FRONTLINE PHYSICIAN

A Publication of the Indiana Academy of Family Physicians

SPRING 2004

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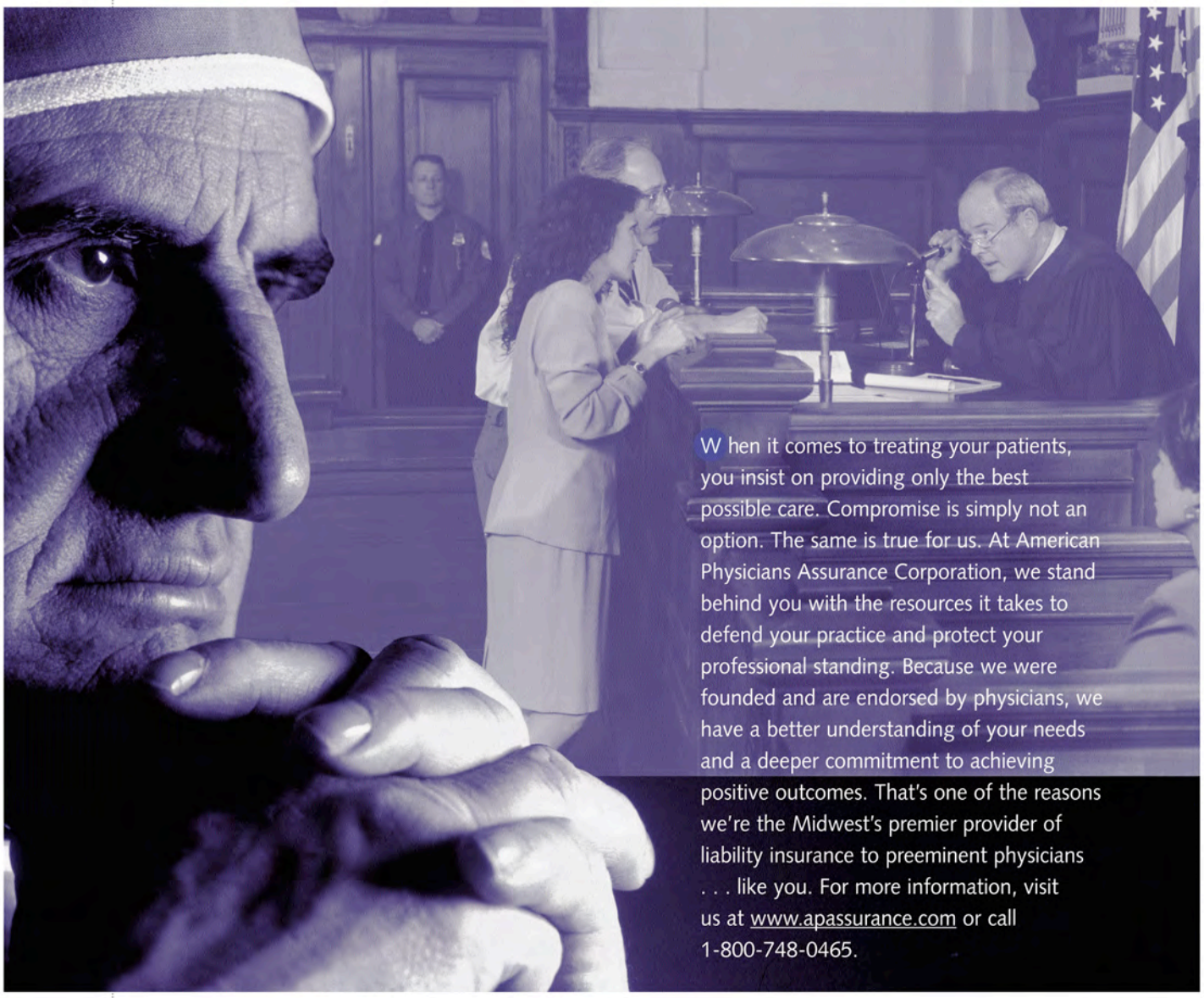
When Compromise Is Not An Option



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FRONTLINE PHYSICIAN

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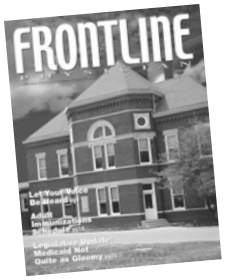

About The Cover:

Pictured on this issue is the Indiana Medical History Museum.
www.imhm.org

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

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

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Indiana Academy of Family Physicians

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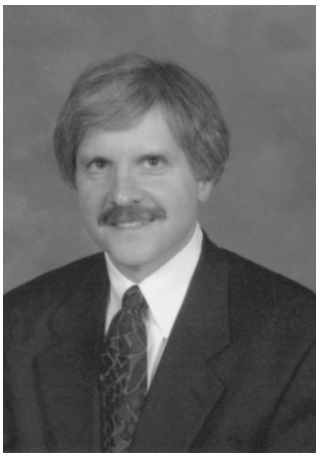

Richard Feldman, M.D., President
Indiana Academy of Family Physicians

In recent months there's been much attention in the media about escalating corporate health care costs and the difficulty of employers to provide health insurance coverage for their workers. Because businesses have had to shift an increasing share of the insurance costs to employees, more and more lower paid workers have dropped their health coverage. This is also true in Indiana.

There are many reasons for skyrocketing health care costs. These include the high cost of pharmaceuticals, the failure of managed care to control expenditures, increasing insurance company profit margins, and advancing technology. Our American health care system does not follow the usual economic rules of supply and demand. Instead we've over-built, over-utilized, and duplicated services. Additionally, it is difficult to contain costs when patients have third-party insurance plans paying first-dollar coverage.

This year in the Indiana General Assembly, the biggest health care topic has been over-building and duplication of services. This discussion has focused on the controversial remedies of "certificate of need" and "moratorium." These measures could limit the development of for-profit health care facilities, including specialty or "niche hospitals," long term care facilities, imaging centers, and surgery centers.

In preparation for this debate, the IAFP sent surveys to members in order to better define the opinions of Indiana family physicians. We found that many members passionately believe that for-profit niche hospitals increase the cost of health care, and that too many are being built. Furthermore, our members believe these entities are having an adverse affect on not-for-profit, full-service community hospitals—decreasing their ability to provide the least profitable services and to care for everyone in the community.

Despite this prevailing view, we are very aware of the need for family physicians to protect their ability to perform procedures

Prent's Message

that are sometimes denied in community hospitals due to the politics of their medical staff organizations. We also learned that some of our members have financial interests in hospitals and other health care facilities, including surgery centers for a variety of financial and practice reasons.

All of these concerns were included in our testimony at the legislature this session in both the House and Senate. The IAFP maintained a neutral poisition. Because these are such complicated issues that need to be thoroughly examined, we voiced strong support for the creation of a study commission.

There really is, however, a greater issue to be addressed in the discussion of high health care costs. Family physicians understand all too well that high rates of chronic disease resulting from unhealthy lifestyles is in large part responsible for our current health care crisis. This ultimately adversely affects our entire Indiana economy.

While the Indiana General Assembly has given a great deal of attention to economic development and economics paying for health care, it has made relatively little commitment to curtailing our epidemic of chronic disease. The future of our economy also depends on the good health of the public.

Improving an economy with a sick population is like trying to fill a bucket with a hole in it. An unhealthy population is an economic drain that must be repaired if Indiana is to be ultimately successful in creating business opportunities and jobs. Industry is no longer in the mood to tolerate high health care costs. And they are well aware that these costs are in good measure associated with treating the chronic diseases caused by the unhealthy lifestyles of Hoosier workers. Preventing disease is always less expensive than treating it.

