



INDIANA ACADEMY OF
FAMILY PHYSICIANS

Quarterly Publication for Indiana's Family Physicians

Winter 2011

FRONTLINE

PHYSICIAN

Plan Now to Serve as
Physician of the Day
PG 9

Indiana AFP Values Opportunity
to Serve Alongside State Legislators
PG 10

Marian University College of
Osteopathic Medicine
PG 13

Coding and Billing Update
PG 18

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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.

Advocacy

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

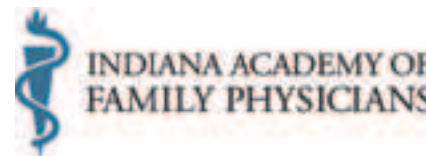
Membership

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

Education

We aim to be the provider of choice for family physician education in Indiana

**Family Medicine: Exceptional
Physicians, Exceptional Care**



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Contents



Features

Indiana AFP Values Opportunity to Serve Alongside State Legislators.....	10
Marian University College of Osteopathic Medicine	13

Extras

Plan Now to Serve as Physician of the Day.....	9
Managing Chronic Joint Pain	14
IAFP Awards: Call for Nominations	16
Call for Nominations for 2012 IAFP Officers	17



In Every Issue

President's Message	8
Mark Your Calendar.....	9
Coding and Billing Update	18



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Deanna Willis, MD

Welcome to the Winter *FrontLine*!

Fall 2011 brought great attendance at our Annual Fall Continuing Medical Education (CME) conference! Self-Assessment Module (SAM) sessions to help members achieve their Maintenance of Certification process were particularly well attended, and we are excitedly looking to offer even more opportunities for SAM sessions at our future CME events!

The Indiana Academy of Family Physicians was recently asked by the American Academy of Family Physicians (AAFP) to be the featured chapter for *AAFP News Now*. Our Physician of the Day program at the Indiana State Legislature was the focus of the *AAFP News Now* article, with many of our members featured in text and photos as part of the article. The program allows us to support our state legislators by working to keep them healthy and productive for their important work during the legislative sessions. Supporting them in this way provides them with a unique view of the role and importance of family physicians. Showcasing our program nationally has created some exciting conversations about the great work we are doing.

The IAFP Annual Convention heads to Indianapolis this year. Mark your calendars to bring your family and enjoy the sites and activities that downtown Indianapolis has to offer. The JW Marriott hotel is within walking distance to the Indianapolis Zoo, the Eiteljorg Museum, the Indianapolis Indians ballpark, the Canal and Circle Center Mall, to name a few. With our Congress of Delegates being open to all members, we look forward to having you join our business session, where we make decisions that have a powerful impact on the practice of family medicine in Indiana. This is a great opportunity to let your voice be heard and help guide the work of our Academy.

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Mark Your Calendar

2012 IAFP Spring SAMs and CME

Friday, March 9-Saturday, March 10, 2012
Medical Academic Center, Carmel

2012 IAFP Annual Convention

July 26-29, 2012
JW Marriott Hotel, Indianapolis

AAFP Events

National Conference of Special Constituencies (NCSC)

May 3-5
Hyatt Regency Crown Center
Kansas City, Missouri

Annual Leadership Forum (ALF)

May 3-5
Hyatt Regency Crown Center
Kansas City, Missouri

National Conference of Family Medicine Residents and Medical Students

July 26-28
Bartle Hall
Kansas City, Missouri

Scientific Assembly

October 17-20
Pennsylvania Convention Center
Philadelphia, Pennsylvania



Plan **Now** to Serve as Physician of the Day in 2012

Interested in politics?
There is a reason many of
our Physicians of the Day
serve year after year, be-
cause serving as the Phy-
sician of the Day puts you
in the heart of the action
at the Indiana Statehouse.

The Indiana Academy of Family Phy-
sicians and the Indiana State Medical
Association will once again sponsor
the Physician of the Day program at

the 2012 General Assembly. Your as-
sistance is needed! This interesting and
fun program allows you to observe the
legislative process firsthand, meet with
your state legislators and leave a great
impression about family medicine on
the General Assembly.

IAFP members can volunteer to spend
one or more days at the Statehouse
during the legislative session. As the
Physician of the Day, you will provide
episodic primary care services for the
legislators and their staffs during the
time the state legislature is in session.
On days when the full House and Sen-

ate are in session, the Physician of the
Day is introduced on the floor of both
houses. Your day at the Statehouse will
last from 8:30 a.m. to 4:30 p.m.

We are currently still scheduling physician
volunteers for the months of January and
March 2012. If you are interested in serv-
ing 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 day. THANK YOU!

