

FRONTLINE

PHYSICIAN

A Publication of the Indiana Academy of Family Physicians • Winter 2010

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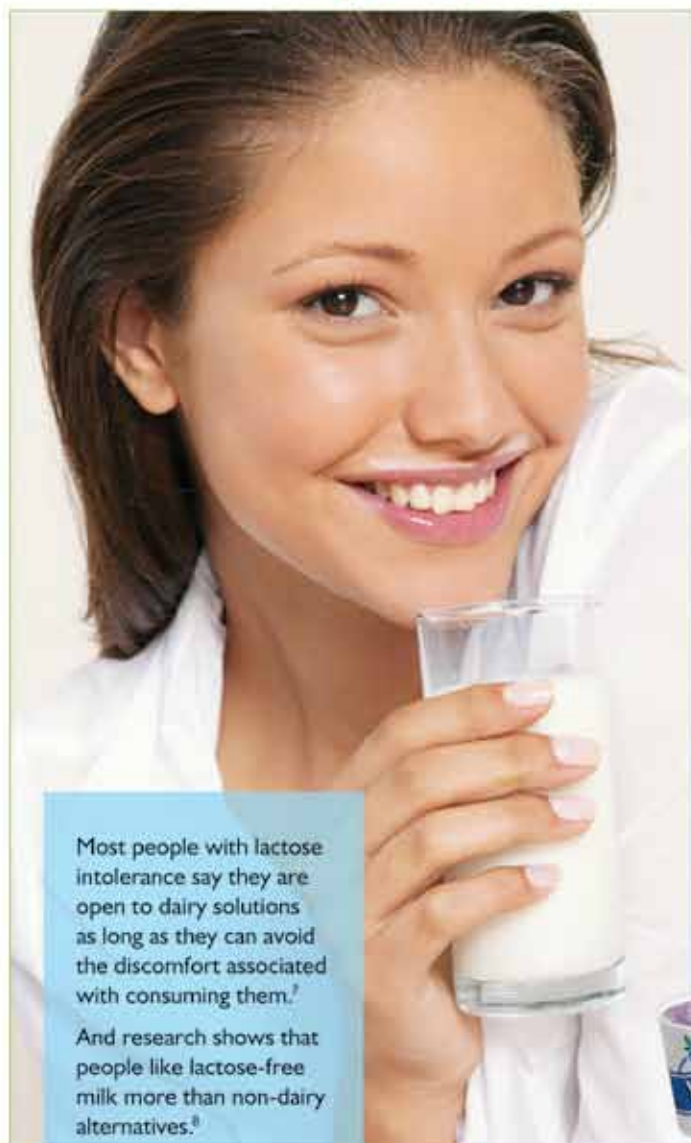
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Lactose Intolerant? Enjoy Dairy Again



Most people with lactose intolerance say they are open to dairy solutions as long as they can avoid the discomfort associated with consuming them.⁷

And research shows that people like lactose-free milk more than non-dairy alternatives.⁸

Many health authorities agree that low-fat and fat-free milk and milk products are an important and practical source of key nutrients for all people – including those who are lactose intolerant.^{1,2,3,4,5,6}

It's valuable for health and nutrition professionals to encourage and educate individuals with lactose intolerance to consume dairy foods first, before non-dairy options, to help meet key nutrient recommendations.

A Solutions-Focused Approach

People who are lactose intolerant should know that when it comes to dairy foods, practical solutions can help them enjoy the recommended three servings of low-fat and fat-free dairy foods every day*, without experiencing discomfort or embarrassment:

- Gradually reintroducing milk back into the diet by trying small amounts of it with food or cooking with it.
- Try drinking lactose-free milk, which is real milk just without the lactose, tastes great and has all the nutrients you'd expect from milk.
- Eating natural cheeses, which are generally low in lactose, and yogurt with live and active cultures, which can help the body digest lactose.



Visit nationaldairycouncil.org for more information, management strategies and patient education materials.



NATIONAL DAIRY COUNCIL



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



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1 U.S. Department of Health and Human Services and U.S. Department of Agriculture. Dietary Guidelines for Americans, 2005. 4th Edition, Washington, DC: U.S. Government Printing Office, January 2005.

2 National Institutes of Health Consensus Development Conference Statement. NIH Consensus Development Conference: Lactose Intolerance and Health. Draft statement, issued at 7:47 p.m. ET on February 24, 2010. http://consensus.nih.gov/2010/01images/lactose/lactose_draftstatement.pdf

3 American Academy of Pediatrics. Lactose intolerance in infants, children, and adolescents. Pediatrics. 2006; 118 (3):1279-1286.

4 USDA, FNS. Special Supplemental Nutrition Program for Women, Infants and Children: Revisions in the WIC Food Package. Interim Rule; 7 CFR, Part 246.

5 National Medical Association. Lactose Intolerance and African Americans: Implications for the Consumption of Appropriate Intake Levels of Key Nutrients. Journal of the National Medical Association. Supplement to October 2009; Volume 101, No. 10.

6 Wooten, WJ and Price, W. Consensus Report of the National Medical Association: The Role of Dairy and Dairy Nutrients in the Diet of African Americans. Journal of the National Medical Association 2004; 96:15-315.

7 NPD Group. Fluid Milk Concept Test for Dairy Management Inc. November, 2007.

8 Palacios OM, et al. Consumer Acceptance of Cow's Milk Versus Soy Beverages: Impact of Ethnicity, Lactose Tolerance And Sensory Preference Segmentation. Journal of Sensory Studies, 2009, 14:5.

* The 2005 Dietary Guidelines for Americans recommend 3 servings for individuals 9 years and older, and 2 servings for children 2-8 yrs.