General Motors officials complained to state government in1997 that their most expensive health care plans are right here in Indiana. Apparently nothing has changed because they were here again last fall saying the same thing to the Health Finance Committee. With health care costs chewing up corporate bottom lines, why would industries necessarily want to locate, expand or even maintain presence in Indiana? We can anticipate hearing a stronger message in this regard from business and industry in the coming months and years.

Indiana is fortunate that it remains one of the states with the highest rate of insured. But health insurance does not guarantee health. In many respects, Indiana is one of the unhealthiest states in the country. We are fifth highest in tobacco use and obesity. We are among the leading states in heart disease, stroke, chronic lung disease, diabetes, and tobacco-related and other types of cancer.

It's time to also make an investment in the health of the public. Even in this difficult time of budget deficits, the state could at least begin to redirect attention to two of our most important health-related problems—tobacco and obesity. These are the top causes of preventable illness and premature death and the major causes of most of our chronic diseases. We can't afford not to do it, both from a health and economic standpoint.

The General Assembly could start by restoring full funding to the Indiana Tobacco Use and Prevention Agency. This agency is responsible for creating and maintaining our once proud comprehensive statewide tobacco control program that served as one of the nation's model initiatives. It's shameful that during the last legislative session the funding was cut from $32.5 million to $10.8 million. This effectively dismantled a successful program responsible for the very impressive reductions in Indiana youth smoking recently reported by two separate studies. Now it is essentially gone because effective programs must be both comprehensive and adequately funded.

Obesity must also be addressed. We need to change Indiana culture regarding eating habits and exercise. This is a detrimental problem that should be looked at in much the same way as tobacco use. We can begin with stronger emphasis on physical education and the elimination of junk foods in the schools, but to truly change behaviors it ultimately must be addressed in a comprehensive way. One idea is for the legislature to convene a commission to study obesity and develop an integrated plan for funded initiatives to combat this epidemic.

In 1914, Indiana Governor Samuel Ralston declared his belief that preventable disease had a detrimental effect on the state's economy when he wrote, "Our moral sense is so shocked that we hesitate to figure in dollars the vast millions in loss it entails upon our economy." His words are as true today as they were nearly 90 years ago. Ralston had it right then and General Motors has it right today.

Executive Vice-President

KEVIN P. SPEER, JD

Legal Risks Involved in Waiving Payments

Health care providers occasionally want to waive the amounts owed by patients for items and services, such as co-payments, co-insurance amounts, and deductibles (individually and collectively referred to as "Co-Payments") for both Medicare patients and those covered by commercial managed care plans ("Commercial Payors"). Both kinds of waivers may expose the provider to legal risk, as discussed below.

Waiver of Co-Payments for Medicare Beneficiaries. Waiver of Co-Payments for Medicare patients is clearly not permitted, except in very limited circumstances. The Federal Civil Monetary Penalties Law ("CMP Law") and the Fraud and Abuse Anti-Kickback Statute are discussed below.

Under the CMP Law, a person who offers or transfers to a Medicare or Medicaid beneficiary remuneration that the person knows or should know is likely to influence the beneficiary's selection of a particular provider, practitioner, or supplier of Medicare or Medicaid payable items or services may be liable for penalties of up to $10,000 for each act. There is an exception for waiver of Co-Payments if the waiver: (i) is not part of an advertisement or solicitation; (ii) is not routinely done; and (iii) is made after determining in good faith the financial need of the patient or exhausting reasonable collection efforts.

Waiving Co-Payments for patients covered by government health care programs also presents risk to the provider under the Anti-Kickback Statute. The Statute is intent-based. To be found in violation, the provider must knowingly and willfully offer or transfer remuneration to a patient in exchange for the patient using items or services covered by a governmental health care program. Even if the provider does not have such intent, there is still risk that the Department of Health and Human Services Office of Inspector General ("OIG") and, ultimately, a judge or jury could misconstrue the provider's intent. The only way to entirely avoid risk is to satisfy the Waiver of Co-Insurance and Deductibles Safe Harbor, which protects waivers in very limited circumstances, or to obtain a favorable Advisory Opinion from the OIG. Potential penalties for being found in violation of the Statue are imprisonment for up to five years, civil monetary penalties, and/or exclusion from participation in federally funded health care programs.

In 1994, the OIG issued a Fraud Alert that stated the waiver of Co-Payments for any reason other than indigency is fraudulent and/or abusive because it misstates the provider's actual charge,[1] constitutes a kickback to the patient for using Medicare services, and frustrates the policy purpose of deterring unnecessary utilization of services by giving patients a partial stake in medical expenses.

Waiver of Out-of-Network Co-Payments for Commercial Patients. Out-of-network providers sometime want to waive Co-Payments for patients who are covered by Commercial Payors for strategic reasons. Doing so levels the playing field the out-of-network provider and another provider(s) who is in-network with the particular plan. There is no Federal law that expressly prohibits such waivers, but there are several legal considerations that need to be analyzed as the provider determines whether it will waive such Co-Payments.

The Federal Health Insurance Portability and Accountability Act ("HIPAA") makes it a criminal act for anyone to falsify a material fact or make a false statement or representation to a health care benefit program (defined below) in connection with the delivery of or payment for health care, benefits, items, or services. The term "health care benefit program" means any public or private plan or contract, affecting commerce, under which any medical benefit, item, or service is provided to any individual, and includes any individual or entity who is providing a medical benefit, item, or service for which payment may be made under the plan or contract. Providers who waive Co-Payments are exposed to risk under HIPAA because, arguably, the provider is misstating its charge to the Commercial Payor. For example, assume a $100 total charge where the patient has an 80/20 plan. If the provider waives the patient's obligation to pay 20 percent, then, arguably, the Commercial Payor owes only 80 percent of $80.

Other Legal Risks of Waiving Commercial Payor's Co-Payments. The routine waiver of Co-Payments could raise issues under Medicare charge-based reimbursement. If the waiver is routine, the provider's charge master or fee schedule is called into question because it may not represent the provider's real charges, putting the provider at risk of misstating its charges to Medicare. The routine waiver of Co-payments can also run afoul of commercial managed care

agreements in which payment is based on discounted charges in a similar manner. In addition, the routine waiver of Co-Payments may cause risk to the provider under State law statutory and common law fraud theories.

These considerations lead to the question of when the waiver of Co-Payments becomes "routine?" There is not a clear Federal threshold above which a waiver of Co-Payments rises to the level of routine, although some States' laws may provide guidance on what routine means. Absent State law guidelines, it is necessary to consider all of the facts and circumstances of the situation to assess the risk. The more narrowly the waiver applies (i.e. to a subcategory of the Commercial Payor's patients and/or for a specific service), the lower the risk it would be considered a routine waiver.

Problematic Provisions in Plan Documents. Finally, plan documents may contain language that expressly state the Commercial Payor will deny payment for a claim if the Co-Payment is waived or if the plan participant is not legally required to pay any amount for the item or service covered by the claim.

To summarize, the CMP Law prohibits the waiver of Co-Payments for Medicare beneficiaries, unless the exception for waiver of Co-Payments or other applicable exception is satisfied. Such waivers also present risk to providers under the Anti-Kickback Statute unless the Waiver of Co-Insurance or Deductibles is met or the OIG has issued the provider a favorable Advisory Opinion. A provider who considers waiving commercial Co-Payments should consider the legal issues presented above before making a decision whether to do so. Finally, please consider State laws that could affect this analysis.

[1] For example, if a charge is listed at $100 but a 20% copayment is waived, then the actual charge is arguably $80, and Medicare should only pay 80% of the $80.

