

# FRONTLINE

## PHYSICIAN

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

**Growth for Family Medicine:  
Join Us This Summer  
for the 2010 IAFP  
Annual Convention!**

PG 12

**Unprecedented Participation  
in the 2010 IAFP Residents'  
Day/Research Forum**

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**Report from the AAFP  
Board of Directors**

by Tom Felger, MD

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**All Physicians: Update  
on Supplier Claims  
Processing for Ordering/  
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## COMPARING UFE TO SURGICAL ALTERNATIVES

	UFE	Hysterectomy*
Procedure Time	Approximately 1 hour	A few hours
Hospital Stay	Usually 23 hours	1-3 days
Recovery Time	About 1 week	4-6 weeks
Anesthesia	Local	General
Surgical Incision	No	Yes

\* Laparoscopic surgery is less invasive, however, the overall majority of hysterectomies are still performed abdominally.

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# FRONTLINE PHYSICIAN

Volume 11 • Issue 2

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

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**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

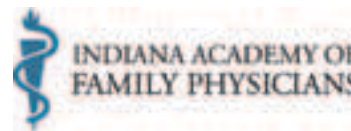
Foster the development of leadership within IAFP and encourage Family Medicine involvement at the community, state and national levels.

### 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.



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FrontLine Physician is published by Innovative Publishing Ink.  
10629 Henning Way, Suite 8 • Louisville, Kentucky 40241  
502.423.7272  
[www.ipipublishing.com](http://www.ipipublishing.com)

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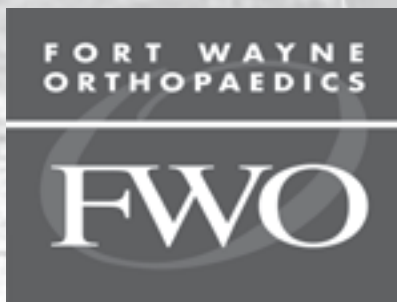
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## Mark Your Calendar



July 22-25, 2010	July 22, 2010	July 23, 2010
2010 Annual Convention French Lick Hotel and Conference Center, French Lick, Indiana	IAFP Board of Directors French Lick Hotel and Conference Center, French Lick, Indiana	IAFP Town Hall Dinner and First Session of Congress of Delegates French Lick Hotel and Conference Center, French Lick, Indiana
July 24, 2010	July 25, 2010	
Second Session of IAFP Congress of Delegates French Lick Hotel and Conference Center, French Lick, Indiana	IAFP Board of Directors French Lick Hotel and Conference Center, French Lick, Indiana	

## AAFP Meetings

### September 27-29, 2010

AAFP Congress of Delegates  
Denver, Colorado

### September 29-October 2, 2010

AAFP Annual Scientific Assembly  
Denver, Colorado

## Set IAFP Policy – Write a Resolution

The IAFP is your Academy, and as a member, you have the valuable opportunity to set the course your association will take by writing a resolution.

Resolutions are debated every year at the Congress of Delegates during the IAFP Annual Convention. Resolutions that are passed then become official IAFP policy.

Think your resolution will not have an impact? In 2008, the IAFP Congress of Delegates debated whether all alcohol purchases should require a valid ID from the purchaser. The resolution passed to require ID on all alcohol purchases, and in 2010, the General Assembly passed that same law with IAFP support.

Attend the IAFP Congress of Delegates on July 23 and 24 during the IAFP Annual Convention in French Lick, Indiana, and be prepared for the IAFP Annual Convention by submitting your own resolution by June 30.

### Writing a Resolution

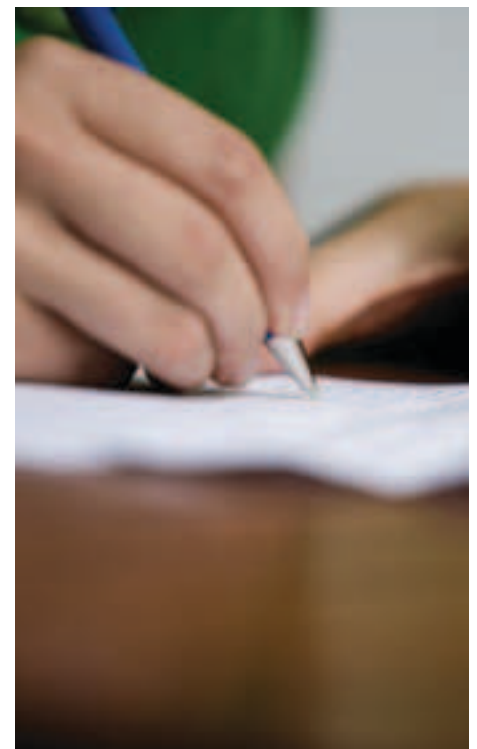
The IAFP utilizes a Whereas/Resolved format:

1. "Whereas" is followed by the background and conditions of the problem
2. "Resolved" is followed by the actions you want the IAFP or AAFP to take
3. Example:

WHEREAS, recent studies have shown the use of cell phones while driving can be dangerously distracting; therefore be it

RESOLVED, IAFP support state legislation restricting the use of wireless communication devices while driving; except in emergency situations; and  
RESOLVED, that the IAFP forward this resolution onto the AAFP Congress of Delegates for their consideration

Questions and resolutions can be sent to Meredith Edwards by e-mailing [medwards@in-afp.org](mailto:medwards@in-afp.org); by fax at 317.237.4006; or by phone at 317.237.4237.



# 2010 General Assembly Session Wrap-Up

by Meredith Edwards

Around 1 a.m. on Saturday, March 13, the Indiana General Assembly finished its 2010 short session. It was not until late Friday that both the House and Senate came to an agreement on two major bills that had held up session for the last eight days: SB 23 (unemployment insurance and HB 1367 education).

The IAFP is excited to report that we had a major success in stopping the abolishment of the Indiana Tobacco Prevention and Cessation agency (ITPC). The IAFP has had a mandate since 2004 to protect ITPC and its funding. SB 298, which contained the provision to eliminate the expert staff and independent board for the agency, passed the Senate but failed to be heard in the House.

Another major success during the 2010 session was stopping a Medicaid mandate that would have required all physicians who take Medicaid patients to have a \$50,000 surety bond for the purpose of recouping fines and overpayments.

The Academy was pleased to see a law requiring universal carding for alcohol purchases in Indiana pass during the 2010 session. The IAFP has supported universal carding for alcohol purchases since the 2008 Congress of Delegates requested the Academy support such a law. But the Academy was disappointed that, once again, Indiana General Assembly failed to pass a ban on texting while driving or a comprehensive indoor smoke-free air law.

## General Assembly Interim Study Committee Preview

During summer 2010, the General Assembly will be taking time to study issues in depth and prepare legislation for the 2011 long session.

As of press time, the legislative leadership had not yet shared the topics that have been assigned to the interim study committees. However, the Academy expects to see the General Assembly study organ procurement and how to combat methamphetamine production through changing pseudoephedrine and ephedrine sales laws.

The Academy is also expecting an interim committee to study on how health care reform will impact Indiana — specifically, how health care reform could exacerbate the primary care physician shortage. If the issue is studied, the Academy plans to use the opportunity to promote the much-needed but unfunded primary care physician loan forgiveness program.

## Elections in 2010

On November 2, 2010, elections will take place that could affect the direction of the state for the next decade. Currently, Indiana has a divided government, with Republicans controlling the governor's office and the Senate and the House being controlled by Democrats. The Democrats control the House by the narrowest of margins, 52-48. It would take only a minimal change for Republicans to control the House.