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FRONTLINE PHYSICIAN

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The mission of the Indiana Academy of Family Physicians is to promote and advance family medicine in order to improve the health of Indiana.

Advocacy and Influence

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

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.



INDIANA ACADEMY OF
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Cover photo taken by IAFP member Yolanda Yoder, MD, of Paoli, Indiana.

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Jason Marker, MD

Membership – Its Rights and Responsibilities

I've been a member of a lot of things in my life — everything from my high school marching band to music clubs (buy six for \$1 with no obligation!) Looking back, the memberships I took the most seriously are the ones to which I contributed the most. Not surprisingly, these are also the memberships from which I received the most in return.

You are a member of the Indiana Academy of Family Physicians, and I'd like you to consider how seriously you take that membership. Is it something you do because someone required you to? Is it something you write the check for once a year and nothing more? Is membership something from which you expect to have a return on your investment?

As more and more of our members are owned by larger health care entities, I am concerned that we will separate our members from the important rights and responsibilities of membership and reduce it to simply "something my boss pays." That would be a profound loss for us as an Academy. Yes, we appreciate your dues dollars, but more importantly, we want members willing to consider seriously what membership means.

Your rights include an understanding that the IAFP will provide assertive advocacy on your behalf. That the IAFP will provide leadership in student and resident development, as well as visionary thinking that leads us into the health care future. Also, that the IAFP will produce excellent meetings and learning opportunities for you. How are we doing at living up to those expectations? If you think we've let you down, and you haven't told us so, you missed another right: the right to be heard as a dissatisfied member. We can only fix those things we know are a problem.

What of your responsibilities? Is paying your dues the only responsibility you have in this game? That seems a little like waiting for your six CDs for \$1 to come in

the mail so you can cancel your membership before you get billed at full price for the next two you really don't want. For any membership you really care about, you would go to some lengths to support and nurture it. You tell others about it and get excited when you think about your next opportunity to gather together. You go above and beyond to grow future leaders so the membership is alive and dynamic into the future.

Is that how we treat the IAFP?

Many opportunities will present themselves in the coming weeks for you to consider your responsibilities of membership in this Academy. Here are a few:

1. The new legislators have been chosen and will soon start their work in Indianapolis. Have you contributed to the PAC so that the IAFP can make an impact with our lobbying?
2. You will be asked to consider volunteering to be a Physician of the Day at the state house. Will you say "yes"? Will you consider bringing along a student or a resident?
3. Plans will be made to offer various programs to students in their early years of medical school training. Have you contributed to the IAFP Foundation so that family medicine opportunities are available to these students?
4. A new year of your ABFM cycle will start. Can the IAFP fill your CME and SAM module needs?
5. You may be asked to precept a student or resident in your office. I know it's not always very efficient, but isn't the effort worth it for our specialty?

Take a moment to consider how you feel about your rights and responsibilities to the IAFP. There's still time to make a year-end contribution to the PAC or IAFP Foundation. There's also still time to plan your New Year's resolution to make 2011 the year that you go above and beyond for family medicine. I promise we'll try to meet you halfway.

January	February	March	April
SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS
1	1 2 3 4 5	1 2 3 4 5	1 2
2 3 4 5 6 7 8	6 7 8 9 10 11 12	6 7 8 9 10 11 12	3 4 5 6 7 8 9
9 10 11 12 13 14 15	13 14 15 16 17 18 19	13 14 15 16 17 18 19	10 11 12 13 14 15 16
16 17 18 19 20 21 22	20 21 22 23 24 25 26	20 21 22 23 24 25 26	17 18 19 20 21 22 23
23 24 25 26 27 28 29	27 28	27 28 29 30 31	24 25 26 27 28 29 30
30 31			
May	June	July	August
SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS
1 2 3 4 5 6 7	1 2 3 4	1 2	1 2 3 4 5 6
8 9 10 11 12 13 14	5 6 7 8 9 10 11	3 4 5 6 7 8 9	7 8 9 10 11 12 13
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22 23 24 25 26 27 28	19 20 21 22 23 24 25	17 18 19 20 21 22 23	21 22 23 24 25 26 27
29 30 31	26 27 28 29 30	24 25 26 27 28 29 30	28 29 30 31
		31	
September	October	November	December
SMTWTFS	SMTWTFS	SMTWTFS	SMTWTFS
1 2 3	1	1 2 3 4 5	1 2 3
4 5 6 7 8 9 10	2 3 4 5 6 7 8	6 7 8 9 10 11 12	4 5 6 7 8 9 10
11 12 13 14 15 16 17	9 10 11 12 13 14 15	13 14 15 16 17 18 19	11 12 13 14 15 16 17
18 19 20 21 22 23 24	16 17 18 19 20 21 22	20 21 22 23 24 25 26	18 19 20 21 22 23 24
25 26 27 28 29 30	23 24 25 26 27 28 29	27 28 29 30	25 26 27 28 29 30 31
	30 31		

Mark Your Calendar

2011 Residents' Day/Research Forum

Friday, May 13, 2011

IUPUI Campus Center, downtown Indianapolis

2011 IAFP Annual Convention

Scientific Assembly and Congress of Delegates

July 21-24, 2011

French Lick, Indiana

AAFP Events

2011 AAFP Scientific Assembly

September 14-17

Orlando, Florida

IAFP CME at Sea Alaskan Cruise

August 6-13, 2011

Holland America Cruise Line

Join us aboard Holland America Line's Vista-class luxury ship, the *MS Westerdam*, as it sails the inside passage to Alaska! The *Westerdam* is the third in Holland America Line's series of Vista-class ships and embraces the latest industry and environmental technologies. Your journey includes extraordinary surroundings, new discoveries and all manner of delights. Step on board and into a world of elegant staterooms, gourmet cuisine, comforting spa treatments and glittering nightlife. Benefit from the IAFP's special rates on staterooms and suites. And earn CME credit from leading Indiana faculty members!

