history obtained or physician's examination findings (e.g., clear age discrepancy, surgical scarring not accounted for in surgical history)

## What Do I Have to Do Then?

If you bill and accept payment, then as a creditor as defined by the rule, you must:

- Develop a written program to identify, protect and respond to possible risks of identity theft relevant to their practice and the way in which patient accounts are created and maintained in the practice
- Periodically update the program using practice experience, changes in methods of identity theft, changes in methods of preventing identity theft and changes in business arrangements (e.g., new outside billing or collection contracts)
- Provide oversight from owners, board of directors or senior management, including identifying a person who will be responsible for the program's implementation and review of reports and changes to the program
- Require staff to create a report, at least annually, outlining the effectiveness of the policies and procedures in addressing the risk of identity theft in connection with the opening of covered accounts and with respect to existing covered accounts, service provider arrangements, significant incidents involving identity theft and management's response and recommendations for material changes to the program
- Take steps to ensure that service providers that conduct activities with patient accounts have reasonable policies and procedures to prevent, detect and mitigate the risk of identity theft

The extent of how this affects your practice will vary depending upon the size of the practice and risk factors. If you have a small practice in a long-term community, it is possible that you know your patients by name, and then your risks would be considerably smaller than a large multi-specialty practice that would increase the chance of medical identify theft.

*For a complete version of the article, please visit www.in-afp.org, and click on Communications – FrontLine Physician.*

# 2009 IAFP Faculty Development Day

"Residents and the ITE" was the main theme of this year's IAFP Faculty Development Day, which was held on Wednesday, March 4, in Indianapolis. Attendees from family medicine residency programs throughout Indiana gathered to hear "Residents and the ITE: Strategies and Resources," presented by **Tom O'Neill, PhD**, vice president of psychometric methods & scoring, of the American Board of Family Medicine, after which **Sharree P. Grannis, MD**, program director, Indiana University Family Medicine Program, presented a cohort discussion/presentation on the same topic.

After a networking lunch, the next topic on the agenda was "More Than Just Survival: The Challenges and Opportunities of International Medical Graduates," presented by **Mary E. Dankoski, PhD**, assistant dean for faculty affairs and professional development, assistant chair for academic affairs, Department of Family Medicine, Lester D. Bibler scholar and associate professor of clinical family medicine, Indiana University School of Medicine; **Megan M. Palmer, PhD**, director of faculty advancement in the Health Professions for IUPUI; **Dawn Whitehead, PhD**, director of curriculum internationalization for IUPUI; and **Sharree P. Grannis, MD**. Rounding out the day was a team problem-solving "survival" session, presented by Drs. Dankoski and Grannis.

**Thank you to our presenters, especially Dr. Grannis, who was this year's program chair, and all of our attendees. Your continued support is greatly valued.**

# Congratulations, Residents' Day/Research Forum Winners

On Thursday, March 5, the IAFP hosted its annual Residents' Day/Research Forum in Indianapolis. Our three judges, **Debbie Allen, MD**, **Teresa Lovins, MD**, and **Ray Nicholson, MD**, heard oral presentations and viewed poster presentations from family medicine residents from across Indiana. Thank you to everyone who participated, to our judges and to **Julia Fashner, MD**, of St. Joseph Regional Medical Center – South Bend Family Medicine Residency Program, who was our moderator for the day and is our Committee on Research Day chair.

**Oral Case Presentations**
**First Place:** An Unusual Cause of Abdominal Pain in Pregnancy
**Thomas Opheim, MD**, St. Vincent FM/IM Combined Program ($250)

**Second Place:** Forearm Abscess
Primary Author: **Jason Everman, DO**, St. Vincent Family Medicine ($150)
Co-author: **Curt Ward, MD**, St. Vincent Family Medicine

**Third Place:** Abdominal Pain Secondary to Addison's Disease by Primary Adrenal Tuberculosis
Primary Author: **Raymond Smith, MD**, St. Vincent Family Medicine ($100)
Co-Author: **Elizabeth Roth, MD**, St. Vincent Family Medicine