The major issue for General Assembly members in 2011 will be the redistricting bill, and it will stay the same for the next 10 years. Obviously, both caucuses would like to be in control and drawing the maps. As a result, we will see an expensive and well-fought campaign by Republicans and Democrats for the House.

The Academy will again raise money for its PAC. Your Board of Directors directs our contributions, and we limit our donations to leadership of both caucuses and to members of the health and insurance committees. Your leadership and staff appreciate your contributions to the IAFP PAC.

Questions regarding the IAFP's legislative activities may be directed to Meredith Edwards at [medwards@in-afp.org](mailto:medwards@in-afp.org) or at 317.237.4237.







## IAFP Legislative Efforts Need Your Help

2010 is an election year, and Indiana state legislators who are favorable to family medicine issues are busy campaigning for re-election.

Supporting candidates who support family medicine is an essential element of the IAFP's legislative work. A donation from the IAFP PAC not only helps to keep our supporters in office, but it also reminds them that when they think of health, they should think family medicine.

Remember: 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.

If you have not given to the IAFP PAC, please 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.

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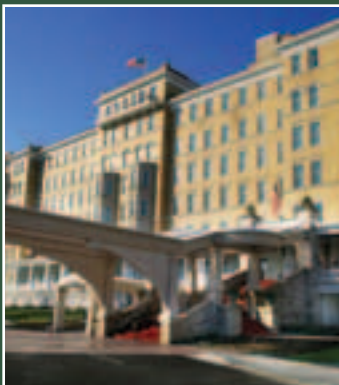
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# Join Us This Summer for the 2010 IAFP Annual Convention!

The 2010 IAFP Annual Convention will be held in French Lick, Indiana, from Thursday, July 22, to Sunday, July 25, 2010. Last year, our new, shorter schedule was a great success, so this year, we are planning a similar program, which allows 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.



*Growth for Family Medicine*



*Join us this summer for:*

- More than 20 AAFP Prescribed CME credits: top-quality Evidence-Based CME taught by family medicine faculty members from across the nation
- Congress of Delegates: have a voice in Academy policy
- Town Hall Meeting bringing together key health care leaders
- Exhibit Show
- The beautiful surroundings of the historic French Lick Hotel and Conference Center





French Lick's lush landscaping

## Bring the Whole Family

### Youth Activities

The IAFP Annual Meeting creates a great opportunity for your children to make new friends that they can reconnect with each year and for you to enjoy valuable family time. Children and teens will enjoy the French Lick Hotel's many recreational activities, such as an indoor and outdoor swimming pool, bowling alley, Wii games and a whole host of hotel-organized entertainments, such as Kid Arts, My Movies, Hey Dude Ranch, Hoosier Safari and a *High School Musical* Party.

### Spouse/Guest Activities

Activities for adults at the French Lick Hotel include two pools, a spa, a fitness center, golf courses and other recreational activities (more at [www.frenchlick.com](http://www.frenchlick.com)). Your spouse will also enjoy the President's Banquet/Family Party.

## Special Events

### Annual President's Banquet, Award Ceremony & Installation of Officers, Followed by All Member Family Party – Saturday, July 24

We have again combined our President's Awards Banquet and our All Member Party into one exciting event for the whole family. The banquet honors our incoming and outgoing president and our 2010 IAFP Family Physician of the Year. A special dinner is offered simultaneously for children. At 8:30 p.m. children may join their parents for a

dessert buffet and dancing, with entertainment by the Marlins. Purchase tickets on the registration form.

## Don't Miss:

### All-Member Congress of Delegates

The IAFP will hold its All-Member Congress of Delegates on July 23 and 24. All members are invited and encouraged to attend the Congress, because every IAFP member is a delegate, and every participant will have a vote and voice at the Congress. The Academy looks forward to each and every member's participation in this year's Congress of Delegates.

### Fellowship and Networking Opportunities

Meet colleagues from around the state, and visit with old friends.

### Exhibit Show

Call on them! Visit the Exhibit Show to learn about the newest clinical advances, practice management tips and services.

### Town Hall Meeting

This year, we're bringing together key leaders from Indiana health care to discuss issues that affect family physicians each and every day! More information coming soon.

## General Information

### Register Early

The French Lick Hotel sells out early — take time TODAY to plan your attendance!

- Register online (<https://www.mtgs-etc.com/registration/inafp/inafp16/inafp16.asp>)
- Download a registration form ([http://www.inafp.org/files/public/2010\\_IAFP\\_Annual\\_Meeting\\_Registration\\_Form.pdf](http://www.inafp.org/files/public/2010_IAFP_Annual_Meeting_Registration_Form.pdf)) and fax to 317.237.4006
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### Special Needs

Please complete the box on the registration form if you require special accommodations or have specific dietary needs.

### Location and Hotel

The completely renovated French Lick Hotel in southern Indiana offers a swimming pool and fitness room, golf courses, a spa and endless recreational opportunities. **Call 888.694.4332 to reserve your room at a rate of \$169 (Tuesday through Friday) and \$199 (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.

View our condensed schedule and some CME topics on the following pages. More information will be available soon.

# Preliminary IAFP Annual Convention Schedule with CME Topics for Each Day

## THURSDAY, JULY 22

8 a.m.-7 p.m.

Registration Open

9 a.m.-2 p.m.

Special Pre-Assembly Diabetes Workshop, free for all IAFP members and their clinical staff. Visit [www.talkingdiabetescme.com](http://www.talkingdiabetescme.com) for more info or call your Academy at 317.237.4237.

2:30-4 p.m.

Executive Committee

4-6:30 p.m.

Board of Directors

7-10 p.m.

Board/VIP Dinner

## FRIDAY, JULY 23

7:30 a.m.-3:30 p.m.

CME sessions (breakfast break available and continuous refreshment break available all day with extensive light fare and beverages)

10 a.m.-3 p.m.

Exhibits Open

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

Lunch

5-6:30 p.m.

Town Hall Dinner

6:30 p.m.

First Session,  
Congress of Delegates



"The Mansion" at the Pete Dye Golf Course

7:30 p.m.

Reference Committees

9 p.m.

AfterGlow

### Friday's CME Topics Will Include:

#### AAFP Chapter Lecture Series: The Overactive Bladder – Omar Hamada, MD

##### Learning Objectives:

Upon completion of this activity, the participant will be able to:

- Evaluate overactive bladder in a patient and determine the appropriate course of treatment
- Create an action plan for an elderly patient who may present with overactive bladder
- Counsel a patient with overactive bladder on how to cope with the disorder and/or modify behavioral risks (smoking, drinking, poor diet, lack of exercise) that may exacerbate the condition

This activity is supported by an educational grant to the AAFP from Astellas and Pfizer.

#### Reducing Cardiovascular Risk – John Komari, MD

#### Eat What You Love, Love What You Eat: Helping Your Patients Break Their Eat-Repent-Repeat Cycle – Michelle May, MD

Dr. Michelle May is a mindful eating expert and author who writes, speaks and teaches about ending senseless yo-yo dieting and resolving mindless and emotional eating. She has been interviewed for *Body+Soul*, CNN Health, Discovery Health Channel, *Fitness*, Fox News Radio, *Glamour*, Oprah and Friends Radio with Dr. Oz, *Parade*, *Parents*, *Self*, time.com, *USA Weekend*, *US News & World Report*, *Vim & Vigor*, *The Washington Post*, *WebMD*, *Weight Watchers*, *Woman's Day*, *Woman's World* and many more. Dr. May is an expert in mindful eating, yo-yo dieting, emotional eating, intuitive eating, nutrition, fitness and healthy lifestyles.