Indiana AFP Values Opportunity to Serve *Family Physicians Volunteer for Physician of the Day*

STORY HIGHLIGHTS

- The Indiana Academy of Family Physicians operates a long-standing initiative called the Physician of the Day program.
- A partnership between the Indiana AFP and the Indiana State Medical Association ensures that a physician is on call in the Statehouse every day of each legislative session.
- Physicians take care of immediate health needs of legislators and other statehouse staff members, and they get to see the political process at work.

Why would a busy family physician put in a 14-hour day to serve as physician of the day for the Indiana Statehouse? Ask Indiana AFP Board Chair Jason Marker, M.D., of Wyatt, who volunteers for his chapter's Physician of the Day program several times every year. On those legislature duty days, Marker's alarm rings at 5 a.m. because his journey begins with a three-and-a-half-hour drive south to Indianapolis.

"I am physician of the day for six hours, make the trip back and arrive home around 7 p.m.," said Marker. "The cost to me to do this is the cost of not seeing patients for a day," which averages about \$1,000 in lost income. But in Marker's view, it's time well spent.

Every year, the Indiana AFP, in a partnership with the Indiana State Medical Association, recruits physician volunteers to staff the Indiana Statehouse each day the General Assembly is in session.

"Immeasurable and invaluable." That's how Indiana AFP President Deanna Willis, M.D., of Indianapolis, describes the chapter's Physician of the Day program — an initiative so successful that its run exceeds 35 years.

"One of the reasons the Physician of the Day program is so important is that we're able to demonstrate to the legislature that we value their activity, and we support them in a general way," said Willis. "That creates positive synergy."

"I would say that the biggest value of the program is that it helps make sure that our legislators are in the statehouse doing their jobs; they're not spending the day driving back to their home community to see their doctor about a cold," said Marker.

"You want your legislators working, whether they're making decisions you like or decisions you don't like," he added. And it's also good for doctors to be down in the statehouse "understanding how the laws are made that affect how we practice medicine."

According to Willis, the program opens up lines of communication and builds relationships between legislators and the Indiana AFP.

She said those connections — further enhanced by the chapter's yearly legislative breakfast during which legislators have a chance to visit with family physician constituents in an informal setting — can make a real difference when it comes to lawmaking that supports family medicine.

For the upcoming 2012 session, the Indiana AFP will ensure that a family physician is on call in the statehouse every Monday through Thursday in January and March; February falls to the Indiana State Medical Association. Each of the state's 10 family medicine residency programs is given two days to fill during the session. Third-year residents can serve alone; first- and second-year residents can attend with a faculty member.

The Day's Agenda

The physician of the day reports for duty around 8:30 a.m. and sees patients in a small cinderblock office on the lower level of the statehouse. The room is modestly equipped with an exam table, a small desk, a log book, Internet access and a cabinet stocked with OTC medications. There is no receptionist.

Physicians bring their own stethoscope and prescription pad. Their instructions are to provide first aid, acute care and emergency services to elected officials and other statehouse staff members as needed and until further medical support is available. Physicians carry a pager so they are not tied to the medical office.

Only a handful of life-threatening emergencies have arisen in years past. One legislator suffered a stroke, and another, while on duty at the statehouse, developed sepsis after a prostate biopsy. At least two lawmakers have suffered heart attacks while on the floor of the Indiana House of Representatives.

Indiana Chapter Counts Legislative Wins

Indiana AFP President Deanna Willis, M.D., of Indianapolis, said the chapter's visible and healthy relationship with the state legis-

Alongside State Legislators

Program

lature pays dividends when it comes to chapter members' efforts to advocate issues important family physicians and their patients.

In 2010, for example, a scope-of-practice bill was introduced in the legislature that would have required physicians to be granted hospital privileges to do surgical procedures.

"This bill would have had a substantial impact on our rural members, who often do surgical procedures in the office because they don't have a local hospital," said Willis. The chapter's advocacy efforts prevailed, and the bill did not pass.

Meredith Edwards, the Indiana AFP's director of legislative and regional affairs, ticked off other legislative priorities of the chapter that succeeded — albeit with collaboration from other organizations. In the 2011 legislative session, the Indiana AFP saw the

- preservation of \$1.9 million in family medicine residency funding in the state budget at a time when all state agencies incurred a 15 percent cut;
- passage of an amendment to allow residents to sign death certificates;
- clarification of a physician assistant law and the easing of burdens on primary care physicians without an expansion of scope of practice; and
- halt of an expansion of scope of practice for physical therapists in the state who had lobbied hard for the right to see patients without a physician referral.

Although the Indiana AFP's legislative efforts encompass much more than the Physician of the Day program or the annual legislative breakfast, Edwards said keeping the face of family medicine in front of legislators via the Physician of the Day Program most certainly has played a part.