Visit http://www.specialeventcruises.com/iafp_2011.html for more information and registration details.



Membership Update

Active Members:	1,657
Inactive Members:	16
Life Members:	177
Resident Members:	253
Student Members:	156
Supporting Members (FP):	3
Supporting Members (non-FP):	5
Total Membership:	2,267

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 the IAFP office with your current e-mail address.

Legislative Update

by Meredith Edwards



If you thought the fall political ads were tough, wait until Indiana's 2011 General Assembly session starts in January. Indiana's legislators will be drafting the state budget for the next two years, and it will not be an easy task.

Legislators and experts have been heard quoting that the state will have to shave off up to \$1.3 billion in spending from the annual budget. According to the Indiana Fiscal Policy Institute's *Fiscal Year 2010 Close Out Report*, "Put another way, the \$1.3 billion budget gap is equal to the combined appropriations for most of what people think of when they think of state government. In addition to state prisons, state police and state parks, this total includes money spent for the General Assembly, the judiciary, tax administration, financial management, human resources, procurement and day-to-day administration, and all other elected officials."

With the budget this tight, it would not surprise the IAFP if negotiations this year are especially long and difficult. The IAFP is preparing to fight for sustaining physician Medicaid payment, the Family Medicine Residency funding and tobacco-prevention funding in the state budget.

The General Assembly's interim study committees have wrapped up for the fall, giving the IAFP an idea of what legislation we can expect to see introduced next year. We are anticipating legislation that will change the current laws around purchasing pseudoephedrine or ephedrine. Some legislators are interested in seeing the medications become prescription-only, while others are instead

hoping to require better tracking of who is purchasing pseudoephedrine and ephedrine.

As the session approaches, more legislators are announcing their plans to introduce legislation. Sen. Patricia Miller (R-Indianapolis) intends to author legislation requiring national criminal background checks for an extensive list of licensed providers, including nurses, physicians, psychologists, physician assistants, genetic counselors and dietitians. Rep. Charlie Brown (D-Gary) and Rep. Eric Turner (R-Cicero) have announced that they will be authoring a statewide smokefree air law again this session. And outcry throughout the state about the drug commonly referred to as spice has resulted in Rep. John Barnes (D-Indianapolis) announcing that he will introduce a statewide ban of the substance.

There are also signs that nonphysicians will be seeking expansions to their scope of practice. We have heard that pharmacists, who can currently give the influenza vaccine, are interested in expanding their scope to be able to prescribe and give other immunizations.

By the time you read this, the statewide elections will be completed, and we will know what changes to General Assembly leadership have been made. Be sure to watch for regular updates in our *e-FrontLine* for the most up to date information.

If you have any questions about IAFP's advocacy work, please contact Doug Kinser or Meredith Edwards at 317.237.4237 or at medwards@in-afp.org.

Indiana's Influence at AAFP Congress of Delegates in Denver, Colorado

AAFP Congress Elects New Leaders and Adopts New Policies



Clif Knight, MD, IAFP past president and Indiana delegate, addresses the AAFP Congress of Delegates.

For three days in Denver, Colorado, the AAFP Congress of Delegates met to determine the future policies and leaders of the AAFP.

On September 29, the Congress officially elected three new AAFP Board members and the president-elect. For the Board, the Congress chose Barbara Doty, MD, of Wasilla, Alaska; Richard Madden Jr., MD, of Belen, New Mexico; and Robert Wergin, MD, of Milford, Nebraska. For president-elect, the Congress chose Glen Stream, MD, of Spokane, Washington. Dr. Stream will take the office of president in 2011 at the opening of the AAFP Scientific Assembly in Orlando.

For the two days prior to the elections, the AAFP Congress considered reports from the commissions and officers of the AAFP, along with more than 50 resolutions submitted by state chapters. These resolutions included the nine the IAFP Congress forwarded on to the AAFP this year. Great thanks to our Indiana delegates to the AAFP Congress, Clif Knight, MD, and Richard Feldman, MD, along with our alternate delegates, David Pepple, MD, and Worthe Holt, MD, who all represented the IAFP at the Congress and provided testimony supporting the resolutions from Indiana.



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OUR MISSION



The mission of the Indiana Academy of Family Physicians is to promote and advance family medicine in order to improve the health of Indiana.

2010 Strategic Plan

As we see the world around us changing at a rapid pace, it becomes necessary to revisit and update a strategic plan more often. While we intend to revisit the three objectives again in 2-3 years, we will closely monitor the measures and will likely revise the strategies and initiatives annually — or as needed.