##### Learning Objectives:

Upon completion of this activity, the participant will be able to understand:

- The bio-psycho-social drivers of eating important for the development of products and consumer messages
- How to effectively engage consumers to make sustainable healthy lifestyle choices
- Strategies for communicating messages to patients that promote mindful eating and fearless enjoyment of food

#### Strategies to Address Prescription Drug Misuse and Abuse

This activity focuses on addressing the issues that arise from prescription drug abuse. Each year, millions of patients are treated for a variety of serious medical conditions with prescription drugs whose therapeutic benefits are accompanied by psychoactive effects. Recent indicators reveal that the misuse and abuse of prescription drugs are rising, and we are faced with the challenge of minimizing the potential for misuse without impeding patients' access to needed medical care. About 70 percent of Americans — approximately 191 million people — visit a health care provider, such as a primary care physician, at least once every two years. Thus, health care providers are in a unique position not only to prescribe needed medications in an optimal fashion but also to encourage patients to use their medications appropriately, to identify problems as they arise and to help patients recognize their problems and adopt strategies to address them.

#### What's New About Medicaid Managed Care?

## SATURDAY, JULY 24

7 a.m.

Second Session, Congress of Delegates (breakfast break available and continuous refreshment break available all day with extensive light fare and beverages)

8 a.m.-12:30 p.m.

Exhibits Open

8:45 a.m.-4:20 p.m.

CME sessions

11:30 a.m.-12:30 p.m.

Lunch in Exhibit Hall

6 p.m.

Reception

6:30 p.m.

President's Reception and Special Recognition of New AAFP Fellows



6:30 p.m.  
Dinner Party for Children Ages 3-11

7 p.m.  
President's Awards Banquet & Installation of Officers

8:30 p.m.  
Children Join Parents for Dessert Buffet and Dancing

#### **Saturday's CME Topics Will Include:**

##### **The New Horizon of Stroke Care – Robert Flint, MD** **Learning Objectives:**

Upon completion of this activity:

- The participant will be able to describe the advantages of telemedicine in the management of acute stroke
- The participant will be able to become involved in systems of stroke care in association with a hospital and emergency medical system
- The participant will be able to discuss the experimental treatments in development for the prevention and acute intervention of stroke
- The participant will be able to consider the use of the latest developments in the rehabilitation of patients with stroke

##### **Dyslipidemia Management –**

##### **Five Issues to Consider Before You Treat – Louis Kuritzky, MD**

Dyslipidemia is an increasingly common medical problem seen in primary care patients both with coronary heart disease (CHD) and those without CHD. It is more than just LDL-C, as it includes HDL-C and triglycerides. However, according to a survey by the NLA (National Lipid Association), only 51 percent of all physicians reported being "familiar" with total cholesterol recommendations and correctly identified the desirable levels for LDL-C, HDL-C and TGs. Alarming, 23 percent were unfamiliar with the cholesterol guidelines altogether. Hence, patients with dyslipidemia are being undertreated and are forfeiting the significant risk reduction benefits inherent with appropriate treatment.

##### **Learning Objectives:**

Upon completion of this activity, the participant will be able to:

- List the NCEP ATP lipid goals for patients at various levels of CV risk
- Stratify cardiovascular risk factors with respect to dyslipidemia to identify and determine appropriate lipid management strategies
- Assess the efficacy and safety of current therapies for dyslipidemia

- Discuss the side effect profiles and drug interaction potential for the various statin therapies
- Improve patient communication to convey the significance of achieving lipid goals to all patients

##### **AAFP Chapter Lecture Series: Using Reminder and Recall Systems to Improve Adolescent Immunization Rates – Ted Ganiats, MD**

##### **Learning Objectives:**

Upon completion of this activity, the participant will be able to:

- Identify barriers to immunizations among adolescents
- Recognize the importance of reviewing immunization records at each visit, including illness or sports injuries
- Construct an effective approach for increasing adolescent immunization rates in practice through the use of reminder and recall systems

This activity is supported by an educational grant to the AAFP from Merck and Co.

##### **Travel Medicine 101 – Maurice Henein, MD**

##### **Learning Objectives:**

Upon completion of this activity, the participant will:

- Be able to identify required/recommended vaccines for travel
- Be comfortable with routine health advice for travel
- Be aware of other resources your patient can access if you do not provide all travel medicine services

##### **Common Pediatric Sports Injuries – Todd W. Arnold, MD**

##### **Learning Objectives:**

Upon completion of this activity, the participant will be able to:

- Identify common pediatric injuries related to sports and feel comfortable treating them
- Recognize the importance of previous injury and how it impacts future injury

## **SUNDAY, JULY 25**

7:30-10 a.m.

CME Breakfast/Session: **Cutaneous Infections and Infestations – Patricia Treadwell, MD**

10 a.m.

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# New CDC Report Highlights Tobacco Control Progress in Indiana

## *State Hits Historic Low in Adult Smoking Rate*

Long-awaited results from the Centers for Disease Control and Prevention (CDC) were released this spring, showing a highly significant downward trend in adult smoking rates in Indiana between 2001 and 2009.

State health officials report newly finalized 2009 Behavior Risk Factor Surveillance Program (BRFSS) data show the smoking rate for Hoosier adults dropped from 26 percent in 2008 to 23.1 percent in 2009.

Although the change between 2008 and 2009 is not considered statistically significant, the new adult smoking prevalence is the lowest adult smoking rate since the BRFSS began gathering data on Hoosiers. The Indiana Tobacco Prevention & Cessation Agency (ITPC) became operational in 2002.

The report, entitled *Tobacco Control State Highlights 2010*, outlines several key measures of tobacco control programs, including smoking prevalence, cigarette excise tax rates, smoke-free air laws and counter-marketing media campaigns. The report is based on 2008 data, so does not include the recently finalized 2009 BRFSS data. **Studies show when states concentrate on a combination of high-impact, proven strategies — particularly smoke-free laws and higher cigarette prices — tobacco use can be cut substantially. The price of cigarettes in Indiana was increased in 2007. Since then, cigarette consumption has dropped nearly 25 percent.**

Karla Sneegas, executive director, ITPC, said the new 2009 adult smoking rate validates the hard work of the state's tobacco control program and the progress achieved by its local and state partners committed to ending tobacco use.

"Seeing this decrease in adult smoking, especially during a time of economic hardship, is very promising," Sneegas said. "ITPC's community-based commitment to policy change in Hoosier communities, together with our outreach directly to smokers through the Indiana Tobacco Quitline, are high-impact strategies that are delivering results."

Nationally, smoking rates have stalled. In the 1990s, the nation experienced significant declines in smoking rates among adults and youth, but those declines have stalled since 2004.

CDC's State Highlights report uses consistent state-specific data to measure tobacco control progress in all 50 states and the District of Columbia and allows states to compare their efforts. The report is designed to address the public health impact of smoking and draw attention to the concentrated emphasis needed to end the tobacco use epidemic.