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we devote

everyminute

of

everyhour

of

everyday

to

everybeat

of

yourheart

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Let Your Voice Be Heard:

SUBMIT RESOLUTIONS BY JUNE 23

What's the best way to play a role in directing Academy policy and to address the issues that concern you most? Write a resolution. The IAFP Congress of Delegates will consider all resolutions when they convene July 22 and 23 in French Lick.

Please submit your resolutions to the Academy in writing or via e-mail. Once submitted, resolutions will be reviewed for format and published on the Web site for input and comment by the membership.

Members who submit resolutions are invited to attend the meeting in French Lick and speak on behalf of their resolutions.

Guidelines for drafting resolutions:

- Use the template provided to ensure your resolution follows the appropriate format.
- State the intent of your resolution clearly and concisely. Keep in mind that each resolution should deal with a single topic or subject.
- Submit your resolution in a timely manner. To be considered this year, the Academy office must receive your resolution by June 23.

Drafting Whereas Clauses

The whereas clauses simply explain the problem or situation. Since the whereas statements explain and support the resolved portion, they precede the resolved clause in the written text. The Reference Committee does not adopt whereas sections of the resolution, but if the sections are not stated clearly and factually and in a manner that directly relates them to the resolved portion, they may produce unnecessary debate and detract from the effectiveness of the resolution. Please carefully check the facts, quotes, references and statistics used. Verify all data you use.

Drafting Resolved Clauses

The resolved clauses stand alone and should be written as such. The resolved clause is the only portion of the resolution that will be voted on. Therefore, the resolved portion should be clear and action-oriented. Keep the resolved clause focused on what is desired as the end result.

Sometimes, it is easier to write the resolved clauses first. That forces you to identify the desired action. After finishing the resolved clause, write the whereas clauses, checking each to determine if the clause is relevant and provides necessary information. Be sure to provide adequate support for your resolved clause, but limit your wheras clauses to a reasonable number.

The Academy encourages you to participate in this process. It gives you a more direct voice into the policies and activities of your Academy.

Deadline for resolutions to be submitted by June 23.

Send resolutions to IAFP, Attn: EVP, 55 Monument Circle, Suite 400, Indianapolis, IN 46204 or to iafp@in-afp.org.

Resolution Template

Title:

_____

Submitted by:

_____

WHEREAS,

_____;

and

WHEREAS,

_____;

and

WHEREAS,

_____;

therefore be it

RESOLVED,

_____;

and therefore be it further

RESOLVED,

_____.

Fiscal Note: $

_____.

INDIANA ACADEMY OF FAMILY PHYSICIANS

Nominate Your Peers

Throughout the years, the Indiana Academy of Family Physicians has strived to better healthcare in Indiana. In recognition of individuals who work to improve the practice of family medicine, the IAFP bestows awards on an annual basis. This call for nominations plays an important part in the process of recognizing outstanding service. Nominations must be in writing and submitted on official nomination form with appropriate attachments. The IAFP Commission on Membership Services and Public Relations will review the entries and present its recommendation to the IAFP Board of Directors for approval. Nominations for the awards will be accepted from IAFP members until April 1. Thank you for your participation in recognizing these outstanding family physicians and supporters of family medicine.

Lester D. Bibler Award

The Lester D. Bibler Award is designated to recognize long-term dedication, rather than any single significant contribution, and is given on the basis of dedicated effective leadership toward furthering the development of family medicine in Indiana. This award was named in honor of the "Founding Father" and first president of IAFP.

A. Alan Fischer Award

The A. Alan Fischer Award is designed to recognize members who have made outstanding contributions to education for family practice, in undergraduate, graduate and continuing education spheres. This award was named in honor of Dr. Alan Fischer, a long-time member of the IAFP who actively served the Indiana Chapter and AAFP and who established the IUSM Dept of Family Medicine and the IU Family Practice Residency Program.

Jackie Schilling Certificate of Commendation

The Jackie Schilling Certificate of Commendation was established to recognize non-family-physicians who have been deemed to contribute in a distinguished manner to the advancement of family medicine in Indiana. Those considered for the award come from careers in many fields, including medical education, government, the arts and journalism. In 1999, the award was named after the past IAFP Executive Vice President, Jackie Schilling.

Distinguished Public Service Award

The Distinguished Public Service Award is presented to IAFP members in good standing who have distinguished themselves rendering a community or public service. The service must be entirely separate from purely professional achievement in research and scientific endeavors. The service for which this award is bestowed should have been performed on a voluntary basis and should have benefited the local and/or state community in a civic, cultural or general economic sense and, except in unusual circumstances, should have been uncompensated.

Indiana Family Physician of the Year Award

Nominees for the Indiana Family Physician of the Year Award must be members in good standing with both the IAFP and AAFP. Nominees must provide their patients with compassionate, comprehensive, and caring family medicine on a continuing basis and must be directly and effectively involved in community affairs and activities that enhance the quality of their community. Nominees must be a family physician who is a credible role model professionally and personally to the community, to other health professionals, and to residents and medical students and who can effectively represent the specialty of family practice and the IAFP/AAFP in public speaking.

For more information and nomination forms, please contact Amanda Bowling at (317) 237-4237 or (888) 422-4237.

Nominate 2004 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 on July 22 in French Lick. At the time of the meeting, additional nominations from the floor may be made. The said election of officers shall be the first order of business at the second session of the Congress of Delegates on July 23.

Offices to be filled for 2004-2005 are: president-elect, first vice president, second vice president, speaker of the Congress of Delegates, vice speaker of the Congress of Delegates, one AAFP delegate (two year term), and one AAFP alternate delegate (two year term).

The Nominating Committee 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 elected.

If you are an active member of the IAFP, you may submit your name as a candidate. All candidates for office must submit a letter of intent, a glossy black and white photo, and curriculum vitae. This information must be received prior to April 10.

If you have questions, please contact Kevin Speer or Deeda Ferree at 317-237-4237 or dferree@in-afp.org.

Indiana Academy of Family Physicians

Members Receive AAFP Degree of Fellow

Several members of the Indiana Academy have achieved the degree of fellow of the American Academy of Family Physicians (FAAFP).

Established in 1971, the AAFP Degree of Fellow recognizes family physicians that have distinguished themselves through service to family medicine and ongoing professional development. This year's Fellowship class brings the total number of AAFP Fellows to more than 29,000 nationwide. AAFP Fellowship entitles the physician to use the honorary designations, "Fellow of the American Academy of Family Physicians," or "FAAFP."

Criteria for receiving the AAFP Degree of Fellow consists of a minimum of six years of active, life or inactive membership in the organization; extensive continuing medical education, participation in public service programs outside the physician's medical practice; conducting original research and serving as a teacher in family medicine.