Family physicians who serve as physician of the day generally say it's easier than a day at their office, where they often juggle a daily deluge of complicated chronic care patients. Instead, the environment at the statehouse is more akin to a retail health clinic setting, where patients present with such complaints as coughs and colds, a sore elbow, or a bout with poison ivy.

An added bonus of the program is that patients who do not indicate a primary care physician for follow-up care are provided with names of family physicians for referral.

"It's a good medical opportunity, a good political opportunity and a neat experience," said Marker, who's looking forward in 2012 to expanding the reach of the program to medical students.

"They're going to have their first exposure to the politics of medicine, and at least in my case, they're going to be trapped in the car with me for six hours if I want to talk to them about the importance of



family medicine," joked Marker. "This could be a nice easy intro for them and a key to enhancing the pipeline workforce issues that [family medicine has]."

A Resident's Eye-Opening Experience

Timothy O'Donnell, M.D., of Plainfield, is a family physician in his first year of practice. He accompanied his family medicine residency director to the statehouse during his first year of residency as a way to fulfill the residency program's community service requirement. He volunteered again during his second and third years.

O'Donnell said he'd never given much thought to the political process before that first experience. "Realizing how much impact policymaking has on public health was eye-opening and a little concerning too, because not many of the legislators are involved in health care, so they don't always understand what they're voting on," said O'Donnell.

The family medicine resident saw firsthand how the political process worked; he observed legislative floor debates and lobbyists scrambling in the hallways to schedule meetings with legislators. Once he gets established in his new practice, O'Donnell said he



Clif Knight, MD, serves as Physician of the Day

Tom Felger, MD, engaged in a discussion with Senator Tom Wyss (R) and Representative Win Moses (D), both of Fort Wayne, while serving as Physician of the Day in 2008.

intends to re-involve himself in the political side of medicine. The Physician of the Day program “opened up my awareness to the role of politics and how that impacts overall patient care. I do need to be involved, and I understand that now more than ever,” he said.

Legislator Praises Program

Indiana State Rep. F. Dale Grubb has been in the Indiana legislature for 23 years. Having served as both a majority and a minority caucus chair, Grubb said he’s had some responsibility for oversight of the Physician of the Day program. “I assure you that every elected person, and staff people, too, are very appreciative of them being there,” said Grubb.

“Most of us live somewhere else in the state and have no personal physician to take care of us in Indianapolis,” he said, noting that sometimes a legislator’s day begins at 7 a.m. and isn’t over until midnight. “It can be pretty consuming, and it’s very convenient for members to have a physician close by when we have those lengthy days.”

Having physicians from around the state visit the statehouse also gives legislators a chance to hear a practicing physician’s perspective on pending health care legislation, said Grubb.

Richard Feldman, M.D., is the director of medical education and residency training at Franciscan St. Francis Health in Indianapolis. Feldman was responsible for O’Donnell’s first Statehouse experience. He’s also Grubb’s personal physician, even though Grubb’s hometown of Covington is more than 80 miles northwest of Indianapolis.

Feldman counts at least three other state legislators among his patients, and those relationships were born and cemented as a result of Feldman’s many stints over the years as physician of the day.

“The whole experience is such a powerful public relations tool for the Academy because the legislators truly appreciate our help and our presence there,” said Feldman, who also served as the Indiana state health commissioner for four years.

“We create relationships, appreciation and a lot of good will,” said Feldman. And that means when family physicians go to the statehouse to testify about a public health issue, like tobacco or immunizations or patients without insurance, legislators are more willing to listen.

Game-Changing Conversations

Each morning of the legislative session, the physician of the day is introduced in the House and the Senate, and when the physician is not tending to a patient, he or she is free to observe the work of the legislature.

Physicians on volunteer duty are asked to refrain from lobbying legislators or testifying in any official capacity. But they are free to mingle with legislators, and sometimes, those back-of-the-room conversations have resulted in positive changes in legislation.

Clif Knight, M.D., of Indianapolis, another regular on the volunteer list, served as physician of the day last spring and recalled a bill related to supervision of physician assistants that was discussed during the final week of the 2011 legislative session.

“I was there as those discussions were going on, and I had a chance to speak with one of our senators who was helping to shepherd that bill and give her my opinion and advice on how to make that a better bill,” said Knight. “I believe that the final wording was adopted as it went through,” he added.

“I think our Academy is highly regarded by our legislature,” said Knight. “We’re not knocking on their door about 30 bills every year; we’re very selective about what we prioritize and what has the greatest impact on patient care and our members.”

Chapter President Willis put it this way: “I think we’ve really set the stage for some amazing work at the Statehouse.”

Originally published in AAFP News Now, October 26, 2011. © American Academy of Family Physicians.