**According to CDC Director Thomas R. Frieden, MD, MPH, "Smoke-free laws, hard-hitting ads and higher cigarette prices are among our strongest weapons in this fight against tobacco use. We must redouble efforts to bring down smoking rates, prevent suffering and premature death and cut health care costs by reducing smoking."**

Sneegas said that the key to making further progress is tied to Indiana's need to implement these strategies, as outlined by the CDC, including protecting all workers from secondhand smoke and providing the free services of the Indiana Tobacco Quitline to every smoker who is ready to quit. The Academy continues to prioritize these efforts as key legislative initiatives each year.

An attempt was made to dismantle ITPC and move the remnants to the Indiana State Department of Health during the recent legislative session. Local, state and national partners in tobacco control were successful in saving the Agency in 2010 and remain poised to protect it so that life- and dollar-saving measures will continue long into the future. ITPC is funded entirely by funds from the 1997 Tobacco Master Settlement Agreement.

Family physicians are encouraged to refer tobacco users who are ready to quit to the Indiana Tobacco Quitline (800.QUIT.NOW). Those who participate in the Fax Referral system can request that the Quitline call patients at a time that is convenient for them — taking the responsibility to make that initial contact off of the patient. For more information on Indiana's tobacco control program, please visit: [www.itpc.in.gov](http://www.itpc.in.gov). For an online version of the *Tobacco Control State Highlights 2010*, visit CDC's Office and Smoking and Health at [www.cdc.gov/tobacco](http://www.cdc.gov/tobacco).



# UNPRECEDENTED PARTICIPATI

On Friday, March 19, 2010, family medicine residents, faculty members and IAFP members from across the state joined us for the popular Annual Residents' Day/ Research Forum at the Hyatt Regency in Indianapolis, Indiana. This year, we had an unprecedented response to our call for abstracts, with more than 20 abstracts submitted. Our extended schedule was moderated by **Amy LaHood, MD**, of Indianapolis, and our judges were **Ray Nicholson, MD**, of Evansville; **Debbie Allen, MD**, of Indianapolis; and **Ashraf Hanna, MD**, of Fort Wayne, who is your Academy's current president.

Thank you to the members of our Committee on Residents' Day: **Carrie Anderson, MD; John Fleming, MD; Amy LaHood, MD; and Curt Ward, MD.**

Thanks also to **Debbie Allen, MD**, and **Shaun Grannis, MD**, who presented an informative review of recent major family medicine research projects that have been conducted at the Indiana University School of Medicine.

We hope to continue this event in future years with such fantastic numbers of abstracts! Stay tuned for information on submitting your abstract for our 2011 Residents' Day!

## PRIZE WINNERS

### ORIGINAL RESEARCH



**First Place: Tracey Guildenbecher, MD, St. Vincent FMR, Indianapolis**  
*Use of ACE-Is, ARBs and Statins in Women of Childbearing Potential*



**Second Place: Jason Everman, DO, St. Vincent FMR, Indianapolis**  
*Raising Osteopathic Awareness in an Allopathic Residency*



**Third Place (tie): Cynthia Ebini, MD, Indiana University FMR, Indianapolis**  
*Sweet Success or Lost in Translation???*



**Third Place (tie): Christine Kelly-Shock, MD, St. Vincent FMR, Indianapolis**  
*Comparison of Rates and Duration of Breastfeeding in Mothers at the St. Vincent Joshua Max Simon Primary Care Center to National Averages and Assessment of Factors That Influence Their Decisions on Feeding*

# ON in the 2010 IAFP Residents' Day/Research Forum

**Also Chosen to Present an Original Research Presentation:**  
**Samson Barasa, MD, Union Hospital FMR, Terre Haute**  
*Did You Know How Weather Seasons Affect the No Shows at Your Clinic?*

## PERFORMANCE IMPROVEMENT

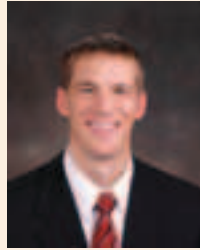


**First Place: Christopher C. Cuevas, MD, PharmD, St. Vincent FMR, Indianapolis**  
*Improving COPD Care at the St. Vincent Primary Care Center*



**Second Place: Jonathan Walters, MD, Deaconess FMR, Evansville**  
*Group Visit Strategies*

## POSTERS



**First Place: Michael J. Sanderson, MD, St. Joseph Regional Medical Center FMR, South Bend**  
*Improving Diabetic Management Through Group Meetings*



**Second Place: Jason Everman, DO, St. Vincent FMR, Indianapolis**  
*I Think I Had a Seizure*



**Third Place: Raymond P. Smith, MD, St. Vincent FMR, Indianapolis**  
*Three Weeks of Weakness*

**Also Chosen to Present a Poster Presentation:**  
**Christopher C. Cuevas, MD, PharmD, St. Vincent FMR, Indianapolis**  
*TRALI – An Unfortunate Complication of a Relatively Routine Treatment*

**Sofy Y. Sendoya, MD, Indiana University FMR, Indianapolis**  
*Too Much of a Good Thing*

## CASE PRESENTATIONS



**First Place: EmmaLeigh M. Smith, MD, Memorial Hospital of South Bend FMR, South Bend**  
*Cannabinoid Hyperemesis Syndrome*



**Second Place: Christopher C. Cuevas, MD, PharmD, St. Vincent FMR, Indianapolis**  
*A Common Presentation of an Uncommon Lesion*



**Third Place (tie): Stacy Majoras, ATC, DO, St. Joseph Regional Medical Center FMR, South Bend**  
*Lemierre's Syndrome: From One Jugular to Another*



**Third Place (tie): Bradley J. Haupricht Jr., MD, Ball Memorial FMR, Muncie**  
*When Exercise Goes Too Far*

**Also Chosen to Present a Case Presentation:**  
**Jieyu Lowery, MD, Fort Wayne Medical Education Program, Fort Wayne**  
*Take Another Look at Pneumothorax*

**Matthew B. Main, MD, Community Health Network FMR, Indianapolis**  
*Hyperemesis Gravidarum – Diagnosis At Large*

**Luis Felipe Romero, MD, Indiana University FMR, Indianapolis**  
*Favorable Outcomes in an Unusual Case of Right-Atrium Angiosarcoma in a Young Male*

**Cezary Wojcik, MD, PhD, Deaconess FMR, Evansville**  
*Rubinstein-Taybi Syndrome Associated with Chiari Type I Malformation Caused by a Large 16p13.3 Microdeletion: A Contiguous Gene Syndrome?*



# Report from the AAFP Board of Directors

by Tom Felger, MD

As I am about halfway through my term as an AAFP director, I thought I'd share some thoughts about the AAFP and recent Academy actions. I am still very honored to serve at this level. As I have shared with some of you, it has been more work than I expected but also more fun. I am particularly excited to have been part of the recent Academy efforts in the health reform process. What an amazing time to be involved.

I am sure that some of you reading this are not excited about all of the Academy's positions in the reform discussion and actions that were taken. Certainly, in an organization our size, it is impossible to please all of our members. The need for health care reform has been recognized by family physicians for many years. The policies that the AAFP has operated under during the reform process were created and modified by our Congress of Delegates as far back as the late '80s.

I think that even with a flawed bill finally through Congress, the Academy succeeded in most of its goals. Who would have thought just a year ago that our national leaders, media and public would now recognize that strong primary care is the foundation for a successful health care system AND that family physicians deserve to be paid more? It is, to me, simply amazing that such a complete awareness of our value and the inequities of our payment system are now well-known.