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Ahler Kenneth, MD
Aiello Robert, MD
Albert Raphael, MD
Alessi John, DO
Allen Deborah, MD
Allen Larry, MD
Allman Rex, MD
Amos Susan, MD
Anderson Garland, MD
Anderson James, MD
Andrew Jerald, MD
Asher James, MD
Atkins Clayton, MD
Atkins Steven, MD
Bacchus H M, MD
Baker Eldon, MD
Banguis Lucia, MD
Banning V, MD
Barker John, MD
Barnes Gilbert, MD
Barrett Warrick, MD
Barton Reginald, MD
Batterton Owen, MD
Beardsley Frank, MD
Beaver Ernest, MD
Beaver Norman, MD
Beaver Walter, MD
Beckman Teresa, MD
Beeler Franklin, MD
Benedict Harold, MD
Bennett J B, MD
Bhatt Jayshree, MD
Bierlein Alan, MD
Billena Raymundo, MD
Black Maurice, MD
Black Kenneth, MD
Black Thomas, MD
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Blanke William, MD
Blix Fred, MD
Blood Michael, MD
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Bradley Mark, MD
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Brake Karen, MD
Breitwieser David, MD
Brewer Robert, MD
Bridges Alvin, MD
Brown Stewart, MD
Brown Randall, MD
Browne Thomas, MD
Brownson Paul, MD
Buck Gregory, MD
Bugno Craig, MD
Burket Cecil, MD
Burkhart David, MD
Burton Bruce, MD
Butler James, MD
Cain David, MD
Calhoun Charles, MD
Campbell Lee, MD
Cannon Daniel, MD
Carey John, MD
Carnes J, MD
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Carter Arnold, MD
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Coulter Merlin, MD
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Crase John, MD
Creed Gary, MD
Dahling Fred, MD
Darst Marc, MD
Dauscher Dean, MD
Day Lynn, MD
Day Michael, MD
De Armitt Walter, MD
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Domingo Ricardo, MD
Doshi Parul, MD
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Glass Paul, MD
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Huber Richard, MD
Hull Joel, MD
Irwin Gerald, MD
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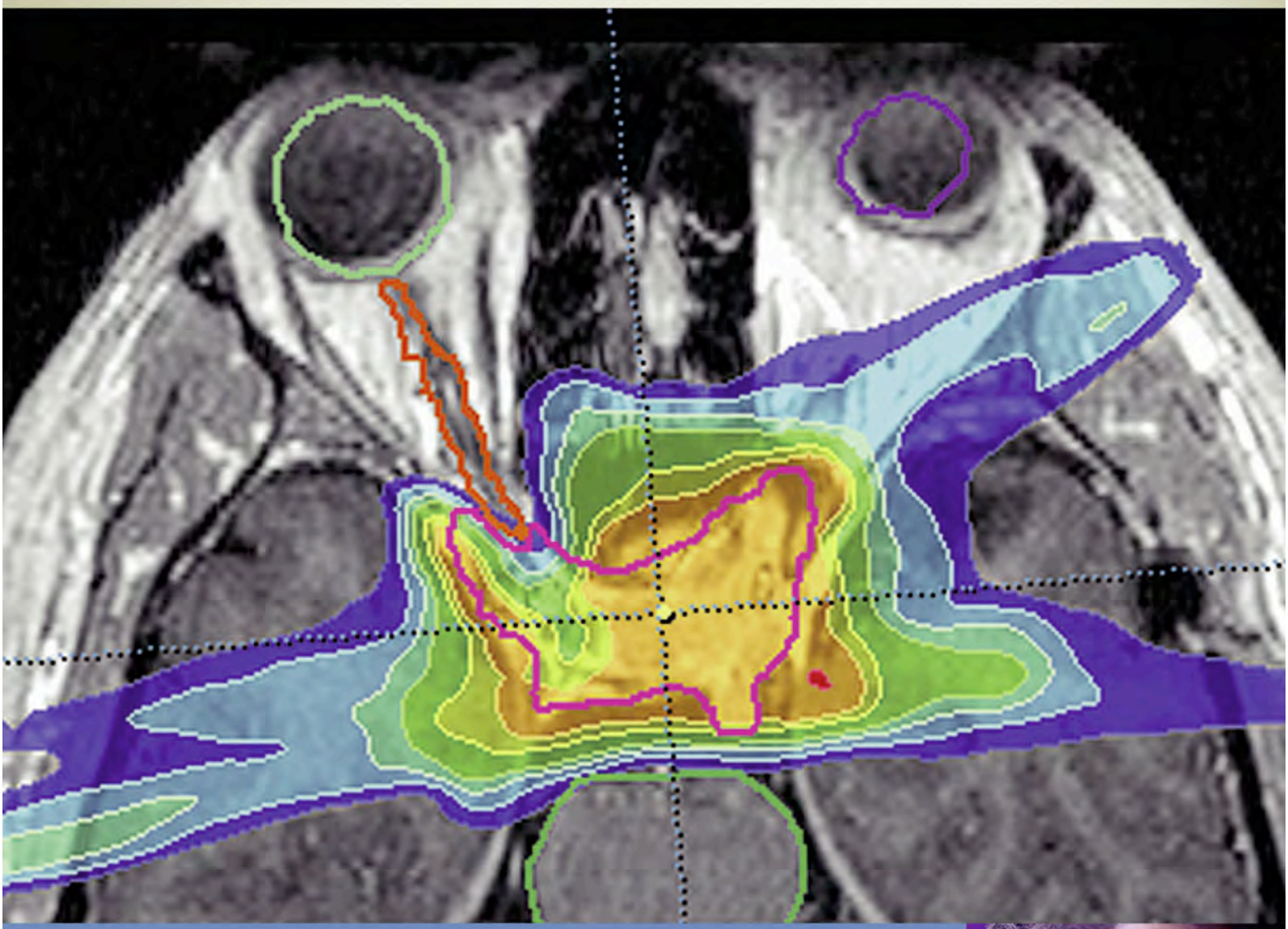

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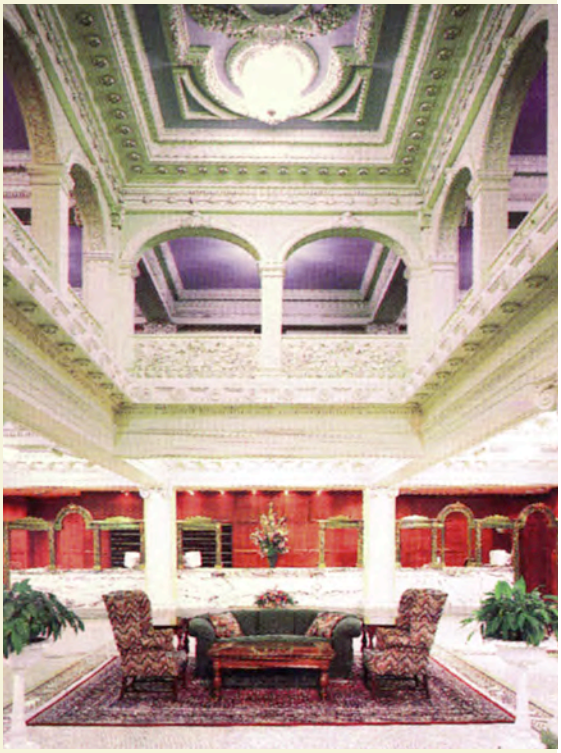

Attend Indiana's Premier

CME Event for Family Physicians

At this year's annual meeting you'll find more than 25 hours of quality CME planned by family physicians for family physicians including lectures, hands-on-learning, clinical topics and practice management issues. Faculty include state and nationally known speakers.

Come to the IAFP Annual Meeting from July 21 to 25 at the French Lick Resort, nestled in southern Indiana. You can enjoy summer days at this historical resort, and spend time with your peers and medical school classmates. Network with your peers and leaders in family medicine. See new products. Bring the family and spend time in family activities and sports activities–including golf, tennis, swimming, and more.

All arrangements from the selection of CME offerings to family activities are based on previous evaluations and IAFP Member CME Needs Assessments. Every effort is made to improve the program each year.

General Information

Register early. Special CME sessions and workshops fill quickly as does the hotel. EARLY BIRD DRAWING: Register by June 15 to be included in a drawing for refund of the CME registration fee.