Marian University College of Osteopathic Medicine

by Paul Evans, DO, Vice President and Founding Dean

The state's newest medical school continues to progress. Our groundbreaking ceremony was held on August 24, 2011. Michael A. Evans, president and CEO of AIT Labs in Indianapolis, generously gave \$48 million to start the new College of Osteopathic Medicine and build our new home at Marian University. The new building, named the Michael A. Evans Center for Health Sciences in his honor, will house the medical school and the School of Nursing. This high-tech facility will feature energy-efficient construction, a simulation center for both standardized and simulated patient scenarios and many 21st-century educational technology features. The new COM will start a class of 150 osteopathic students in August 2013.

Presently, the college is on track to receive provisional accreditation from the AOA Commission on Osteopathic College Accreditation (COCA) and the North Central Higher Learning Commission (HLC). If standards are met as we expect, this will occur in July 2012. Recruiting activities are planned to start soon for students, faculty members and staff members to be hired in early 2013. Applications should begin in summer 2012 and interviews in the fall of that year. Full accreditation should be awarded upon graduation of our first class of DOs in 2017.

The MU-COM clinical training network is growing, with many hospitals in the state supporting our new clinical teaching mission for clerkship students. Hospitals in Indianapolis and around the state have been enthusiastic and gen-

erous in supporting the first new medical school in Indiana in more than a century. We are also working to expand graduate medical education opportunities for those who will enter residency training starting in 2017. This is being done directly with hospitals in the state; additionally, Marian is an academic partner with the Michigan State University COM in the Statewide Campus System. MSU-COM is assisting in a regional effort to increase residency slots with us.

I will keep the IAFP informed of our growth and development. Our goal is to train new physicians, many of them family doctors, for the state of Indiana. The need is great. We hope to be an important part of improving the care of Hoosiers in a strong partnership with the academy in the years ahead.



A digital image of the new College of Osteopathic Medicine, currently under construction



Paul Evans, DO, FAAFP, FACOFP, vice president and dean of the Marian University College of Osteopathic Medicine; and Anita Siccardi, EdD, APRN, BC, professor and dean of the School of Nursing, at the groundbreaking ceremony for the new college





Managing Chronic Joint Pain

Addressing the Challenges in the PCP Setting

by Keith Berend, MD, Joint Implant Surgeons, Inc., New Albany, Ohio

As physicians, we are required to navigate an increasingly challenging and ever-changing health care environment. Regardless of practice area or geographic location, we find ourselves delicately balancing between the delivery of optimal patient care and expanding administrative responsibilities. As implementation of health care reform moves forward, an influx of newly insured patients has the potential to stress every aspect of our health care system. While physician shortages in the coming years are predicted across a variety of clinical specialties, primary care practitioners will be hit the hardest as they see an expanding, aging population with an array of chronic comorbid conditions.

Primary care practitioners are in the unenviable position of being on the front lines for diagnosis and treatment for many of these conditions and for recognizing the need and appropriate time to refer a patient to a specialist. This requires a breadth and depth of expertise that can be challenging to cultivate, achieve and maintain given the demands on our time.

These challenges have been brought to light in two peer-reviewed publications — one in the *Journal of General Internal Medicine* and the other in the *Journal of the American Geriatrics Society*. The first study, conducted by three primary care physicians, Ang, Thomas and Kroenke, examined primary care physicians' recommendations for treating specific patients with osteoarthritis.¹ The 149 physicians who participated in the study were provided 10 patient scenarios where they were to determine the best course of treatment — surgical or non-surgical — and also were tested on their awareness of total joint replacement success rates. Overall, 79 percent of the physicians responded correctly when surgery was the best course of treatment, as determined by a panel of experts for the paper, and 77 percent for non-surgical approaches. Interestingly, though, 83 percent of respondents underestimated the ≥ 90 percent success rate of total joint replacement surgery. The authors concluded that there is a need for CME programming on orthopedics in the primary care setting.

The second article by Schonberg, et al., examined patient perceptions of physician discussions and recommendations regarding total joint replacement.² The authors surveyed 174 patients age 65 and above with severe hip or knee osteoarthritis not controlled

by medication about their in-office discussions in the primary care setting and with an orthopedic specialist. While 87 percent reported discussing their arthritis with their primary care physician, only 26 percent indicated that total joint replacement was brought up as a treatment option. These individuals were more likely to undergo surgery than those who did not discuss it as a treatment. In fact, only 23 percent of patients whose doctor did not recommend joint replacement ended up having joint-replacement surgery.