**Fourth Place:** OB Triaging: That Is a Foot
**Gordon Givan, MD**, St. Joseph Regional Medical Center ($50)

**Poster Presentations**
**First Place:** Patient Internet/E-mail Availability and Interest at the Family Medicine Center
Primary Author: **Stephen Drye, MD**, St. Joseph Regional Medical Center ($125)
Co-Author: **Julia Fashner, MD**, St. Joseph Regional Medical Center

**Second Place:** Aortic Dissection and Ruptured Sinus of Valsalva Aneurysm Mimicking Pulmonary Embolism
Primary Author: **Colleen Brown, MD**, St. Vincent Family Medicine ($75)
Co-Authors: **Steve Gerke, MD, Polly Moore, MD**, and **Bruce Waller, MD**

**Oral Original Research and Performance Improvement Presentations**
**First Place:** Comparison of Satisfaction, Readiness, Education, and Pregnancy Outcomes Between Group and Traditional Prenatal Care Models (Original Research)
Primary Author: **Emily Abernathy, MD**, St. Francis Family Medicine Residency ($250)
Co-Author: **John Beerbower, MD**, St. Francis Family Medicine Residency

**Second Place:** Evaluating Outcomes of the Joshua Max Simon Primary Care Center Health Fair (Original Research)
Primary Author: **Seth Rinderknecht, MD**, St. Vincent Family Medicine ($150)
Co-Author: **Amy LaHood, MD**, St. Vincent Family Medicine

**Third Place:** The Breathing Experience (Performance Improvement)
Primary Authors: **Daniela Lobo, MD**, and **Ban Kinaia, MD,** IU School of Medicine ($100)
Co-Author: **Kristal Williams, PharmD, CAE**, IU School of Medicine

# Medicare Advantage – Private Fee-for-Service Plans

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

Newby Consulting, Inc. is frequently asked about Medicare Advantage private fee-for-service plans. This article addresses the most common questions we receive.

A private fee-for-service (PFFS) plan is a Medicare Advantage (MA) health plan that has a contract with the Centers for Medicare & Medicaid Services (CMS) to provide Medicare beneficiaries with all their Medicare benefits plus any additional benefits the company decides to provide.

One major difference between a PFFS Medicare Advantage Organization (MAO) and other MAOs is that, in most cases, people who join a PFFS MAO **are not required** to use a network of providers. Beneficiaries can see any provider who is eligible to receive payment from Medicare and agrees to accept payment from the PFFS MAO.

A provider is aware in advance of enrollment in a PFFS when notice of enrollment for this beneficiary was obtained from

- The beneficiary (e.g., presentation of an enrollment card)
- CMS
- A Part A/B Medicare Administrative Contractor (MAC)
- The MA Organization

**Terms and Conditions of Participation**

A private fee-for-service organization is required to make its terms and conditions of payment reasonably available to providers. A provider has reasonable access to the plan's terms and conditions of payment if the plan makes accessible its terms and conditions of payment through:

- Postal service
- Electronic mail
- Fax
- Telephone
- A plan Web site

It is then the provider's responsibility to call or fax the PFFS plan or to visit the PFFS Web site to obtain the plan's conditions of participation. However, announcements in newspapers, journals, magazines or on radio or television are not considered communication of the terms and conditions of payment.

The PFFS terms and conditions of payment establish the rules that providers must follow if they choose to furnish services to an enrollee of a PFFS plan. At a minimum, the terms and conditions will specify:

- An explanation of the deeming process, including provider eligibility
- A list of all services that the plan provides
- The amount the PFFS organization will pay for all plan-covered services
- Provider billing procedures, including prompt payment and hold-harmless requirements
- The amount the provider is permitted to collect from the enrollee including balance billing
- Whether the network provider must obtain advance authorization from the PFFS organization before furnishing a particular service
- Beneficiary Appeal and Grievance requirements

**Provider Types – Direct Contracting, Deemed Contracting and Non-Contracting**

When an enrollee in a PFFS plan offered by an MA Organization obtains services from a provider, then for those services, that provider is classified into one of the following three mutually exclusive provider types:

- A provider is a **direct-contracting** provider if that provider has a direct contract (that is, a signed contract) with the MAO
- A provider is a **deemed-contracting** provider if:
  - The provider is aware in advance of furnishing services, that the person receiving the services is enrolled in a PFFS plan
  - The provider has reasonable access to the plan's terms and conditions of payment
  - The service provided is covered by the plan
- A provider is a **non-contracting provider** if that provider does not have a direct contract and is not "deemed"

Deemed-contracting providers have the right to decide on a patient-by-patient and visit-by-visit basis whether to treat PFFS plan enrollees. It is important to emphasize that although a provider who does not have a direct contract with the plan may choose to provide or not to provide services, the provider does not have the option of becoming non-contracting. Rather, once the provider provides services, the provider automatically becomes deemed-contracting, provided the deeming conditions listed above have been met.

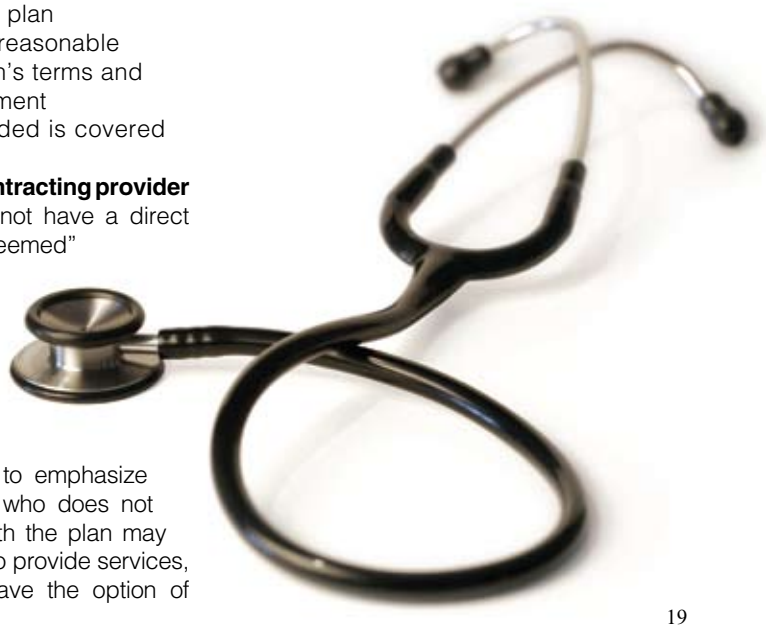
**Payment**

The total reimbursement amount of a service is the total amount the provider is entitled to receive, from both the plan and the enrollee, excluding permitted balance billing. A PFFS plan **may choose** to pay less than original Medicare for a given service. In such a case, the plan must demonstrate that it can **meet access requirements** through a **network of direct-contracting providers.**

The total reimbursement amount paid to **deemed-contracting providers** must be the same as the total reimbursement amount paid to direct-contracting providers and may differ from (i.e., be higher or lower than) the original Medicare amount.

The total reimbursement amount for non-contracting providers is always the amount they would have received under original Medicare.

*View the rest of this article at www.in-afp.org under Professional Development – Coding and Billing Information.*



# New Tools for **Screening** and **Intervention** in Patient Drug Use

*AAFP News Now*, May 4, 2009, © AAFP

| Patient reports lifetime use of one or more substances: **Ask** the following questions for each drug mentioned (scores will be tallied at the end). *For Tobacco and Alcohol, go to page 6.* | Never | Once or Twice | Monthly | Weekly | Daily or Almost Daily |
|---|---|---|---|---|---|
| 1. In the *past 3 months*, how often have you used each of the substances you mentioned (first drug, second drug, etc.)? | 0 | 2 | 3 | 4 | 6 |
| **If the answer to Question 1 is "Never," skip to Question 5. Otherwise, continue: *In the past three months...*** | | | | | |
| 2. How often have you had a strong desire or urge to use? | 0 | 3 | 4 | 5 | 6 |
| 3. How often has your use of (first drug, second drug, etc.) led to health, social, legal, or financial problems? | 0 | 4 | 5 | 6 | 7 |
| 4. How often have you failed to do what was normally expected of you because of your use of (first drug, second drug, etc.)? | 0 | 5 | 6 | 7 | 8 |
| **For each substance *ever used* (i.e., those mentioned in the "lifetime" question):** | NO | YES, but not in the past three months | | YES, in the past three months | |
| 5. Has a friend or relative or anyone else ever expressed concern about your use of (first drug, second drug, etc.)? | 0 | 3 | | 6 | |
| 6. Have you ever tried and failed to control, cut down, or stop using (first drug, second drug, etc.)? | 0 | 3 | | 6 | |
| 7. Have you ever used any drug by injection? (nonmedical use only) | | Recommend HIV/ Hepatitis B & C Testing | | Ask about pattern of injecting. Recommend HIV/ Hepatitis B & C Testing | |