ADVOCACY

Shape health care policy in Indiana through interactions with government, the public, businesses, the health care industry, and our patients

Strategy 1: Initiate the development of a coalition of health care organizations

Strategy 2: Enhance reputation as the recognized expert on issues impacting primary care

Strategy 3: Provide information to key legislators about successful scholarship and loan repayment programs in other states to lay the groundwork for a similar program in Indiana

MEMBERSHIP

Serve as the essential resource for the professional success of the Family Physician workforce in Indiana

Strategy 1: Optimize the infrastructure of the association in anticipation of changes in the health care environment

Strategy 2: Prepare and enable members for leadership opportunities within the Academy, health care teams, organized medicine, and their communities

Strategy 3: Capitalize on opportunities to work with the medical schools in Indiana

Strategy 4: Maintain and grow membership

Strategy 5: Attract students to family medicine prior to medical school

EDUCATION

Be the provider of choice for family physician education in Indiana

Strategy 1: Offer education that attracts the maximum number of physicians and allied health providers

Strategy 2: Prepare the association for the AAFP CME policy and ACCME guidelines and regulations

Call for Nominations for 2011 IAFP Officers

At least 90 days prior to the IAFP Annual Assembly each year, the Nominating Committee shall announce nominations as required by the Bylaws. These nominations shall be formally presented at the first meeting of the Congress of Delegates, which this year will be July 22 and 23 in French Lick. At the time of the meeting, additional nominations from the floor may be made. The said election of officers shall be the first order of business at the second session of the Congress of Delegates on July 23.

Offices to be filled for 2011-2012 are: president-elect, second vice president, speaker of the Congress of Delegates, vice speaker of the Congress of Delegates, one AAFP delegate (two-year term) and one AAFP alternate delegate (two-year term).

The Nominating Committee's objective is to select the most knowledgeable and capable candidates available. The committee is also responsible for determining the

availability of those candidates to serve, should they be selected.

If you are an active member of the IAFP and are interested in submitting your name as a candidate, you must submit a letter of intent, a glossy black-and-white photo and a curriculum vitae. The deadline for nominations for 2011 IAFP officers is Thursday, March 10, 2011. If you have questions, please contact Kevin Speer or Deeda Ferree at 317.237.4237.

IAFP Awards: Call for Nominations

The members, leaders and staff of the Indiana Academy of Family Physicians seek to improve the health of the people of Indiana by promoting and enhancing the practice of family medicine. In order to recognize the achievements and dedication of its members, the IAFP Board of Directors honors individuals with the following awards each year.

Lester D. Bibler Award

The Lester D. Bibler Award is given to an active member of the Academy who, through long-term dedication and leadership, has furthered the development of family medicine in the state of Indiana.

A. Alan Fischer Award

Established in 1984, the A. Alan Fischer Award is designed to recognize persons who, in the opinion of the Board of Directors of the IAFP, have made outstanding contributions to education for family medicine in undergraduate, graduate and continuing education spheres. The award was named in honor of Dr. Alan Fischer, a longtime member of the IAFP who actively served both the Indiana chapter and AAFP. Dr. Fischer established the Department of Family Medicine (Practice) at Indiana University School of Medicine and the IU Family Medicine (Practice) Residency Program.

Certificate of Commendation

The Jackie Schilling Certificate of Commendation was established to recognize non-physicians who have been deemed to contribute, in a distinguished manner, to the advancement of family medicine in the state of Indiana. The recipients of the award are considered to be persons of repute in many fields, including, but not limited to, medical education, government, the arts and journalism. In 1999, the award was named after past IAFP Executive Vice President Jackie Schilling.

Distinguished Public Service Award

The Distinguished Public Service Award is to be presented to members in good standing who have distinguished themselves by providing a community or public service. The service for which this award is bestowed should have been performed on a voluntary and uncompensated basis and should

have benefited the community in an exceptional way. Service must be separate from the candidate's job responsibility.

Indiana Family Physician of the Year Award

The Indiana Family Physician of the Year must have maintained membership in good standing with both the IAFP and AAFP and must have been in practice for at least 10 years. Nominees must provide their patients with compassionate, comprehensive and caring family medicine on a continuing basis, and must be directly and effectively involved in community affairs and activities that enhance the quality of their communities. A nominee must be a family physician who is a credible role model professionally and personally to his/her community, to other health professionals and to residents and medical students. Nominees must also be able to effectively represent the specialty of family medicine and the IAFP and AAFP in a public forum.

Outstanding Resident Award

The Outstanding Resident Award seeks to reward a mature family medicine resident who demonstrates exceptional interest and involvement in family medicine and exemplifies a balance of the qualities of a family physician. The recipient of this award should exemplify the following qualities: community service and social awareness, evidence of scholarly inquiry, caring and compassionate patient care, involvement in Academy affairs locally or nationally, balance between personal and professional activities and mature interpersonal and collegial skills.

This call for nominations plays an important part in the process of recognizing outstanding service. Nominations must be in writing and submitted on an official nomination form with appropriate attachments. The IAFP Commission on Membership & Communications will review the entries and present its recommendation to the IAFP Board of Directors for approval. Nominations will be accepted from IAFP members until Thursday, March 10, 2011.

If you would like a nomination form or need more information, please check www.in-afp.org or contact Missy Lewis via e-mail (mlewis@in-afp.org) or phone (317.237.4237). Thank you for your participation in recognizing outstanding family physicians and supporters of family medicine. You are a valuable advocate for your specialty!





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Member News

IAFP Members Receive Pfizer Teacher Development Awards

Two Indiana community-based family physicians and part-time teachers were selected to receive 2010 Pfizer Teacher Development Awards. Award recipients are selected based on their scholastic achievement, leadership qualities and dedication to family medicine. Congratulations to Risheet R. Patel, MD, of Community Health Network Family Medicine Residency Program in Indianapolis; and Brandon W. Zabukovic, MD, of Memorial Hospital Family Medicine Residency Program in South Bend.

Community Health Network Foundation Lands \$2.4 Million in Federal Grants

Community Health Network Foundation

has been awarded more than \$2.4 million in grants from the federal government. The U.S. Department of Health and Human Services' funding will be used to transform a family medicine residency program into a patient-centered medical home model.

Congratulations to program director Diana Burtea, MD, and her team!