The results of these studies paint a picture of potential unmet need in the dialogue on chronic joint pain, specifically as it relates to patient-provider communication about surgical treatment options. This highlights the possibility that patients who are appropriate candidates for surgery and who could achieve a significant improvement in quality of life from it may be living with severe chronic joint pain for far longer than necessary. Furthermore, I see a significant increase in the utilization of long-term narcotics prescribed by primary care physicians for the treatment of chronic joint pain. In many of these patient scenarios, total joint replacement offers a more definitive and reliable treatment method to improve quality of life.

Decades of clinical studies demonstrate the benefits of joint replacement surgery for certain individuals, including a decrease in pain, an increase in mobility and an overall better quality of life. Of course, surgery should only be considered after conservative treatments have failed, since, like any invasive procedure, it is not without risks. However, it is vitally important that patients have the opportunity to understand the risk-benefit equation of joint-replacement surgery so they can make a fully informed decision regarding treatment.

I have learned through my patients that some individuals may be hesitant to ask their primary care provider about joint replacement as a result of perceptions regarding the procedure. As a result, patients may live in considerable pain, resulting in a more sedentary lifestyle that could exacerbate chronic comorbid conditions, including obesity, high cholesterol, high blood pressure and diabetes. Unfortunately, this can lead to an inextricable cycle for the patient, with comorbid conditions contributing to increased joint pain but also limiting the degree to which joint replacement surgery is an option. And, as much as we all have heard the

messages promoting movement, for people with advanced degenerative joint disease, movement may simply not be an option.

In general, I tell each patient that the decision to move forward with joint replacement surgery is based upon his or her quality of life. When the conservative measures have failed to provide adequate relief and the pain and dysfunction of joint disease is preventing the patient from enjoying his or her activities of daily living, inhibiting his or her ability to work and/or affecting his or her sleep patterns; the time may be near.

In my experience, the more informed a patient is about the procedure, the more willing he or she might be to exploring the option further. Unfortunately, this puts the onus on the often over-extended primary care team to provide that education. To the extent possible, it is useful to provide a broad overview of what a patient should expect before and after the surgery. A good tool to help in this discussion can be found on the IAFP website under Education & Practice Management (<http://www.in-afp.org/education-practice-management/education-practice-management/>). Furthermore, it is the role of the orthopedist to provide rapid access to an office consultation for the primary care physician and his or her patients.

Given the complexity of managing patients with severe osteoarthritis and comorbid conditions, a fair question is at what point to refer a patient to an orthopedic specialist patients so that the patient is physically and mentally ready for surgery, should he or she choose to pursue that option.

Researchers based in the United Kingdom sought to answer that question, and their findings were published in *Family Practice* in September 2010.³ Musila, Underwood and colleagues convened a guidelines development group consisting of patients, general practitioners, orthopedic surgeons and other health care professionals with the objective of developing a consensus approach to patient referral. They were tasked with rating the appropriateness of referral in 108 scenarios.

Consensus was difficult to achieve in many scenarios. However, two scenarios were clear: do not refer a patient with mild or moderate knee symptoms who does not want to be referred, but do refer a patient with severe symptoms who wants to be referred. This leaves a large gray area — what about the patients with severe arthritis who don't have a preference for referral? The group could not reach a consensus. Respecting a patient's wishes is very important, but for those patients who are unsure or ambivalent, it is helpful to educate them fully on the options and at least explore alternative options that may ease their suffering.

As we look to the changes ahead in the health care environment, I envision greater emphasis on consistent referral practices not only for orthopedics, but other specialty areas as well. I believe that primary care professional associations, like the Indiana Academy of Family Physicians and their local and national counterparts, will continue to explore this as an area of educational focus for their members. Through such efforts, primary care physicians will have the tools and resources necessary to efficiently and effectively provide outstanding care.

1. Ang DC, Thomas K, Kroenke K. An exploratory study of primary care physician decision making regarding total joint arthroplasty. *J Gen Intern Med.* 2007 Jan;22(1):74-9.
2. Schonberg MA, Marcantonio ER, Hamel MB. Perceptions of physician recommendations for joint replacement surgery in older patients with severe hip or knee osteoarthritis. *J Am Geriatr Soc.* 2009 Jan;57(1):82-8. Epub 2008 Nov 21.
3. Musila N, Underwood M, et al. Referral recommendations for osteoarthritis of the knee incorporating patients' preferences. *Fam Pract.* 2011 Feb;28(1):68-74. Epub 2010 Sep 3.



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The Degree of Fellow was established in 1971 by the AAFP Congress of Delegates as a way to recognize AAFP members who have distinguished themselves among their colleagues, and in their communities, by their service to family medicine, the advancement of health care to the American people and professional development through medical education and research.

The Degree of Fellow will be conferred during the President's Banquet at the IAFP Annual Convention, on Saturday evening, July 21, in Indianapolis. Those wishing to receive their Degree of Fellow at that time should have their application submitted to the AAFP no later than Friday, May 25, 2012.