The NIH's National Institute on Drug Abuse, or NIDA, is offering physicians and other health care professionals an online screening tool and other free resources intended to help them assess patients' tobacco, alcohol and illicit and nonmedical prescription drug use and to intervene with those at high risk of abusing these substances.

NIDA's first Physicians' Outreach Initiative, called NIDAMED, includes an online screening tool, a comprehensive resource guide for clinicians, a quick reference guide and a patient-tested postcard. NIDA said in an April 20 news release that the initiative stresses the importance of the patient-doctor relationship in identifying unhealthy behaviors before they evolve into life-threatening conditions.

The institute said the NIDAMED tools, which target primary care clinicians, were developed because research shows that screening, brief intervention and referral to treatment can promote reductions in patients' alcohol and tobacco use. In addition, there's growing evidence that reductions in illegal and nonmedical prescription drug use also can be achieved.

"Not only will these tools potentially help clinicians identify the use of drugs such as cocaine and heroin, they can also identify patients who are misusing prescription medications," said Acting Surgeon General Steven Galson, MD, who participated in the recent unveiling of the initiative.

The online screening tool was adapted from the Alcohol, Smoking and Substance Involvement Screening Test, or ASSIST, which was developed by the World Health Organization to identify substance use. The tool guides clinicians through a short series of questions. Based on a patient's responses, it generates a substance involvement score that suggests the level of intervention needed.

Thomas Houston, MD, of Columbus, Ohio, chairman of the Academy's Tobacco Cessation Advisory Committee and a member of its Commission on Health of the Public and Science, said he tried out the screening tool and liked it.

"It's quite good for physicians who are not well-trained in alcohol or drug screening or treatment. It's an easy way to learn patients' use of these substances, and it links to very good resources," he told *AAFP News Now*.

Houston said he entered fabricated information about fictitious patients in answer to questions on how much alcohol the patients drank each day and whether the drinking ever resulted in injuries or trouble with the law. The tool categorized the so-called patients as problem drinkers and determined that they needed to seek assistance. A similarly performed assessment of at-risk smokers yielded a link to smoking cessation guidelines from HHS.

Family physicians underdiagnose these problems, Houston explained. "We ask about tobacco use frequently but not about these other substance problems. They don't bubble to the surface in an office visit to treat hypertension, diabetes and other problems, even though these substances can add to other illnesses," he said.

In addition to the online screening tool, NIDAMED offers a comprehensive resource guide with detailed instructions on how to implement the screening tool, discuss screening results, offer a brief intervention and make referrals. The quick reference guide serves as a prompt to medical professionals to initiate screening, and it provides a snapshot of the NIDA-modified ASSIST tool, briefly summarizing the questions, scoring schema and next steps.

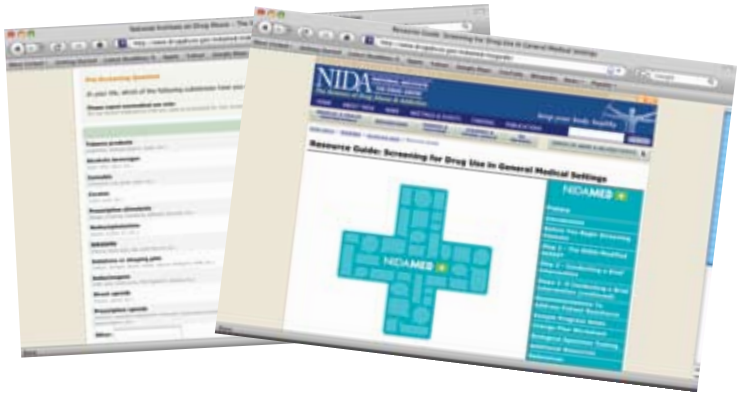
The NIDAMED physician toolkit also boasts a patient-tested postcard — one of a series that focuses on the dangers related to substance abuse — that encourages patients to communicate with their doctors about *all* the drugs they use and offers Web links for more information. The cards can be distributed in physicians' offices or clinic waiting rooms.