As I mentioned above, the act is flawed, but it does have specific benefits for our patients and members. I suspect there will be several years involved in "fixing" many parts of the act. There are two parts of the act that will help family physicians directly. A 10 percent bonus payment for primary care in Medicare is mandated, and, at a future date, state Medicaid payments will be equal to Medicare payment, which, in Indiana, at least, is a major improvement. We all have seen our patients either not get care or skip medications due to having no health insurance coverage. There will be about 30 million more of our patients covered as the process evolves.

Your Academy leadership and the Washington staff were very much players at the table. At times, they were not excited about how the process worked, but many calls were made by Congress and the White House to the AAFP for our advice on various parts of the bill and asking for our support. Our three presidents, Drs. Heim, Goertz and Epperly, were all at White House functions representing family medicine. I was even asked to attend a White House rally in Ohio shortly before the bill finally passed. Time will tell if the reform that passed will lead to the less-expensive and better-quality care that we all want for our patients.

A pleasant piece of news to share is that our efforts at the RUC and with CMS in recent years have been partially successful. Medicare fees for our two most frequent codes, 99213 and 99214, went up 31 percent and 25 percent respectively from 2006 to 2010. Not enough, but progress.



Another issue that the Board dealt with in 2009 and 2010 was the creation of a Consumer Alliance program for the AAFP. Some of you may remember that the AAFP recently — about three years ago — faced a major financial crisis that resulted in major budget cuts and changing some operational parts of the AAFP. The crisis had two origins. One was the major shift in pharmaceutical advertising and support of CME. This is now about \$10 million per year less than several years ago. The second was a decision by leadership to fund significant advocacy efforts for our members and patients. As mentioned above, this has been largely successful.

As part of exploring ways to preserve as much Academy services as possible, the Board created the Consumer Alliance Program. This involves formal agreements with corporations to use Academy resources for access to information about their products. This is done using the Academy-owned familydoctor.org Web site. The AAFP retains all control of the information published. Safeguards have been built into the process to ensure accurate information is put out to the public.

Unfortunately, the first Alliance partner was the Coca-Cola Company. The agreement specifically excluded the traditional red can of Coke, but even so, a number of our members reacted to the aura of Coke and not the reality of our complete control of the published material and the fact that the Academy will be paid for our help in distributing their information. Since their material has appeared on familydoctor.org, there have been no complaints of biased or untrue content. There will likely be other alliances in the future, and, hopefully, they will be better received than the Coke alliance has been. Ultimately, we should be able to preserve our programming without having to resort to a major dues increase.

I hope this information helps you understand a portion of what the AAFP is doing now. Feel free to ask me about any AAFP concern you have.

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# The Name of the Game Is the Claim

## Part 2: The Gap in Term Disability Plans

by Mark D. Mousty, President, Benefits Corporation of Indiana

*Editor's note: Please see the Spring 2010 issue of FrontLine Physician for Part 1 of this article.*



As a physician, you have invested time, energy and money pursuing a lifelong dream — to practice in the field of medicine. Your lifestyle now reflects the income you have been earning as a physician, and your family is enjoying the benefits of what your skills, efforts and education can provide. **But what will you do if you become disabled and cannot perform the duties of your specialty?**

**In part 1, we discussed** the fact that most physicians purchase individual disability insurance (IDI) early in their careers, but most IDI policies are limited to providing just a small percentage of what physicians earn monthly — typically only \$10,000 to \$15,000. **As income increases, a “gap” may exist between a physician’s income and the income the IDI policy replaces.**

The answer to why someone needs disability insurance is this — **when you get sick or hurt and cannot work (and earn an income), your DI policy is the best financial alternative available.**

**Once you understand that a DI policy is the best financial alternative to pay your bills,** the next question is about the policy itself. Many want to know what they should look for in a DI policy. My reply to this is simply: **“The name of the game is the claim.”** That is, you should buy the policy that has the best chance of paying you at claim time. So what factors go into this “claim-paying ability”? I look at four key factors — (1) the **reputation** of the carrier, (2) the **experience** that carrier has in the DI marketplace, and (3) the **financial stability** of the carrier, which were discussed in Part 1.

### Part 2: The Gap in Long-Term Disability Plans

**Contract Language** – this might be the most important factor of all. You want to look for a contract that gives you the best chance of getting paid. Unlike many other types of insurance, there are a few phrases and words that can mean the difference between

a claim being paid or not being paid. More specifically, we want to look at three key components. They are: **(1) Definition of Disability, (2) Definition of Earnings and (3) Residual or Partial Disability and Benefit Periods.**

*Definition of Disability* — the best contract to buy is one that insures the specific duties of a specialty or sub-specialty. These go beyond the basic “own occupation” contract, which usually state that “you will be considered disabled if you cannot do the material and substantial duties of your own occupation, and/or have a loss of income (usually 20 percent or greater).” Specialty/sub-specialty language states that “you will be covered if you cannot do the specific duties of your specialty/sub-specialty.” A great example would be a radiologist who also does injections — an “own occupation” contract might cover him/her as a “medical doctor,” and a specialty contract might cover him/her as a “radiologist”; but a sub-specialty contract would insure him/her as a “radiologist who handles injections.” If this doctor cannot do injections anymore due to a sickness or injury, that is considered a material duty and would be covered. The other contracts may not pay if it is determined that this doctor can do the material and substantial duties of a medical doctor or even a radiologist.

*Definition of Earnings* — look in the contract and see how earnings are defined. Some contracts will only insure W-2 earnings paid by the employer but do not cover any bonuses, commissions, production formulas or K1 earnings if he/she is a partner. Obviously, the best language is that which covers any and all compensation paid to the employee. This is especially important for occupations such as doctors or attorneys, who

are normally not strictly salaried employees but make money based on patients or clients seen.

*Residual Payments* — how does the contract define partial disability, and how are earnings considered in determining the benefit level? Also, look at what formula is used when calculating the residual benefit. Many carriers only consider one type of formula (such as offsetting the LTD benefit by 50 percent of the earnings earned after returning to work), but a better scenario would be to look for language that

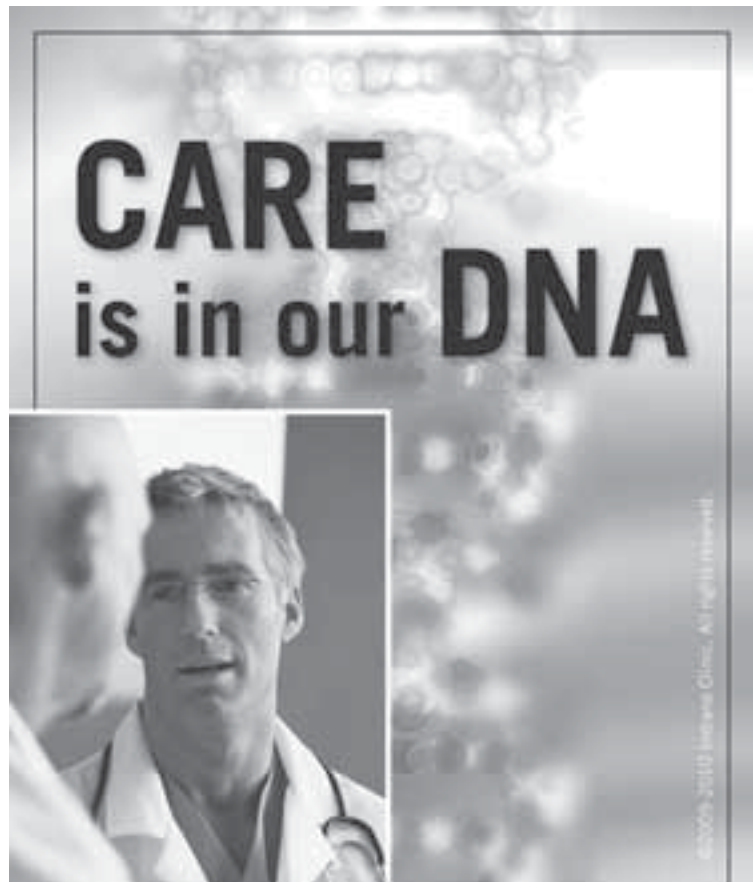


considers the best of two formulas (the 50 percent offset or a proportionate loss formula).