To be awarded the Degree of Fellow, one must have been an AAFP member (Resident and/or Active) for six years, and must accrue 100 points from any of the sections as described below.

Lifelong Learning (65 points possible)

Board certification and recertification; certificates of added qualifications; additional degrees and fellowships; CME meetings and activities; and current certifications

Practice/Quality Improvement (80 points possible)

Practice in underserved areas; military deployment; services provided outside regular office practice; obstetrical care and special procedures; performance improvement activities in office; service as medical chief of staff or department chair; service on board or committee of hospital, system, HMO, etc.; leadership positions held in practice; TransforMED or Patient-Centered Medical Home participation, incorporation of METRIC into practice or program

Volunteer Teaching

(114 points possible)

Lecturing at AAFP and state chapter meetings, as well as meetings such as RAP, STFM, AFMRD, ADFM and NAPCRG; volunteer teaching at a FM residency program; volunteer precepting or mentoring for medical students and/or residents; teaching METRIC in a residency program; volunteer lectures for students and/or residents;

service as chair of or advisor to a chapter student interest committee or student interest group; instruction of a national certification program (i.e., ALSO, ATLS, PALS, ACLS)

Public Service (82 points possible)

Charitable medical services and humanitarian missions; government/community services in an elected or appointed office; public relations activities that explain the specialty; health education outside of the office; community nonprofit awards; leadership in community, voluntary or religious organizations; volunteer medical services

Publishing and Research (95 points possible)

Published research or articles and non-published research presented at an AAFP-sponsored function; service on an editorial board; contributions to chapters of a medical book; participation in research, practice-based or as part of a group

Service to the Specialty (93 points possible)

Serving as a legislative Key Contact; presenting legislative testimony; participation as Physician of the Day; service as committee chair, officer or delegate/alternate in another medical organization; service as IAFP or AAFP president or officer, board member, commission chair or committee member; service as board member of IAFP PAC or Foundation Board of Trustees; family medicine awards given by IAFP or another FM organization; participation in AAFP non-clinical education; Speak Out participation

For more information, visit: <http://www.aafp.org/online/en/home/membership/fellowship/fellow.html>.



Call for Nominations for 2012 IAFP Officers



The IAFP's 2011-2012 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 21 and 22 in Indianapolis. 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 22.

Offices to be filled for 2012-2013 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 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 2012 IAFP officers is Thursday, March 9, 2012. If you have questions, please contact Kevin Speer or Deeda Ferree at 317.237.4237.

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Coding and Billing Update

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

2012 CPT Changes Affecting Family Practice Physicians

We recently returned from the American Medical Association's (AMA) CPT and RBRVS 2012 Annual Symposium. This article details some of the coding changes affecting family physicians; however, all physicians should review the 2012 CPT for additional changes not discussed in this article. All CPT codes and modifiers are copyright 2011 American Medical Association.

Revised Definition of New and Established Patient

In an attempt to provide clarification for physicians and qualified licensed health care professionals' (nonphysician providers) decisions regarding new versus established patients, the AMA changed the definitions. CPT 2012 includes the following language:

*Solely for the purposes of distinguishing between new and established patients, professional services are those face-to-face services rendered by a physician and reported by a specific CPT code(s). A new patient is one who has not received any professional services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice within the past three years.*

*An established patient is one who has received professional services from the physician or another physician of the **exact** same specialty **and subspecialty** who belongs to the same group practice within the past three years.*

The AMA panel was asked whether the definition of a "subspecialty" should be based on taxonomy codes or on the CMS provider specialty listing included in Chapter 26 §10.8.2 of the *Medicare Claims Processing Manual*. Taxonomy codes are provider self-designated, and additional specialties are recognized and have tax-

onomy codes that are not necessarily recognized by third-party payers or state medical boards as a subspecialty.

When applying for a National Provider Identifier (NPI) from the National Plan and Provider Enumeration System (NPPES), a health care provider must select the Healthcare Provider Taxonomy Code or code description that the health care provider determines most closely describes the health care provider's type/classification/specialization and report that code or code description in the NPI application. In some situations, a health care provider might need to report more than one Healthcare Provider Taxonomy Code or code description in order to adequately describe the type/classification/specialization. Therefore, a health care provider may select more than one Healthcare Provider Taxonomy Code or code description when applying for an NPI but must indicate one of them as the primary.

The NPPES does not verify with the health care providers or with trusted sources that the Healthcare Provider Taxonomy Code or code description selections made by health care providers when applying for NPIs are accurate (e.g., the NPPES does not verify that an individual who reports a Physician Code is, in fact, a physician or a physician with the reported specialization). The NPPES does, however, validate that the Code and code description selections exist within the current version of the Healthcare Provider Taxonomy Code Set.