To access the National Institute on Drug Abuse tools for physician intervention, visit the following Web sites:

Online screening tool: http://www.drugabuse.gov/nidamed/index.php

Comprehensive guide on screening for drug use: http://www.drugabuse.gov/nidamed/resguide/

Quick Reference Guide on screening for drug use: http://www.drugabuse.gov/nidamed/quickref/screening_qr.pdf



# H1N1 Hits Indiana

As we go to press, the H1N1 situation is evolving rapidly. The current number of confirmed cases in Indiana is 110. Your best resources for the most up-to-date info are the Indiana State Department of Health's flu Web site at www.h1n1.in.gov and the Centers for Disease Control and Prevention at www.cdc.gov/h1n1flu, with general info sections and guidance for health care providers, lab testing information and much more.

The Indiana State Department of Health (ISDH) has created a call center to answer general questions from Indiana residents. Residents may call 877.826.0011 from 8 a.m. to 4:45 p.m., Monday through Friday.

A second call center has been created for health care providers. This call center is staffed by physicians. Providers only with specific clinical questions should call 866.233.1237.

The following lab submission guidelines are excerpted from **an Official Indiana Health Alert Network Advisory Message released on April 30, 2009.**

*The Indiana State Department of Health (ISDH) would like to thank healthcare providers for their diligence in identifying potential cases of Influenza A/(H1N1)/North America infection. ISDH and local health departments are investigating all potential leads and are working to protect and effectively educate the community.*

***Laboratory Submission Guidelines***

*Due to potential limitations in specimen supplies and laboratory capacity we ask that all laboratory submitters adhere strictly to the following submission requirements:*

*Patients must present with signs and symptoms characteristic of influenza (fever >=100 degrees Fahrenheit with cough or sore throat), AND*

*a. Have had a positive test result for influenza A, OR*
*b. Have traveled to another state or country with confirmed cases of A/H1N1/North America/Human influenza within 7 days of illness, OR*
*c. Have been in contact with someone ill with a suspected, probable, or confirmed case of the current outbreak strain within 7 days of illness.*

*Complete the entire ISDH Virology submission form, including travel history and exposure to suspected, probable, or confirmed cases of the current outbreak strain within 7 days of illness.*

*Note: Specimens that are influenza B positive with rapid influenza testing should not be sent.*

*Note: The ISDH Laboratory cannot test swabs that have already been used to perform rapid testing.*

*As this outbreak develops, laboratory submitting requirements may change so continue to review ISDH alerts.*

# Tar Wars News


McKenzie Freeman, from Hancock County, was selected as this year's Tar Wars Poster Contest Winner in Indiana. McKenzie and her family will be traveling to Washington, D.C., next month to participate in the Tar Wars National Conference with other students from around the country. Then, on Sunday, August 9, McKenzie will toss out the first pitch before the Indianapolis Indians take the field. Students and teachers who participated in Tar Wars are invited to attend the game as a gift in thanks for their participation. IAFP members are invited to attend as well. To request tickets (FREE!), please contact Dawn O'Neill (doneill@in-afp.org) with your requested number of tickets and an address where they should be sent. Tickets will be made available on a first-come, first-served basis!

# Meet the IAFP's 2009 Partners

We are pleased to recognize the following organizations as leaders in the IAFP's partnership program. Our partners share our commitment to providing an exceptional experience for our physician members and their staff. Their time and financial support benefit our members and help us successfully implement the IAFP's mission and goals. Join us in thanking our partners for their commitment to us.

**Strategic Partner**
St. Vincent Health

**Corporate Partners**
Abbott
Anthem
Atlantic Health Partners, LLC
Center for Diagnostic Imaging
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