Location

The French Lick Resort is nestled in southern Indiana. Room rates for IAFP registrants are $91 per night. Special room requests (i.e., connecting rooms, suites) are based on availability. Rooms are available for people with disabilities. To make room reservations, call the hotel at (800) 457-4042.

Alternate Housing

Lane's Motel, (812) 936-9919, is within walking distance from the resort and offers nice sleeping rooms and a pool. RV hookups are also available at Lane's. Also, the Beechwood Inn, which is similar to a bed & breakfast, has a limited number of rooms. For reservations, call (812) 936-9012.

For more information, call the IAFP headquarters office at (317) 237-4237 or at (888) 422-4237 if you have any questions. You can also email us at iafp@in-afp.org.

Official Notice

Indiana Academy of Family Physicians

NOTICE IS HEREBY given of the 56th Annual Scientific Assembly and Congress of Delegates of the Indiana Academy of Family Physicians to be held in French Lick, Indiana, July 21-25, at the French Lick Springs Resort.

PURSUANT TO CHAPTER IX, Section 1 of the IAFP Bylaws; the regular meeting of the Congress of Delegates will convene on Thursday, July 22 at 7 p.m. (first session) and Friday, July 23 at 5 p.m. (second session).

The Congress of Delegates will receive and act upon the reports of officers and committees/commissions, elect officers, and transact any and all business that may be placed on the agenda.

Resolutions must be received 30 days prior to the first session of the Congress. A call for resolutions and instructions for writing resolutions is included in this publication. If you would like to write a resolution and need further information, please contact the IAFP office.

Adult Immunization Schedule

Encourage immunization in adults as well as children to reach 2010 goals

Research shows the nation – including Indiana – is not yet meeting HHS's Healthy People 2010 goals for immunizations. This is a good time to check the 2003-2004 Recommended Adult Immunization Schedule available at http://www.aafp.org/x14956.xml or printed here for you to copy for your offices. The schedule indicates the recommended age groups for routine administration of currently licensed vaccinations for persons 19 and older. Representatives from the AAFPO Commission on Clinical Policies and Research participated in CDC's Advisory Committee on Immunization Practices to develop the schedule, which the AAFP has adopted as policy.

A. For women without chronic diseases/conditions, vaccinate if pregnancy will be at 2nd or 3rd trimester during influenza season. For women with chronic deseases/conditions, vaccinate at any time during the pregnancy.

B. Although chronic liver disease and alcoholism are not indicator conditions for influenza vaccination, give 1 dose annually if the patient is >= 50 years, has other indications for influenza vaccine, or if the patient requests vaccination.

C. Asthma is an indicator condition for influenza but not for pneumococcal vaccination.

D. For all persons with chronic liver disease.

E. For persons < 65 years, revaccinate once after 5 years or more have elapsed since initial vaccination.

F. Persons with impaired humoral immunity but intact cellular immunity may be vaccinated. MMWR 1999; 48 (RR-06): 1-5.

G. Hemodialysis patients:Use special formulation of vaccine (40 ug/mL) or two 1.0 mL 20 ug doses given at one site.Vaccinate early in the course of renal disease. Assess antibody titers to hep B surface antigen (anti-HBs) levels annually. Administer additional doses if anti-HBs levels decline to <10 milliinternational units (mIU)/ mL.

H. There are no data specifically on risk of severe or complicated influenza infections among persons with asplenia. However, influenza is a risk factor for secondary bacterial infections that may cause severe disease in asplenics.

I. Administer meningococcal vaccine and consider Hib vaccine.

J. Elective splenectomy: vaccinate at least 2 weeks before surgery.

K. Vaccinate as close to diagnosis as possible when CD4 cell counts are highest.

L. Withhold MMR or other measles containing vaccines from HIV-infected persons with evidence of severe immunosuppression.MMWR 1998; 47 (RR-8):21-22; MMWR 2002; 51 (RR-02): 22-24.

Recommended Immunizations for Adults with Medical Conditions, United States, 2003-2004

Vaccine ▶ / Medical Conditions ▼	Tetanus-Diphtheria (Td)*[1]	Influenza[2]	Pneumococcal (polysaccharide)[3,4]	Hepatitis B*[5]	Hepatitis A*[6]	Measles, Mumps, Rubella (MMR)*[7]	Varicella*[8]
Pregnancy		A					
Diabetes, heart disease, chronic pulmonary disease, chronic liver disease, including chronic alcoholism		B	C		D		
Congenital Immunodeficiency, leukemia, lymphoma, generalized malignancy, therapy with alkylating agents, antimetabolites, radiation or large amounts of corticosteroids			E				F
Renal failure / end stage renal disease, recipients of hemodialysis or clotting factor concentrates			E	G			
Asplenia including elective splenectomy and terminal complement component deficiencies		H	E,I,J				
HIV infection			E,H			L	Pregnancy

Recommended Adult Immunization Schedule, United States, 2003-2004

Age Group ▶ / Vaccine ▼	19-49 Years	50-64 Years	65 Years and Older
Tetanus, Diphtheria (Td)*	1 dose booster every 10 years [1]		
Influenza	1 dose annually [2]	1 dose annually [2]	
Pneumococcal (polysaccharide)	1 dose [3,4]		1 dose [3,4]
Hepatitis B*	3 doses (0, 1-2, 4-6 months) [5]		
Hepatitis A*	2 doses (0, 6-12 months) [6]		
Measles, Mumps, Rubella (MMR)*	1 dose if measles, mumps, or rubella vaccination history is unreliable; 2 doses for persons with occupational or other indications [7]		
Varicella*	2 doses (0, 4-8 weeks) for persons who are susceptible [8]		
Meningococcal (polysaccharide)	1 dose [9]		

KEY

- **For all persons in this group**
- **Catch-up on childhood vaccinations**
- **For persons with medical/ exposure indications**
- **Contraindicated**

What's Happening at the IAFP Foundation?

The Adopt-A-Student Program Continues

The IAFP Foundation Adopt-A-Student program will continue to help medical students discover Family Medicine in 2004. This program provides summer externships to medical students between their first and second years of medical school. The Foundation has sponsored student externships through the Adopt-A-Student program since 1998. Currently, it is still unclear how many students the Foundation will sponsor this summer.

In 2003, the Foundation sponsored an eight-week externship for Jamie Ulbrich, a medical student from Gary, Ind. Jamie worked at the Gary Community Health Center with her family physician preceptor, Dr. Janet Seabrook.

In addition to working alongside Dr. Seabrook in a practice setting, Jamie became involved in the Gary community. She volunteered her time to health-related community organizations, including the Lupus Foundation of Northwest Indiana.

The Foundation would like to extend our thanks to Jamie for participating in the Adopt-A-Student program and to Dr. Seabrook for taking time to teach medical students about the daily life and activities involved in practicing Family Medicine.

In 2004, the Adopt-A-Student program is supporting four students – more than in any previous program year!

The Foundation is currently looking for preceptors for these participants. Preceptors must be practicing IAFP members. This commitment entails hosting a medical student in your office for an eight-week externship during the summer. The Foundation will also accept co-preceptor situations, in which multiple family physicians serve as preceptors for a single student. Please help medical students explore the opportunities involved with the specialty of Family Medicine by becoming an Adopt-A-Student Preceptor this summer.

Get Involved in the Historic Doctor's Office at the Medical Museum

The Foundation is continuing its efforts to establish a historic doctor's office exhibit at the Indiana Medical History Museum in Indianapolis. Donations to this project will help the museum restore the building that houses the exhibit and prepare the medical artifacts for display.

The Foundation is also collecting stories for the Family Practice Stories Project. The project is intended to focus on the stories or experiences of individual family physicians in Indiana. The Foundation hopes the resulting family practice stories book can be incorporated into the historic doctor's office exhibit.