*Benefit Period* — if you have an older DI policy that has an age-65 benefit period and were born after 1937, you may have a gap in coverage. This is due to Social Security Full Retirement Age rules and is a reason you should review your DI policy.

The common factor in all of the above points is this — **there are phrases and language that will either help you get paid at claim time or hinder that claim payment.** That is why I counsel people looking for the “best” disability income policy to consider buying the one that gives them the best chance of getting paid. The name of the game is the claim. You may notice that I have not yet mentioned price (or premium). The reason for that should be evident — the better the contract language, the more it will probably cost. But that shouldn’t be a major factor when choosing the best disability income policy. This is definitely an area where buying the bargain doesn’t work. No disability income policy is a bargain if it won’t pay at claim time.

The name of **this** game is the claim!



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# DOMESTIC VIOLENCE AND PREGNANCY

## Consequences and Intervention Strategies for Family Physicians

by Caitlin Finnegan Priest, MPH, Director of Special  
Projects & Public Policy, Indiana Perinatal Network

### Domestic Violence 101

Domestic violence is a pattern of assaultive and coercive behaviors that may include physical injury, psychological abuse, sexual assault, isolation, intimidation and threats. These behaviors are aimed at establishing control by one partner over the other (Family Violence Prevention Fund, 2004). In addition to injuries resulting from assault, sequelae of abuse can include chronic pain, intestinal disorders, depression, substance abuse, sexually transmitted diseases and unwanted pregnancies.

### Abuse During Pregnancy

According to the CDC, violence during pregnancy is as common as gestational diabetes or preeclampsia. Abuse prior to and during pregnancy heightens risk for poor outcomes including high blood pressure, vaginal bleeding, severe nausea, vomiting, or dehydration, kidney or urinary tract infections, preterm or low-birthweight delivery and delivering an infant requiring NICU care.

A review of Indiana maternal death records from 2002 to 2005 reveals that homicide accounted for just over 16 percent of deaths to pregnant and postpartum women — a figure that may under-represent the actual burden of abuse on maternal mortality in Indiana.

National data show that young women, African-American women and women with late or no prenatal care are at the highest risk for pregnancy-associated homicide.

### The Role of the Family Physician

Health care providers, technicians and office staff members play a critical role in intervention, prevention and access to resources for patients experiencing abuse. The physician's office may be one of the only places where a victim can speak freely without her abuser being present. In its policy statement on violence and abuse, the American Academy of Family Physicians urges members to "be alert for risk factors as well as signs of family violence with each patient encounter; [and] be capable of providing an appropriate response when these issues are identified."

### Identifying and Screening for Abuse

Myriad warning signs alert the clinician to the presence or history of abuse, including behavioral indicators, such as withdrawal or depression, or injuries in-

consistent with narrative. Record review may reveal a history of non-adherence to care plans or poor control of chronic medical conditions. The presence or history of obstetric complications — notably any injuries during pregnancy, especially to the abdomen or breasts — should raise red flags.

### Why Routine Screening?

Routine screening is recommended instead of the less sensitive and less efficient “indicator-based” approach. Routine screening acknowledges the high prevalence of intimate partner violence in health care settings and provides opportunities for education and prevention.

### When Should I Screen?

Many guidelines recommend that screening should occur during gynecological, family planning and preconception visits. Pregnant patients should be screened throughout the course of the pregnancy, including at the first prenatal visit, at least once per trimester and at the postpartum checkup.

### How Should I Screen?

When screening for abuse, the provider should:

1. Ensure privacy and safety
2. Frame the inquiry as common and routine
3. Ask respectfully and non-judgmentally
4. Use open-ended and direct questions

## Responding to Abuse...

### What If She Says No?

If the patient does not acknowledge abuse but you continue to suspect it, offer information including referrals and



phone numbers, encourage her to return if she has any problems, and document the history and physical in her chart.

### ...And What If She Says Yes?

When a patient discloses abuse, especially when pregnant, it is critical to assess immediate safety needs — including current danger, whether the violence is escalating, the presence of weapons in the home, the type and extent of injuries and any connection between the abuse and current health issues.

The provider should listen, communicate concern and emphasize that the patient is not to blame for the abuse. Asking and providing information about domestic violence sends invaluable messages to the patient, who may be harboring feelings of shame and guilt or who may believe her experience is normal, her fault or not important. Connecting her to resources

— including shelter, counseling, or legal assistance — reinforces that she is not alone, that help is available and that she and her child deserve to live free from violence and fear.

### For More Information

Further information, including patient and provider educational tools, is available from the Family Violence Prevention Fund at [www.endabuse.org](http://www.endabuse.org). For local resources, visit the Indiana Coalition against Domestic Violence at [www.violenceresource.org](http://www.violenceresource.org).

### About the Indiana Perinatal Network

*The mission of the Indiana Perinatal Network is to lead Indiana to improve the health of all mothers and babies. IPN provides resources for mothers and families, offers the latest information to health care providers and promotes sound public policies. IPN has a proven ability to bring together diverse disciplines and organizations to reach consensus on complex issues affecting the health of Indiana's mothers and babies. For materials, resources and membership information, visit [www.indianaperinatal.org](http://www.indianaperinatal.org).*

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# Uterine Fibroid Embolization (UFE)

by Karen Ehrman, MD, FSIR



Fibroids are the most common type of benign tumor of the uterus, occurring in 20 percent to 50 percent of the total female population. These tumors can cause many problems — most commonly, heavy menstrual bleeding, pelvic pain or bulk-type symptoms (pelvic/bladder pressure, frequent urination during day or night, constipation, abdominal bloating or backaches).

For most women with symptoms, the standard treatment has been hysterectomy or myomectomy. Fortunately, with the advancement of medicine, there are other options. One such option is embolization of uterine fibroids or UFE. This treatment helps shrink the fibroids and is a non-surgical, less-invasive procedure that is performed by an interventional radiologist.

UFE has been used for years to treat severe postpartum hemorrhage, and interventional radiologists have begun using UFE to treat fibroids. The procedure is less invasive than surgery and can be used for multiple fibroids. “Basically, a small catheter is threaded into the arteries that supply the flow of blood to the fibroid,” says Dr. Karen Ehrman. “UFE cuts off the blood supply to the fibroid and causes it to shrink.” She says that the procedure preserves the uterus, has a lower complication rate and a faster recovery time than a hysterectomy and has high success and patient satisfaction rates.

Most women with symptomatic fibroids are candidates for UFE and should obtain a consultation with an interventional radiologist to determine whether UFE is a treatment possibility for them. Uterine fibroid embolization may be a good treatment option for women who choose not to receive blood transfusions

or who have other serious health conditions which make surgical procedures exceptionally dangerous.