The Healthcare Provider Taxonomy Codes and code descriptions that health care providers select when applying for NPIs may or may not be the same as the categorizations used by Medicare and other health plans in their enrollment and credentialing activities. The Healthcare Provider Taxonomy Code or code description information collected by NPPES is used to help uniquely identify health care providers in order to assign them NPIs, not to ensure that they are credentialed or qualified to render health care.

This distinction is important to physicians practicing in a multispecialty group. Based on the discussions as well as clarification from the Part A/B Medicare Administrative Contractor, the "subspecialty" designation used by CMS will continue to be their Provider Specialty Code list, which requires board certification for most specialties and subspecialties. Since other payers may have their own list that may or may not be easily identified, at this time, we recommend using the CMS listing for all payers unless the payer's enrollment application states otherwise.

Initial Observation Care

The AMA added typical times to the initial observation care codes 99218-99220, which allows physicians to report the appropriate level of care based on time. Remember, when the level of care is based on time, more than 50 percent of the physician/nonphysician practitioner's total time must be spent in counseling and/or coordination of care.

When coding by time, the physician must document the total face-to-face time in the office/other outpatient setting or the total floor/unit time in the hospital or nursing facility settings. The amount of time spent in counseling/coordination of care must be documented. Most payers do not accept phrases like "more than 50 percent ..." or "> 50 percent..." These payers want to see the total number of minutes as well as the number of minutes spent in counseling/coordination of care. Finally, the physician must document a synopsis of the counseling and/or activities to coordinate care to support selecting the level of care based on time.

Prolonged Services

The AMA changed the introductory language for prolonged service with direct and indirect patient contact in CPT 2012. In addition to the physician-specific reference, the introductions now include "or other qualified health care professional."

This addition clearly indicates that, when appropriate, licensed nonphysician providers can report these codes.

The prolonged service codes with direct patient contact no longer include the phrase “face-to-face,” and the codes may now be used in the observation setting.

Although *CPT* may no longer require face-to-face time as a prerequisite for reporting the prolonged service codes that require direct patient contact, that is not true for reporting the codes to Medicare. At the time this article was written, CMS’ instructions for using prolonged service codes remain the same. As noted in the *Medicare Claims Processing Manual*, Chapter 12, §30.6.15.1 — Prolonged Services with Direct Face-to-Face Patient Contact Service (Codes 99354-99357):

Physicians may count only the duration of direct face-to-face contact between the physician and the patient (whether the service was continuous or not) beyond the typical/average time of the visit code billed to determine whether prolonged services can be billed and to determine the prolonged services codes that are allowable.

- *In the case of prolonged office services, time spent by office staff with the patient, or time the patient remains unaccompanied in the office cannot be billed.*
- *In the case of prolonged hospital services, time spent reviewing charts or discussion of a patient with house medical staff and not with direct face-to-face contact with the patient, or waiting for test results, for changes in the patient’s condition, for end of a therapy, or for use of facilities cannot be billed as prolonged services.*

Immunization Administration for Vaccines/Toxoids

The introductory language has been updated to clarify that that conjugates and adjuvants are not considered a “component” of a vaccine when reporting codes 90460 and 90461. The new language also clarifies that multivalent antigens or multiple serotypes of antigens against a single organism are considered a single component of a vaccine.

For example, pneumococcal vaccine has up to 23 antigens but is a single-disease vaccine and should not be considered as a combination vaccine. Influenza has multiple sub-types but is fundamentally a single-disease vaccine.

The AMA wanted to clear any confusion in code 90644: tetanus toxoid as a conjugate vs. tetanus vaccine. The following changes were made to the description of code 90644: meningococcal conjugate vaccine, serogroups C & Y and Hemophilus influenza b vaccine, ~~tetanus toxoid-conjugate~~ (Hib-MenCY-TT), 4 dose schedule, when administered to children 2-15 months of age, for intramuscular use.

Code 90581 has been changed to include both intramuscular and subcutaneous routes of administration. 90581 Anthrax vaccine, for subcutaneous or intramuscular use.

Influenza Vaccines

Code 90654 has been added to report influenza virus vaccine, split virus, preservative-free, for intradermal use.

You will find several new codes for influenza vaccines that are currently awaiting FDA approval.

Medicare Claims for Flu Shots!

Medicare recognizes the following codes for reporting influenza vaccines.