Join the IAFP Foundation

for a round of golf to support the future of family medicine!

The IAFP Foundation is hosting the Second Annual Chuck Schilling Memorial Golf Tournament on Thursday, July 22 at 9:00 a.m. at the French Lick Springs Resort in French Lick, Ind. This year's tournament will benefit the IAFP Foundation's Adopt-A-Student program. The purpose of this important initiative is to educate medical students about the specialty of family medicine. This is also the second year that the IAFP Foundation will be honoring the memory of Chuck Schilling, a significant contributor to this event's past success.

All levels of player are welcome to participate. Pre-arranged foursomes will be accepted, and other assignment requests will be accommodated if possible. Individuals not included in prearranged foursomes will be assigned to a foursome by the golf chair. The registration fee is $85 per player and includes: green fees, a cart, a box lunch and a limited number of beverages while on the course.

For more information about the programs or events above, contact Coral Cosway, IAFP Foundation Director, at 317-237-4237 or ccosway@in-afp.org.

Tar Wars®

Late-breaking Tar Wars® Information

For the second time, Victory Field will be the home of the Tar Wars® Celebration. This is our opportunity to recognize student poster contest participants, and to honor our award winners with a pre-game ceremony on the field. This year's Tar Wars® Celebration will be held on Sunday, June 6 at 2 p.m. when the Indianapolis Indians take on the Rochester Red Wings. Stay tuned to www.tarwarsindiana.org - or contact Missy (mlewis@in-afp.org) at the IAFP office – for up-to-date information. We hope to see you there!

The IAFP Foundation was just notified that our grant proposal to the Indiana Tobacco Prevention and Cessation Agency (ITPC) was approved! This was a very competitive process, as available funds were cut tremendously due to legislative actions in 2003. Due to these cuts, our grant is significantly less than what we received in recent years. Your support is still needed! We are thrilled to be able to expand our Tar Wars® program and have many plans for the upcoming year. Thank you to ITPC and to all of our members who have donated their time and money. Hoosier children appreciate your support!

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Thank You

The Board of Trustees of the Indiana Academy of Family Physicians Foundation would like to thank the individuals and organizations that donated to the Foundation in 2003. Your generosity has provided the Foundation with critical resources needed to fulfill its mission: *"to enhance the health care delivered to the people of Indiana by developing and providing research, education and charitable resources for the promotion and support of the specialty of Family Practice in Indiana."*

FOUNDER'S CLUB MEMBERS

Founder's Club Members have committed to giving $2,500 to the IAFP Foundation over a 5-year period. Members noted with a check mark have completed their commitment. The Board would like to acknowledge that many of the Members on this list also give to the Foundation in addition to their Founder's Club commitment. Members who have done so in 2003 are noted with a diamond.

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Deanna R. Willis, MD, MBA

The IAFP Foundation would like to recognize its newest Founder's Club members. Those individuals who joined the Founder's Club in 2003 are: Dianna L. Dowdy, MD; Deanna R. Willis, MD; and Kevin Speer, JD.

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- ☐ Adopt-A-Student Program
- ☐ Tar Wars®
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- ☐ Historic Family Physician Office Project
- ☐ Jackie Schilling Family Practice Medical Student/Resident Fund
- ☐ Family Practice Stories Book
- ☐ Memorial contribution in memory of

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Amount Enclosed:

☐ $20 ☐ $50 ☐ $100 ☐ $250 ☐ $500 ☐ Other_____

Thank you for your generosity. It will support: Assuring access to family physicians and the quality, comprehensive and affordable healthcare they provide; Enhancing the recruitment, education and training of prospective family physicians; and Supporting other initiatives that further the vision of the Foundation to enhance the quality of healthcare services delivered to Indiana residents.

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Indiana Academy of Family Physicians

Legislative Update: **Medicaid Not Quite As Gloomy**

By Doug Kinser, IAFP Lobbyist

By the time you read this update, the session will have adjourned sine die on March 4. However, as I write this in early February, the House and Senate introduced approximately 973 bills, and there's still buzz from Gov. Joe Kernan's first State of the State. His upbeat message emphasized five points—job growth, improving education through full-day kindergarten, protection for children, line item veto, and the Lt. Governor's initiative for re-structuring of government.

Leaders of both parties dashed the line item veto immediately. Generally, legislators agreed upon the need for job growth and protection for children. Both parties have supported full-day kindergarten, but there is disagreement on how to fund it. HB 1234 passed out of the House 56-40 with eight Republicans joining all Democrats to support the program.

Funding of full-day kindergarten was to occur from the common school fund. To utilize the common school fund, it required passage of HJR 5, a constitutional amendment. On Feb. 4, House leadership, with the support of the Governor, tried to assure the funding in an unprecedented manner. To get the requisite 51 votes for passage, the Speaker allowed Rep. Kromkowski, a member who recently had open-heart surgery, to vote by computer and telephone. Republicans believed it was against the rules and left the chambers. After several hours, the Speaker relented and withdrew Rep. Kromokowski's vote. There is currently no funding for full-day kindergarten.

The State Forecast was announced for the end of the fiscal year, June 30, 2005. Even with the state's fiscal woes accelerating to an estimated $1 billion shortfall, Gov. Kernan said he would not ask legislators to re-open the budget. There seems to be little likelihood that the state can grow its way out of its shortfall. On Feb. 4, there was an additional revenue shortfall of $21 million.

The Medicaid Forecast was released in January with actual numbers from November 2003. It was not as gloomy as in the past. The Medicaid shortfall is estimated at $21.7 million for the end of the fiscal year. There has been no discussion on re-basing of Medicaid provider rates. Extra payments from the federal government were applied to Medicaid to minimize the shortfall. While it benefits the Medicaid shortfall when extra payments are completed in 2005 and since no structural changes have been made, the state will again face shortfalls in the Medicaid budget.

In other news, *the Indianapolis Star* released a poll showing Gov. Kernan beating Mitch Daniels. Gov. Kernan had 49 percent of votes, while Mitch Daniels had 36 percent. A large bloc of voters were undecided. It is expected that the 2004 race for Governor will cost upwards of $30 million, a record amount. In 2000, both candidates combined to spend $19.9 million. At the most recent reporting period, each candidate had approximately $4 million in cash at year-end.

Bills still in play at press time include the following:

- HB 1014 - Childhood Obesity. It is the first public policy initiative to address childhood obesity, albeit in only minimal steps. Dr. Morrell of Rushville testified in support of the bill for the Academy. It passed 54-41 and was sent to Sen. Miller.
- HB 1133 - Hepatitis B. HB 1133 requires Hep B immunization for those children who have not been immunized. It was not given a hearing but was amended into SB29. Per the Academy's request, the bill was amended to capture younger students.