## BENEFITS OF UFE

- 80 percent to 90 percent of patients are satisfied with improvement or complete relief of symptoms
- Growth of new fibroids or re-growth of embolized fibroids is rare
- There is minimal blood loss and therefore no need for blood transfusions
- All the fibroids may be treated during a single embolization procedure

## UFE PROCEDURE

Uterine fibroid embolization (UFE) is 80 percent to 90 percent effective in reducing the symptoms caused by fibroids. Some patients' symptoms go away completely.

Following a detailed pre-procedure consultation, an MRI (magnetic resonance imaging) is performed to determine more accurately the location and size of the fibroids. The MRI will also look at how much blood flow is getting to the fibroids and check the surrounding structures of the pelvis. Once the pre-procedure consultation and MRI results are known, the UFE procedure may be scheduled if this is the treatment option chosen to relieve the fibroid symptoms.

Uterine fibroid embolization involves blocking off the blood supply to the fibroid(s) by blocking off abnormal blood vessels stemming from the uterine arteries.

- The procedure is done with conscious sedation. The femoral artery is punctured after local anesthetic is given.
- The interventional radiologist guides the catheter through the arteries. Once the tip of the catheter is in the uterine artery, an agent is injected into the uterine artery, blocking off the abnormal blood vessels that supply blood flow to the





fibroid(s). The fibroid(s) then undergo involution and volume reduction. The procedure usually takes about one hour.

- When the procedure is over, the catheter is removed and pressure is applied to the femoral artery puncture site for approximately 20 minutes to stop any bleeding. A bandage is then applied. There are no stitches.
- Patients are observed overnight in the hospital. Patients are discharged the next morning with specific, pre-printed instructions for recovery at home. Time is spent with each patient before discharge, reviewing the instructions and answering questions.

## **EXPECTED OUTCOMES**

Following the embolization, patients should be able to return to their usual activities in approximately seven to 10 days. There is an approximate 40 percent to 60 percent shrinkage of all present fibroids over the course of a year. There is a noticeable decrease in fibroid symptoms in about four to nine weeks.

## **FREQUENTLY ASKED QUESTIONS ABOUT UFE**

### **What are the particles used to block the blood supply to the uterine fibroid made of?**

The particles are made of trisacryl gelatin (Embosphere® Microspheres). Particle substances are medical-grade material and FDA-approved for embolization of vascular tumors. There is no silicone in embospheres. The FDA has approved biosphere embospheres specifically for use in the treatment of uterine fibroids.

### **Could the particles travel to another part of the body?**

During the procedure, the particles are precisely injected into the vessel(s) (uterine arteries and/or ovarian arteries) that provide blood flow to the fibroids. Once in place, they stay put because the blood immediately clots in the small arteries, trapping the particles. The particles remain in place as the fibroids shrink and do not break free.

### **Does the procedure ever have to be done more than one time?**

The UFE procedure provides treatment of all the fibroids present in the uterus at one time. The uterine arteries supply 99 percent of all blood flow to the fibroids. By embolizing the uterine arteries, all of the fibroids are treated during a single procedure.

In a small number of women, the procedure may be performed more than one time due to continued blood flow to the fibroids after the initial UFE procedure. Typically, if there is another source of blood flow supplying the fibroids, it can be identified and treated during the initial UFE procedure.

### **Will the procedure work if there is one fibroid or multiple fibroids?**

Yes, UFE is successful with treating one or multiple fibroids. If the right and left uterine arteries are embolized, 99 percent of the blood flow to the fibroids is blocked. Once the blood supply to the fibroids is blocked, the fibroids can shrink up to 40 percent to 60 percent. If each fibroid shrinks approximately 40 percent to 60 percent, regardless of the number, there should be a significant reduction of symptoms.

### **Will the fibroids grow back?**

Embolizing the uterine arteries stops the blood supply to all of the fibroids present in the uterus. Once this blood supply is occluded, new fibroids typically do not grow. All of the fibroids may shrink about 40 percent to 60 percent after the procedure. Although the fibroids will always be present, they become small enough to relieve symptoms. Typically, after the fibroids shrink, they do not grow larger at a later date.

### **What is the chance of entering menopause after UFE?**

For women over 45 years of age, the incidence of entering menopause increases to about 2 percent to 10 percent after UFE. In addition, if the fibroids are receiving blood flow from the ovarian arteries and these blood vessels are embolized, the chance of entering menopause after the procedure is slightly increased.

### **Who does pre-certification?**

Typically, the referring physician will fill out a referral/request for consultation form and pre-certify the patient for an initial consult with an interventional radiologist. During the consultation, the interventional radiologist will determine if the patient is a candidate for UFE based on clinical symptoms and medical history. Then, a pelvic MRI will be performed to determine if the woman is a good candidate, based on the size, location and vascularity (blood flow) to the fibroids. Once the results of the MRI are known, the UFE procedure will be scheduled (if indicated).

### **What are the risks?**

- Less than 1 percent uterine infection (infection of the uterus). Typically treated with antibiotics. There have been a few cases of severe uterine infection reported in the United States. These resulted in additional medical treatment.
- Less than 1 percent non-target embolization. Embolization (blocking the blood flow) of tissue other than fibroid tissue. Most common area of non-target embolization is tissue of the uterus. This occurrence may be mild and not require further treatment. However, it could be serious and result in additional medical treatment. There have been a few cases of non-target embolization reported in the United States.
- Less than 2 percent hysterectomy related to a complication from the UFE procedure. Most common reasons for hysterectomy are uncontrolled uterine infection and non-target embolization of the uterus.
- 2 percent-10 percent menopause following the procedure (typically women over 45 years of age)
- Less than 5 percent hematoma. This typically does not require further medical treatment.
- A reaction to the contrast dye used during the procedure to help visualize the arteries. This is a rare occurrence.

*Dr. Ehrman is an interventional radiologist who sees patients at Community Hospital East and Community Hospital North in Indianapolis.*



# ALL PHYSICIANS

## Update on Supplier Claims Processing for Ordering/Referring Providers

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

Although enrolled in Medicare, many physicians and nonphysician practitioners who are eligible to order items or services or refer Medicare beneficiaries to other Medicare providers or suppliers for services do not have current enrollment records in Medicare.

A current enrollment record is one that is in the Medicare Provider Enrollment Chain and Ownership System (PECOS) and contains the National Provider Identifier (NPI). Beginning January 3, 2011, a physician or nonphysician practitioner who orders any Medicare-covered durable medical equipment, prosthetic, orthotic or supply that does not have a current enrollment record will cause the claim submitted by the Part B provider/supplier to be rejected.

CMS continues to urge **physicians** and **nonphysician practitioners** who are enrolled in Medicare but **who have not updated** their Medicare enrollment record since November 2003 to update their enrollment record now. These physicians and nonphysician practitioners **need to submit an initial enrollment application**, which will establish a current enrollment record in PECOS.

### Fee-for-Service Provider Enrollment Reporting Responsibilities for Individual Physicians Enrolled in the Medicare Program Reportable Physician Changes

After enrolling in the Medicare program, all physicians are responsible for maintaining and reporting changes in their Medicare enrollment information to their designated Medicare contractor. By reporting changes as soon as possible, physicians will help to ensure that their claims are processed correctly.

The reportable events listed below may affect claims processing, a payment amount or a physician's eligibility

to participate in the Medicare program. Physicians are required to report the following reportable events as soon as possible, but no later than 30 days after the reportable event.