Indiana University Expands Family Medicine Residencies

A \$1.9 million federal grant is helping the Indiana University Department of Family Medicine expand its residency program to the Lafayette area.

IU says the stimulus grant will allow the program to add two new residency slots in



collaboration with Clarian Arnett Health, St. Elizabeth Regional Health and Riggs Community Health Center in Lafayette.

Congratulations to program director Sharron Grannis, MD, and her team!

Updates from the Indiana University Department of Family Medicine

The Department of Family Medicine has had another busy and productive year!

We are thrilled to announce our new initiative to expand our Family Medicine Residency Program into the Lafayette area through a \$1.9 million grant from the Health Resources and Services Administration as part of the American Recovery and Reinvestment Act. The grant will enable the program to add two new residency positions in collaboration with Clarian Arnett Health, St. Elizabeth Regional Health and Riggs Community Health Center. Tippecanoe County is entirely a medically underserved area and is surrounded by five counties that, in whole or in part, are designated medically underserved or health professional shortage areas. Currently, no primary care residency program exists in this region. Specific goals of the project are to increase the recruitment of medical students to the Lafayette area for training and recruit 50 percent of the residency class from underrepresented/disadvantaged backgrounds. Other goals include, upon residency graduation, to retain 75 percent of family medicine physicians within a 50-mile radius from Lafayette and to place 50 percent of

family medicine physicians in clinical sites to care for medically underserved populations. Dr. Sharron Grannis, director of the IU Family Medicine Residency Program, serves as P.I. on the grant.

We are also in the midst of developing the building design for a new Family Medicine Center, our largest clinical site and home to the residency program. This is a wonderful opportunity to design the space to support the patient-centered medical home, which is the focus of our discussions. Our new building will be on the corner of 15th Street and Capital Avenue; a new Neuroscience Institute will be built on the site of our current Family Medicine Center.

Additionally, the Department of Family Medicine is developing a plan to launch a Health Services and Translational Science Research Fellowship. This fellowship would be a junior faculty position and will involve the completion of a master of science degree in clinical research through the Regenstrief Institute Clinical Investigator and Translational Education (CITE) Program. Watch for forthcoming information!

What Family Physicians Need to Know About Tobacco Cessation

www.askandact.org

Your patients want you to ask

Patients are more satisfied with their health care if their provider offers smoking cessation interventions — even if they're not yet ready to quit.

Payment for counseling

Medicare pays for tobacco cessation counseling for patients who use tobacco. Use the ICD-9 diagnosis code "305.1 non-dependent tobacco-use disorder, or V15.82 history of tobacco use." For more details on the 2011 changes, get the Coding Reference and Medicare Part B Benefits overview in the Ask and Act Practice Toolkit at www.askandact.org.

Guidelines were updated

Access the U.S. Public Health Service Clinical Practice Guideline, *Treating Tobacco Use and Dependence: 2008 Update*, at <http://www.surgeongeneral.gov/tobacco>.

Quitlines work

Quitlines are staffed by trained cessation experts who tailor a plan and advice for each caller. The national number is **1-800-QUIT-NOW (1-800-784-8669)**. Patients who call this number are routed to their state quitline.

Medication increases long-term smoking abstinence rates

First line medications:

- Bupropion SR
- Nicotine gum
- Nicotine inhaler
- Nicotine lozenge
- Nicotine nasal spray
- Nicotine patch
- Varenicline

Also consider proven combined medications.

Get the Pharmacologic Product Guide in the Ask and Act Practice Toolkit at www.askandact.org.

Counseling works

Even brief tobacco dependence treatment is effective and should be offered to every patient who uses tobacco.

Counseling + medication work best

Studies show that the combination of counseling and medication is more effective than either alone.

AAFP has resources for family medicine offices

Visit the AAFP's tobacco cessation website at www.askandact.org.



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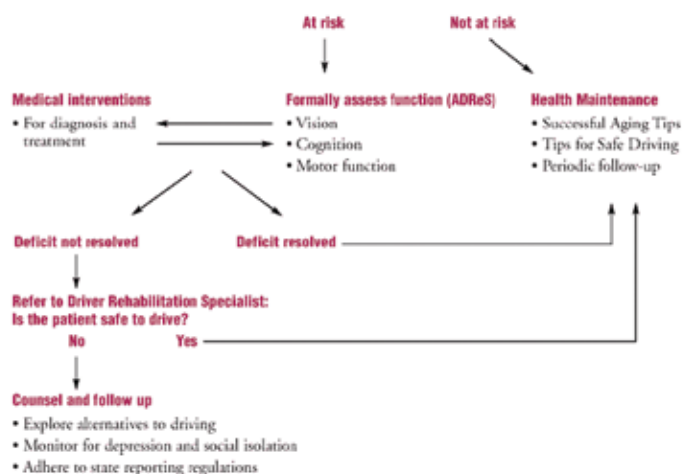
ASK AND ACT
A TOBACCO CESSATION PROGRAM

Assessing and Counseling Older Drivers

Buoyed by the large ranks of baby boomers and increased life expectancy, the United States' older population is growing nearly twice as fast as the total population. Within this population, an increasing proportion will be licensed to drive, and these license-holders will drive more miles than older drivers do today. As the number of older drivers rises, patients and their families will increasingly turn to physicians for guidance on safe driving. Physicians will have the challenge of balancing their patients' safety against their transportation needs.

The NHTSA has resources to help family physicians counsel older drivers. They have reviewed the scientific literature and collaborated with clinicians and experts in this field to produce the following two physician tools:

- An office-based assessment of medical fitness to drive. This assessment is outlined in the algorithm, *Physician's Plan for Older Drivers' Safety* (PPODS) (see below)
- A reference list of medical conditions and medications that may impair driving, with specific recommendations for each one (see website listed below).