CPT	Description	Fee Schedule Allowance
90654	Influenza virus vaccine, split virus, preservative-free, for intradermal use	\$18.383
90655	Influenza virus vaccine, split virus, preservative-free, when administered to children 6-35 months of age, for intramuscular use	\$15.705
90656	Influenza virus vaccine, split virus, preservative-free, when administered to individuals 3 years and older, for intramuscular use	\$12.375
90657	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use	\$6.653
90660	Influenza virus vaccine, live, for intranasal use	\$22.316
90662	Influenza virus vaccine, split virus, preservative-free, enhanced immunogenicity via increased antigen content, for intramuscular use	\$30.923



Do not use 90471 or 90472 for the administration of influenza vaccine. For Medicare claims, regardless of the vaccine code used to report the vaccine, use HCPCS code G0008 to report the administration of influenza vaccine.

G0008: Administration of Influenza Virus Vaccine

The table below includes codes for influenza vaccine and Medicare pricing for dates of service between September 1, 2011, and August 31, 2012.

HCPCS	Description	Fee Schedule Allowance
Q2035	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)	\$11.543
Q2036	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Flulaval)	\$8.784
Q2037	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)	\$13.652
Q2038	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)	\$13.306
Q2039	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Not Otherwise Specified)	Locally Priced

Remember that, for the 2010/2011 flu season, Medicare established separate billing codes for each brand-name influenza vaccine product that typically had been reported using CPT code 90658. While 90658 continues to exist in CPT 2012, Medicare continues to require the temporary HCPCS “Q” codes for the 2011/2012 flu season.

CPT Code 90658 Is Invalid for Billing Influenza Vaccines to Medicare

Effective for claims with dates of service on or after October 1, 2010, the listed in the above chart HCPCS codes are payable for Medicare beneficiaries.

When reporting Q2039, include the name and invoice price for the vaccine in Item 19 or its electronic equivalent.

Mini-Mental Status Examination

Do not be confused by the revision in the descriptions of CPT codes 96110 and 96111. Per CPT instructions, mini-mental status examinations performed by a physician/nonphysician practitioner are included in the evaluation and management code (E/M) and are **not separately billable**. See *CPT Changes: An Insider's View 2012*, for additional information on the following codes.

96110 Developmental screening, with interpretation and report, per standardized instrument form

96551 Developmental testing, (includes assessment of motor, language, social, adaptive, and/or cognitive functioning by standardized developmental instruments) with interpretation and report

Implantable Contraceptive Capsule Codes

Codes 11975 and 11977 have been deleted effective January 1, 2012. Physicians are instructed to use the appropriate codes for insertion of nonbiodegradable drug delivery implant and for removal of implantable contraceptive capsules with subsequent insertion of nonbiodegradable drug delivery implant.

11981 Insertion, non-biodegradable drug-delivery implant
 11982 Removal, non-biodegradable drug-delivery implant
 11983 Removal with reinsertion, non-biodegradable drug-delivery implant

CMS Extends Deadline for Enforcement of the 5010 Electronic Claims Transaction Standard

On Thursday, November 17, 2011, CMS Office of E-Health Standards and Services (OESS) announced that it would *not initiate enforcement action* until Saturday, March 31, 2012, with respect to any HIPAA-covered entity that is not in compliance with the ASC X12 Version 5010 (Version

5010). Notwithstanding OESS' discretionary application of its enforcement authority, the compliance date for use of these new standards remains Sunday, January 1, 2012 (small health plans have until Tuesday, January 1, 2013 to comply).

OESS made the decision for a discretionary enforcement period based on industry feedback revealing that, with only about 45 days remaining before the Sunday, January 1, 2012, compliance date, testing between some covered entities and their trading partners has not yet reached a threshold whereby a majority of covered entities would be able to be in compliance by Sunday, January 1, 2012. Feedback indicates that the number of submitters, the volume of transactions and other testing data used as indicators of the industry's readiness to comply with the new standards have been low across some industry sectors. OESS has also received reports that many covered entities are still awaiting software upgrades.

OESS encourages all covered entities to continue working with their trading partners to become compliant with the new HIPAA standards and to determine their readiness to accept the new standards as of Sunday, January 1, 2012. While enforcement action will not be taken, OESS will continue to accept complaints associated with compliance with Version 5010 transaction standard *during the 90-day period* beginning Sunday, January 1, 2012. *If requested* by OESS, covered entities that are the subject of complaints (known as “filed-against entities”) must *produce evidence of either compliance or a good-faith effort to become compliant with the new HIPAA standards during the 90-day period*.

Continue to put pressure on your vendors regarding the 5010 transaction standards for electronic claims. Although CMS has been known to “blink,” as evidenced by the delay in 5010 enforcement action, there is no guarantee that enforcement will be delayed again before March 31, 2012.



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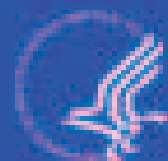
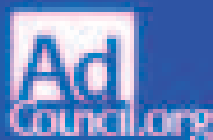
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