- SB360 - Physicial therapist direct access. This bill would allow PT direct access to patients for 1 year for the same condition.
- HB 1350 - Certification of Health Care Interpreters. HB 1350 establishes a minimum experience and education level for medical interpreters. It is not intended to be a mandate on providers. Legislators attempted to minimize the state's fiscal by requiring fees to be established to cover the total cost of the program. HB 1350 passed 96-0 and was sent to Sen. Lawson.
- SB 359 - Moratorium on Comprehensive Care Beds and Hospitals. Sen. Miller's bill began as a moratorium, but the moratorium was deleted and a study was inserted. Most members of the committee agreed that it was far too complicated to implement a CON or moratorium in the short session. There were two hearings that had almost equal opposition and support. SB 359 is now the only bill in play for this issue. Dr. Richard Feldman testified on behalf of the Academy.
- HB 1337 - Non-participating Cigarette Manufacturer Fee. HB 1337 provides a 2.5 cent tax per cigarette on non-participating cigarette manufacturers so that the non-participating manufacturers pay their share of the master tax settlement. In addition, it forces the non-participating manufacturers into the tobacco settlement, which will require them to participate in the marketing prohibitions. Since the tax is larger on the non-participating manufacturers, the participating manufacturers will, theoretically, join in the settlement. HB 1337 passed 91-3 and was sent to Sen. Borst.
- HB 1098 - Child restraints in motor vehicles. After much consternation between legislators, HB 1098 passed 76-18 with certain requirements for children to wear restraints. By passage, it was weakened from its introduced version. HB 1098 was sent to Sen. Wyss and has yet to be assigned to committee.
- SB 70 - Provider Reporting of Discounts and Rebates. SB 70 repeals section 68 of last year's budget bill that required providers to report all discounts. As Sen. Meeks stated, "What sounded like a good idea was not practical to implement." The Academy supports SB 70. SB 70 was sent to Rep. Crawford.

The following bills are essentially dead for the year:

- HB 1221. Insurance Coverage for Infertility. HB 1221 was amended from a "mandate for coverage" to a "mandate to offer" coverage. Despite this effort, most business and insurance companies opposed any mandate. It was re-assigned to Ways and Means, which effectively killed the bill for the year.
- HB 1445 - Prior Authorization Limitation on Asthma Drugs. This is an attempt to change the methodology of a "Preferred Drug List" from a clinical basis to a political basis. While it passed out of Public Health, it did so with a fiscal cost. Medicaid opposed it because of the cost. It was re-assigned to Ways and Means effectively killing the bill.
- HB 1346 - Certificate of Need. Rep. Brown amended his CON bill to become a moratorium and study commission. After more than two hours of testimony, he did not take a vote.
- SB 163 - Health Provider Reimbursement Contracts. Sen. Miller offered a bill to prohibit "most favored nations" clauses between providers and insurers. "Most favored nation" clauses state that agreements between providers and insurers may not contain provisions that offer the insurer a reimbursement rate that is the same or lower than the lowest reimbursement rate that the provider offers to another insurer. It passed out of committee 7-1 but was not called down by Sen. Miller for a vote.
- SB 62 - Medicaid Waiver of Family Planning Services. SB 62 requires Medicaid to apply for a federal waiver for family planning services with the federal government providing 90% of the funding. After much testimony, it passed 9-0. The Coalition asked the Academy and ISMA to support the bill. Neither group signed on. The bill was not called down for the final vote.
- House 1364 - Securitization of Tobacco Money. In a party line vote, House Democrats voted to securitize the Tobacco Settlement money. It would require legislative oversight on how the money is spent. If the bill passed, the Academy would offer testimony that the state should commit additional dollars to cessation of smoking. The bill was not called down for a final vote.

If you have specific concerns, please call Laura Hahn at 317-237-4237 or Doug Kinser at 317-977-1454.

Tips From Our Consultant

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

MEDICARE CLARIFIES COMPONENTS OF A GLOBAL SURGICAL PACKAGE FOR MINOR PROCEDURES

The initial consultation or evaluation of the problem by the surgeon to determine the need for surgery is always separately paid. Please note this policy only applies to major surgical procedures. If this visit occurs the day before or the day of a major surgical procedure, physicians are instructed to use the -57 modifier.

The initial evaluation is **always included** in the allowance for a minor surgical procedure. Modifier –57 should not be used with evaluation and management codes billed on the same day as a minor procedure. Physicians should use modifier -25 with the visit code to indicate a significant, separately identifiable service was provided on the same day as a minor procedure.

CORRECT CODING INITIATIVE EDITS ON INTERNET

The Centers for Medicare & Medicaid Services (CMS) has made it easier for physicians and other providers to bill properly and be paid promptly for their services. CMS has posted on its website the automated edits used to identify questionable claims and adjust payments to reflect what would have been paid had the claim been filed correctly. The edits, known as the National Correct Coding Initiative (NCCI), identify pairs of services that normally should not be billed by the same physician for the same patient on the same day. The NCCI also promotes uniformity among the contractors that process Medicare claims in interpreting Medicare payment policies.

The posting of the NCCI is the most recent in a series of steps CMS has taken to use the Internet creatively to reduce the regulatory burden on physicians and make it easier for them to work with Medicare to improve services to beneficiaries. Earlier this summer, CMS added a feature to its Web site that makes it possible for physicians to determine in advance what they will be paid for a particular service or range of services. The Medicare Physician Fee Schedule Look-up provides both the unadjusted payment rates, as well as the payment rates by geographic location.

While the NCCI is one of the cornerstones of CMS' efforts to ensure that Medicare and beneficiaries do not pay twice for the same service or for duplicative services, CMS believes physicians should have easy access to the edits CMS uses to identify incorrect claims.

The NCCI includes two types of edits. The comprehensive/component edits identifies code pairs that should not be billed together because one service inherently includes the other. The mutually exclusive edits identifies code pairs that, for clinical reasons, are unlikely to be performed on the same patient on the same day. For example, a mutually exclusive edit might identify two different types of testing that yield equivalent results.

Previously, the NCCI edits have been available to physicians and other

providers on a paid subscription basis, but now they are available to anyone with a personal computer. The NCCI edits are posted as a spreadsheet that will allow users to sort by procedural code and by effective date. A "Find" feature allows users to look for a specific code. The edit files are indexed by procedural code ranges for easy navigation. The new Web page also includes links to documents that explain the edits: the *NCCI Policy Manual for Part B Medicare Carriers, Medicare Carriers Manual,* and the NCCI Question and Answer page.

CMS developed the NCCI to promote national correct coding by physicians and other providers and to ensure appropriate payments for Medicare services. The coding policies developed are based on coding conventions defined in the American Medical Association's CPT (Current Procedural Terminology) manual, national and local policies and edits, coding guidelines developed by national medical specialty societies, analysis of standard medical and surgical practice and review of current coding practice. The NCCI is updated quarterly.

The NCCI edits are posted at http://cms.hhs.gov/physicians/cciedits/default.asp. The Medicare Physician Fee Schedule Look-up can be found on the Physicians Resource Page at http://cms.hhs.gov/physicians/default.asp

MEDICARE PRESCRIPTION DRUG, IMPROVEMENT, AND MODERNIZATION ACT OF 2003

The Medicare Prescription Drug, Improvement, and Modernization Act of 2003, which was approved by the House on Nov. 22, 2003, and by the Senate on Nov. 25, 2003, was sent to President Bush for signature on Nov. 25, 2003. It contains several sections of

importance to physicians. Highlights, not all-inclusive, of the new law are detailed below.

§629 changes the amount of the Part B deductible and premium subsidy beginning 2005. Beginning Jan. 1, 2005, the Part B deductible increases to $110 for 2005, and for subsequent years, the amount of the deductible will be based on the previous year's deductible increased by the annual percentage increase in the monthly actuarial rate under §1839(a)(1) of the Act rounded to the nearest $1.

For the first time in the Medicare Program, §811 includes a reduction in premium subsidy based on the beneficiary's income. In general, in the case of an individual whose modified adjusted gross income exceeds the threshold amount, the monthly amount of the premium subsidy applicable to the Part B premium for a month after December 2006 shall be reduced (and the monthly premium shall be increased) by the monthly adjustment amount specified in the law. This means the Part B premium will vary by the beneficiary's income level. Thus, the more income reported, the higher the beneficiary's monthly premium.