Older Drivers: Key Facts

Fact: Safety for older drivers is a public health issue.

Fact: Although many older drivers self-regulate their driving behavior, this is not enough to keep crash rates down.

Fact: The majority of older Americans rely on driving for transportation.

Fact: The crash rate for older drivers is related to physical and mental changes associated with aging.

Fact: Physicians can influence their patients' decision to modify or retire from driving. They can also help their patients maintain safe driving skills.

To achieve this end, primary care physicians can follow the algorithm *Physician's Plan for Older Drivers' Safety* (PPODS), which recommends that physicians:

- **Be alert** to red flags for medically impaired driving
- **Assess** driving-related functional abilities in those patients who are at risk for medically impaired driving
- **Treat** underlying causes of functional decline
- **Refer** patients who require further evaluation and/or adaptive training to a driver rehabilitation specialist
- **Counsel** patients on safe driving behavior, driving restrictions, driving cessation and/or alternative transportation options as needed
- **Follow up** with patients who retire from driving for signs of depression and social isolation

For complete resources to assist you with issues related to elderly drivers, please visit: <http://www.nhtsa.gov/people/injury/olddrive/Olderdriversbook/pages/Contents.html>.



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urologyofindiana.com

Physician Employment Agreements

This article should be used as a resource for physicians who want to be prepared to negotiate an employment agreement. The following outline is an overview of basic issues that a physician may be confronted with in most employment agreement scenarios. While this article should not be used to substitute for legal advice, it provides a description of basic agreement terms typically found in employment agreements, an explanation of why these terms may be significant and a basic overview of certain federal laws that may affect physician employment agreements. This information is not exhaustive and is not intended to constitute legal advice. Before executing an employment agreement, a physician should consult an attorney knowledgeable in health law matters. Finally, please be advised that other agreements — such as independent contractor agreements — are beyond the scope of this article. Such agreements may involve additional state and federal requirements that are not addressed here.

Scope of Work

A physician employment agreement should specify in reasonable detail the physician's scope of services under the proposed employment relationship. When preparing to negotiate an agreement, physicians should carefully review the proposed scope of work to ensure an accurate understanding of physician's potential scope of obligation and the related time commitment. The scope of work should specify the time commitment, whether by the number of hours to be worked by the physician in a given week/month or some other reasonable format, including the clinical and patient-care responsibilities and administrative requirements of the physician. Additional scope or duties of the physician may include, but are not limited to, quality assurance measures, attendance of CME courses, supervision of other medical personnel and on-call coverage. The scope of work will typically be expressed in list form and may be attached to the agreement as an exhibit, so as to allow the physician and employer to revise the scope without rewriting the agreement.

Term

Physician employment agreements typically specify a fixed term, usually subject to earlier termination or extension provisions. While this may be an obvious point, a physician

should ensure his or her agreement clearly states the time period for which the agreement will last (e.g., one year, two years, etc.). Employers typically prefer that physician employment agreements renew automatically at the end of the initial term. While such "auto-renew" provisions provide some administrative efficiencies and safeguards against violation of certain federal fraud and abuse laws for both the employer and physician, such terms should be carefully considered. Physicians should ensure language remains in the agreement that allows for renegotiation despite the auto-renew, as automatic-renewal clauses may commit a physician to another lengthy term and may not allow for salary escalation over time.

Termination

Physician employment agreements will typically have one or two types of termination provisions. A "with-cause" provision allows for both the employer and physician to terminate the agreement for specified reasons, such as loss of licensure or breach of the agreement. On the other hand, a "without-cause" provision may enable the employer and physician to terminate the agreement with no stated reason by providing written notice in advance. Physicians should keep in mind that a fair agreement will allow the physician to also terminate "without cause,"

subject to the same notification period. This notice period should provide a reasonable period of time to allow the physician to secure other employment. It is important that the agreement require the physician to be provided with detailed written notice and a sufficient cure period that gives the physician sufficient time to address and, if possible, correct the problem.

Restrictive Covenants

A restrictive covenant provision will prevent a physician from competing with the employer in a certain geographic area for a certain period of time following termination of employment. Courts have generally held that restrictive covenants are valid and enforceable as long as they are reasonably tailored to protect a legitimate business interest of the employer. However, some states have completely invalidated restrictive covenants.

Indiana courts enforce noncompetition provisions to the extent they are reasonable. The courts will give these provisions "particularly careful scrutiny" and ultimately determine their reasonableness by balancing: whether the restrictions are wider than necessary to protect the employer; the provision's effect on the physician; and its effect upon the public. Physicians must look at the time and geographic limitations to ascertain whether the limits are reasonable before signing. The reasonableness of the geographic scope will depend on the nature of the practice and the population density of the practice area. A physician with a high degree of specialization can expect a more expansive geographic scope to the restrictive covenant.

A physician should also examine the agreement to ascertain what types of activities will be restricted. For example, some restrictive covenants will prohibit a physician from recruiting staff members or soliciting patients. This may be a concern for a physician who has brought an extensive patient base to the former employer. Additionally, there may be a liquidated damage provision, which allows the physician to "buy out" if he or

Multiple issues or concerns can arise in the contexts of restrictive covenant; therefore, it is important to address these issues with an attorney.