- Change in Practice Location occurs when a physician establishes a new practice location, moves an existing practice location, closes an existing practice location or changes any portion of an existing practice location address where Medicare information is sent.
- Change in Final Adverse Action occurs when a physician is debarred or excluded by any federal or state health care program, has his or her medical license suspended or revoked by a state licensing authority, was convicted of a felony within the last 10 years, has his or her Medicare billing privileges revoked by a Medicare contractor or has a revocation or suspension by an accreditation organization.
- Change of Business Structure occurs when a physician changes his or her business structure (e.g., sole proprietorship to sole incorporated owner or vice versa).
- Change in Organization Legal Business Name/Tax Identification Num-

ber occurs when a business owner changes the organization's legal business name and/or Taxpayer Identification Number with the Internal Revenue Service.

- Change in Practice Status occurs when a physician decides to retire or voluntarily withdraw from the Medicare program. This type of change is referred to as a voluntary withdrawal.

#### Other Reportable Changes Include

- Change in Reassignment of Benefits occurs when a physician adds or voluntarily withdraws his or her reassignment of Medicare benefits. Physicians must report this type of change on the CMS-855R.
- Change in Banking Arrangements or any Payment Information occurs when a physician changes his or her bank or bank account or makes other payment information changes. This type of change should be reported immediately to the Medicare contractor. A physician can update his or her electronic funds transfer information by submitting the Electronic Funds Transfer Authorization Agreement (CMS-588) to his or her Medicare contractor.

#### Additional Information

Physicians can apply for enrollment in the Medicare Program or make a change in their enrollment information using either:

- The Internet-based Provider Enrollment, Chain and Ownership System (PECOS)
- The paper enrollment application process (e.g., CMS-855I)

There are three basic steps to completing an enrollment action using Internet-based PECOS. Physicians and non-physician practitioners must:

- 1) Have a National Plan and Provider Enumeration System (NPPES) User ID and password to use Internet-based PECOS.
  - For security reasons, passwords should be changed periodically, at least once a year.
  - For information on how to change a password, go to the NPPES Application Help page available at <https://nppes.cms.hhs.gov/NPPES/Welcome.do> and select the "Reset Password Page" on the NPPES Application Help page.
- 2) Go to PECOS at <https://pecos.cms.hhs.gov> to complete, review and sub-

mit the electronic enrollment application via PECOS.

- 3) Print, sign and date the two-page Certification Statement and mail it with all supporting paper documentation to the Medicare contractor within seven days of the electronic submission.

NOTE: A Medicare contractor will not process an Internet enrollment application without the signed and dated two-page Certification Statement and the required supporting documentation. In addition, the effective date of filing an enrollment application is the date the Medicare contractor receives the signed two-page Certification Statement that is associated with the Internet submission.

Physicians who are enrolled in the Medicare Program but have not submitted the CMS-855I since 2003 are required to submit a Medicare enrollment application (i.e., Internet-based PECOS or the CMS-855I) as an initial application when reporting a change for the first time.

If a physician has any questions about reporting a change, the physician should contact his or her designated Medicare contractor in advance of submitting the CMS-855I.

For additional information regarding the Medicare enrollment process, including Internet-based PECOS, go to <http://www.cms.hhs.gov/MedicareProviderSupEnroll> on the CMS Web site.

#### Medical Policy Update: Tetanus Immunization – Medical Policy Article (A49710)

<http://www.ngsmedicare.com/content.aspx?CatID=2&DOCID=21490>

Tetanus is a neurologic syndrome caused by a neurotoxin elaborated at the site of injury by *Clostridium tetani*. Nearly all cases of tetanus occur in non-immunized or inadequately immunized individuals. Available evidence indicates that complete primary vaccination with tetanus toxoid provides long-lasting protection — 10 years for most recipients. To maintain adequate protection, a booster dose every 10 years is recommended. Consequently, after complete primary tetanus vaccination, boosters, even for wound management, need to be given only every 10 years when wounds are minor and uncontaminated. For other wounds, a booster is appropriate if the

patient has not received tetanus toxoid within the preceding five years (MMWR 40: No. RR-10, 1991).

Immunizations are generally excluded from coverage under Medicare unless they are directly related to the treatment of an injury or direct exposure to a disease or condition. In the absence of injury or direct exposure, preventive immunization is not covered. This medical policy coverage article documents National Government Services' coverage and coding guidelines for the administration of tetanus toxoids.

#### Indiana Physicians/Non-Physician Practitioners Who Bill Part B Medicare for CPT 99310 – Subsequent Nursing Facility Care

<http://www.ngsmedicare.com/Content.aspx?CatID=2&DOCID=21819>

National Government Services is initiating a service-specific **prepayment review** for CPT 99310, subsequent nursing facility care. Previous medical review audit findings revealed that documentation did not support the level of service billed to Medicare.





Based on the findings of these reviews, most errors occurred because the services were billed at a higher level than was substantiated by the documentation.

According to the *CPT Manual*, *CPT* 99310 is representative of subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least two of these three components:

- A comprehensive interval history
- A comprehensive examination
- Medical decision-making of high complexity

The patient may be unstable or may have developed a significant new problem requiring immediate physician attention.

Physicians typically spend 35 minutes with the patient and/or family or caregiver.

The *CMS Medicare Claims Processing Manual*, Chapter 12, §30.6.1, states: "... the medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level

of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a level of service is billed. Documentation should support the level of service reported. Providers should select the code for the service based upon the content of the service."

Providers will receive an additional development request (ADR) letter detailing the specific documentation being requested for the billed services. You must respond within 30 days with the requested documentation. Providers who fail to furnish the requested supporting medical documentation timely will receive a full claim denial. The original ADR letter must be included with the documentation.

## Timely Filing Requirements for Medicare Fee-for-Service Claims

Sometimes things just aren't fair! As part of the *Patient Protection and Affordable Care Act* (PPACA) that President Obama signed into law on March 23, 2010, the time period for filing Medicare fee-for-

service (FFS) claims has been changed. This is one of many provisions we will be identifying during the next several months that are aimed at curbing fraud, waste and abuse in the Medicare Program.

Currently, to be considered "timely," claims with dates of service October 1, 2008, through September 30, 2009, have to be filed by December 31, 2010. If the date of service is greater than one year from the date filed, the provider incurs a 10 percent reduction in payment, which cannot be passed on to the patient.

Under the new law, claims for services furnished on or after January 1, 2010, must be filed within one calendar year after the date of service. The law also mandates that claims for services furnished prior to January 1, 2010, must be filed no later than December 31, 2010. The new timely filing periods are as follows:

- Claims with dates of service October 1, 2009, through December 31, 2009, must be submitted by December 31, 2010.
- Claims with dates of service on or after January 1, 2010, must be filed within one year from the date of service.

The secretary of Health and Human Services is permitted to make certain exceptions to the one-year filing deadline; however, no exceptions have been established at this time.

This change will require closer identification of Medicare Secondary claims. Your staff needs to carefully question patients about any accident to determine if any liability or no-fault insurance is applicable.

Also, at each encounter, be sure your staff questions all patients about their existing insurance coverage. Contact the local Medicare contractor or the Medicare Coordination of Benefits (COB) Contractor when in doubt whether a commercial insurance plan is primary to the patient's Medicare coverage.

The COB Contractor's Customer Call Center's toll free number is 800.999.1118 or TDD/TTY 800.318.8782. Customer service representatives are available from 8 a.m. to 8 p.m., Monday through Friday, Eastern time, except holidays.



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