Malpractice insurance coverage is generally paid by the employer as a fringe benefit and also to address the employer's potential liability. The agreement should specify the type of coverage and the minimum limits. Coverage will be either on an occurrence or claims-made basis. With an occurrence form or certain modified claim-made policies, the physician is covered for malpractice that occurred during the period that the



If the agreement states that the employer will pay for claims-made coverage, the agreement should address who is responsible for payment of the tail coverage. Some

Generally, a physician's compensation is structured as a guaranteed annual sum or salary, as a variable amount based on "production" (usually calculated from billings or collections) or as some combination thereof. An agreement providing base salary should indicate the amount and frequency of payment and how it will be adjusted in future years. If a production formula is used, the agreement should provide details as to how compensation should be calculated. The physician should be sure to understand the formula, because how the agreements define productivity and how the formula is used can have a direct impact on the physician's income.

The federal Stark Law and the regulations promulgated thereunder generally provide that a physician may not make a referral for the furnishing of designated health services (“DHS”) to an entity with which the physician (or an immediate family member) has a financial relationship, unless the arrangement satisfies an applicable exception. In order to satisfy a Stark Law exception, an arrangement must meet every element of an applicable exception. Particularly relevant to physician employment arrangements are the Stark Law exceptions pertaining to bona fide employment relationships, personal services arrangements, physician group practices, in-office ancillary services, aca-

The federal Anti-Kickback Statute makes it a criminal offense to knowingly and willfully offer, pay, solicit or receive any remuneration to induce or reward referrals of items or services reimbursable by a federal health care program. The statute ascribes criminal liability to parties on both sides of an impermissible transaction. There are certain “safe harbors” that will immunize certain relationships implicated by the statute from criminal and civil prosecution. Meeting a safe harbor will exempt a party from criminal and civil liability under the statute; however, the failure to meet a safe harbor does not necessarily mean that the arrangement is unlawful, but it may increase the likelihood of a regulatory challenge. In the context of physician employment relationships, there is a safe harbor for compensation paid by an employer to a bona fide employee. The goal should always be to structure relationships to meet an applicable safe harbor.

This article was prepared by Allison Matters Taylor, Esq., and Lauren Hulls, Esq., of Hall, Render, Killian, Heath & Lyman. Allison was legislative director of the Academy from 2005 to 2008. She passed the Indiana Bar in 2009 and is now a practicing attorney on both the Government Relations and Regulatory teams of Hall Render. Lauren was a law clerk at the Indiana State Medical Association from 2008 to 2009. She passed the Indiana Bar this summer is now a practicing attorney on Hall Render's Reimbursement team.

Coding and Billing Update

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

Influenza Vaccine

Medicare began covering annual influenza immunizations in 1993 for all Medicare beneficiaries. Medicare beneficiaries may receive an influenza vaccine once each influenza season, paid by Medicare, *without* a physician's order and *without* physician supervision. Medicare pays 100 percent of the fee schedule for the cost of the vaccine and its administration when administered by recognized providers. Deductibles, coinsurance and co-payments are NOT applied to this benefit. Assignment must be taken on the claim for the vaccine when administered by physicians, nonphysician practitioners and suppliers.

Medicare tracks utilization of the influenza vaccine and administration by "influenza virus season," not by calendar year. This means a Medicare beneficiary could have more than one influenza vaccine/administration in a calendar year and still have coverage for both services. For example, a beneficiary received an influenza virus vaccination in January 2010, and another influenza virus vaccination is given in November 2010. Both vaccinations would be paid, because the vaccinations were performed in separate influenza seasons.

Typically, one vaccine is allowable per influenza virus season (once a year in the fall or winter). Medicare will pay for more than one influenza virus vaccination *per influenza season* if a physician determines and documents in the patient's medical record that the additional vaccination is reasonable and medically necessary. An additional immunization in the same influenza season requires a physician order.

The administration code for influenza vaccines is G0008 (administration of influenza virus vaccine). The Indiana 2010 payment allowance is \$21 (G0008).

Use ICD-9 code V04.81, prophylactic vaccination and inoculation against influenza, when the beneficiary receives only the influenza vaccine. Use ICD-9 code V06.6, prophylactic vaccination and inoculation against streptococcus pneumoniae (pneumococcus) and influenza, when the beneficiary receives both the influenza and pneumonia vaccines during the same encounter.

Effective on September 1 of each year, the payment allowances for influenza vaccines are updated.

90658 – Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use

Payment allowance for 90658 is based on dates of service. For dates of service from September 1, 2010, through December 31, 2010, the payment allowance for 90658 is \$11.368, rounded to \$11.37.

Additional information on the payment allowance for dates of service after December 31, 2010, will be available in a future Medicare Learning Network Matters (MM) article. These articles

are available on the CMS website and sent by the local Medicare contractor to anyone who has signed up to be part of the contractor's Listserv group.

During the week of November 1, 2010, the Centers for Medicare & Medicaid Services (CMS) published the Final Rule with comment period for the *Medicare Program Payment Policies Under the Physician Fee Schedule and Other Revisions to Part B for Calendar Year 2011*. The following information is found in the final rule and is effective with dates of service on or after January 1, 2011. Payment allowances for the new "Q" codes had not been announced at the time this article was submitted for publication.

Thus, effective with dates of service on or after *January 1, 2011*, Medicare will no longer recognize CPT code 90658 (influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use) but, instead, will use five new HCPCS "Q" codes to report influenza vaccines that would otherwise have been reported under CPT code 90658.

- Q2035 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
- Q2036 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FluLaval)
- Q2037 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
- Q2038 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
- Q2039 Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)

Additional Payment Allowances for Other Influenza Vaccines

Medicare payment allowances for the following influenza vaccines are for the entire 2010-2011 influenza virus season:

CPT Code	Payment Allowance	Description
90655	\$12.398, rounded to \$12.40	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	\$12.375, rounded to \$12.38	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657	\$6.297, rounded to \$6.30	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use

90660	\$22.316, rounded to \$22.32	Influenza virus vaccine, live, for intranasal use (e.g. FluMist)
90662	\$29.213, rounded to \$29.21	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use (e.g., Fluzone High-Dose)

Smoking and Tobacco Cessation Counseling

Medicare allows two individual tobacco cessation counseling attempts per year. Each attempt may include a maximum of four intermediate OR intensive sessions, with a total benefit covering up to eight sessions per year per Medicare beneficiary who uses tobacco. The practitioner and patient have the flexibility to choose between intermediate (more than three minutes, up to 10 minutes) or intensive (more than 10 minutes) cessation counseling sessions for each attempt.

In calculating a 12-month period, 11 months must pass following the month in which the first Medicare-covered cessation counseling session was performed. The Common Working File (CWF) will track the number of sessions based on the smoking cessation codes (CPT and HCPCS), not by provider or whether the counseling is provided to an asymptomatic patient or to a patient who has been diagnosed with a recognized tobacco-related disease or who exhibits symptoms consistent with a tobacco-related disease.

Medicare will allow payment for a medically necessary Evaluation and Management (E/M) service on the same date as tobacco cessation counseling, provided it is clinically appropriate. Such E/M service should be reported with modifier -25 to indicate it is a separately identifiable service from the tobacco use counseling.

Asymptomatic Patients

Effective August 25, 2010, smoking cessation counseling is covered as a preventive service in the absence of signs and symptoms. Patients who do not have signs or symptoms of tobacco-related disease will be covered under Medicare Part B when the following conditions of coverage are met, subject to certain frequency and other limitations:

- Use tobacco
- Competent and alert at the time that counseling is provided
- Counseling is furnished by a qualified physician or other Medicare-recognized practitioner

The diagnosis codes that should be reported for these individuals are:

- ICD-9 code 305.1 (nondependent tobacco use disorder)
- ICD-9 code V15.82 (history of tobacco use)

For claims with dates of service from August 25, 2010, through December 31, 2010, providers will need to use the unlisted CPT code 99199 in order to report these preventive services. This code should be billed with either ICD-9 code 305.1 or V15.82. Item 19 on the CMS 1500 (for electronic claims, the electronic notepad) should include:

- Smoking and tobacco cessation counseling for an asymptomatic patient

- Number of the minutes spent counseling the patient regarding smoking cessation

The following two new HCPCS codes will be effective for dates of service on or after January 1, 2011 to report these preventive services:

- G0436 Smoking and tobacco cessation counseling visit for the asymptomatic patient; intermediate, greater than three minutes, up to 10 minutes
- G0437 Smoking and tobacco cessation counseling visit for the asymptomatic patient; intensive, greater than 10 minutes

CMS has instructed all Medicare payment contractors to price this unlisted code on a claim-by-claim basis.

Medicare will waive the deductible and coinsurance/copayment for counseling and billing with the two new "G" codes on or after January 1, 2011.

Patients Diagnosed with a Recognized Tobacco-Related Disease or Exhibit Symptoms Consistent with a Tobacco-Related Disease

Physicians are instructed to continue to use the following codes for patients who have been diagnosed with a recognized tobacco-related disease or who exhibits symptoms consistent with a tobacco-related disease:

- 99406 Smoking and tobacco use cessation counseling visit; intermediate, greater than three minutes up to 10 minutes
- 99407 Smoking and tobacco use cessation counseling visit; intensive, greater than 10 minutes

Use of the above codes has not changed. The two new "G" codes effective with dates of service on or after January 1, 2011 (and the unlisted code 99199 until December 31, 2010), are only to be used when counseling is provided to an *asymptomatic* patient who has a history of tobacco use.

The above information can be found in *MLN Matters* article MM7133 at: <http://www.cms.gov/mlnmattersarticles/downloads/mm7133.pdf>.

Joy's Observations

At the time this article was submitted for publication, there was no information regarding whether the deductible and coinsurance for codes (99406 and 99407) will be waived in 2011. Seems strange that if the patient doesn't have signs or symptoms of tobacco-related disease, he/she has NO out-of-pocket expense, but the patient with signs or symptoms still must pay his/her deductible and be responsible for 20 percent of the Medicare-allowed amount for basically the same service! Doesn't this seem ridiculous?

Is Your Staff Coding Correctly?

The 2011 CPC Certification Course is now forming at

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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 2010. Your generosity provides 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."

FOUNDER'S CLUB MEMBERS

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

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The IAFP Needs You!

Plan Now to Serve as Physician of the Day in 2011

The Indiana Academy of Family Physicians and the Indiana State Medical Association will once again sponsor the Physician of the Day program at the 2011 General Assembly. Your assistance is needed! **In the current fast-changing health care climate, it is most important that family medicine make an impression on our legislators. This important 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 convenience, 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.

We are in the process of scheduling physician volunteers for the months of February and April. The program operates Mondays through Thursdays only.

If you are interested in serving as the Physician of the Day, please e-mail Chris Barry (cbarry@in-afp.org), or 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!**

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Indiana family physicians have a unique opportunity to attend an alternative Spring Break trip with first- and second-year IU medical students. From March 12 to March 19, 2011, you can help teach dedicated IUSM students, experience Honduran culture, give back to the global community and make a lasting impact. More details and contact information is available at www.in-afp.org/files/public/Physician%20Brochure.

The cost is approximately \$1,600, which includes plane ticket, food and lodging.



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Dr. Kathy Clark, Pediatric Radiologist for Northwest Radiology, shows Landon his chest x-ray and why he was so sick.

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Dr. Kathy Clark



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