The law lays down real specifics on how the Centers for Medicare & Medicaid Services (CMS) is to develop policy for Evaluation and Management (E/M) Documentation Guidelines.

(a) IN GENERAL – The Secretary may not implement any new or modified documentation guidelines (which for purposes of this section includes clinical examples) for evaluation and management physician services under the title XVIII of the Social Security Act on or after the date of the enactment of this Act unless the Secretary –
  (1) has developed the guidelines in collaboration with practicing physicians (including both generalists and specialists) and provided for an assessment of the proposed guidelines by the physician community;
  (2) has established a plan that contains specific goals, including a schedule, for improving the use of such guidelines;
  (3) has conducted appropriate and representative pilot projects under subsection (b) to test such guidelines;
  (4) finds, based on reports submitted under subsection (b)(5) with respect to pilot projects conducted for such or related guidelines, that the objectives described in subsection (c) will be met in the implementation of such guidelines; and
  (5) has established, and is implementing, a program to educate physicians on the use of such guidelines and that includes appropriate outreach.

The Secretary shall make changes to the manner in which existing evaluation and management documentation guidelines are implemented to reduce paperwork burdens on physicians.

In an effort to cut expenditures for the injectables and the limited number of oral medications covered by Medicare, the new law changes the payment basis for drugs beginning in 2004. Payment is currently based on 95 percent of the AWP for:

- A drug or biological furnished before Jan. 1, 2004
- Blood clotting factors furnished during 2004
- A drug or biological furnished during 2004 that was not available for payment as of April 1, 2003
- A vaccine furnished on or after Jan. 1, 2004
- A drug or biological furnished during 2004 in connection with the furnishing of renal dialysis services if separately billed by renal dialysis facilities

For all other drugs paid in 2004, the amount of payment is equal to 85 percent of the average wholesale price (determined as of April 1, 2003) for the drug or biological.

Beginning 2005, payment for most drugs will be based on the average sales price.

NEW PREVENTIVE SERVICES COVERED BEGINNING JAN. 1, 2005

Coverage for the following preventive services was included the Medicare Prescription Drug, Improvement, and Modernization Act of 2003. The following preventive services will be covered on or after Jan. 1, 2005.

§611 COVERAGE OF AN INITIAL PREVENTIVE PHYSICAL EXAMINATION

The term "initial preventive physical examination" means physicians' services consisting of a physical examination (including measurement of height, weight, and blood pressure, and an electrocardiogram) with the goal of health promotion and disease detection and includes education, counseling, and referral with respect to covered screening and other preventive services, but does not include clinical laboratory tests.

The coverage of an initial preventive physical examination is only available when the beneficiary has the exam performed within six months after the individual's effective date for Medicare Part B coverage.

Coverage applies to services furnished on or after Jan. 1, 2005, but only for individuals whose coverage period under part B begins on or after such date.

§612 COVERAGE OF CARDIOVASCULAR SCREENING BLOOD TESTS

The term "cardiovascular screening blood test" means a blood test for the early detection of cardiovascular disease (or abnormalities associated with an elevated risk of cardiovascular disease) that tests for the following:

A. Cholesterol levels and other lipid or triglyceride levels.
B. Such other indications associated with the presence of, or an elevated risk for, cardiovascular disease as the Secretary of Health and Human Services (the Secretary) may approve for all individuals (or for

some individuals determined by the Secretary to be at risk for cardiovascular disease), including indications measured by noninvasive testing.

The Secretary may not approve an indication under subparagraph (B) for any individual unless a blood test for such is recommended by the United States Preventive Services Task Force.

(2) The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency for each type of cardiovascular screening blood tests, except that such frequency may not be more often than once every 2 years.

Coverage applies to tests furnished on or after January 1, 2005.

§613 - COVERAGE OF DIABETES SCREENING TESTS

The term "diabetes screening tests" means testing furnished to an individual at-risk for diabetes (as defined below) for the purpose of early detection of diabetes, including:

A. a fasting plasma glucose test; and
B. such other tests, and modifications to tests, as the Secretary determines appropriate, in consultation with appropriate organizations.

For purposes of coverage for diabetes screening tests, the term "individual at-risk for diabetes" means an individual who has any of the following risk factors for diabetes:

A. Hypertension
B. Dyslipidemia
C. Obesity, defined as a body mass index greater than or equal to 30 kg/m2
D. Previous identification of an elevated impaired fasting glucose.
E. Previous identification of impaired glucose tolerance
F. A risk factor consisting of at least 2 of the following characteristics:
    1. Overweight, defined as a body mass index greater than 25, but less than 30, kg/m2
    2. A family history of diabetes
    3. A history of gestational diabetes mellitus or delivery of a baby weighing greater than 9 pounds
    4. 65 years of age or older

The Secretary shall establish standards, in consultation with appropriate organizations, regarding the frequency of diabetes screening tests, except that such frequency may not be more often than twice within the 12-month period following the date of the most recent diabetes screening test of that individual.

Coverage applies to tests furnished on or after Jan. 1, 2005.

Job Opportunities

Job Posting

Combined urgent care/family practice seeking board certificated/board eligible family physician for a growing, affluent Northwest Indiana community. Very competitive annual salary plus benefits. Rolling dunes and small town atmosphere with an excellent school system. Thirty-five miles from Chicago. Contact Pam at (219) 796-6971 or via e-mail: Firstattending@sbcglobal.net

Practice opportunity for Family or Internal Medicine physician.

Physician selling thriving practice (35 years) in Bloomington, Indiana. No HMOs accepted, some PPO, almost no Medicaid, approximately 29% Medicare, a small number of self-pay and remaining commercial insurances. No OB and no pediatric patients. Minimal call. Incoming physician will work with highly skilled and knowledgeable staff of seven. Staff includes part-time nurse practitioner. Current physician owner will stay with practice for up to 12 months to introduce patients to new physician while gradually reducing time in the office.

Bloomington (the county seat) is located in the rolling hills of Monroe County within the south central region of Indiana. Home to Indiana University, three lakes, two state parks/forests and a thriving town full of unusual shops, ethnic restaurants, and cultural activities.
Those interested in the position can call in confidence to 812.332.7162.

Membership Update

Please Keep Us Up-To-Date

Members, please be sure to
keep your contact information up-to-date
with the AAFP and the IAFP, including your:
address, phone, fax, and e-mail.
To update, please call Amanda at
IAFP: (317) 237-4237 or in-state toll free (888) 422-4237
or abowling@in-afp.org.

Membership Status Totals

Active	1574
Supporting	4
Inactive	20
Life	186
Resident	261
Student	315

New Members

The Academy extends a warm welcome to the following new members:

Active Members

Jihad Charabati, MD
Lafayette, IN

Robert Evard, MD
Carmel, IN

Olusegun Ishmael, MD
Munster, IN

Jose Lopez, MD
Paol, IN

Shannon Riegle, MD
Muncie, IN

Residents Members

Franklin Ademodi, MD
Merrillville, IN

Addison Crag-Chaderton, DO
Merrillville, IN

Student Members

Mr. John Badlea
Indianapolis, IN

Mr. Andrew Bridge
Indianapolis, IN

Mr. Christopher Chiu
Valparaiso, IN

Ms. Emily Contreras
Terre Haute, IN

Ms. Frances Contreras
Terre Haute, IN

Mr. Luke Drake
Indianapolis, IN

Mr. Donald Fahler
Gary, IN

Mr. Derik Geist
Indianapolis, IN

Ms. Christine Groves
Indianapolis, IN

Mr. Jeremy Hacker
Evansville, IN

Ms. Theresa Hansen
Indianapolis, IN

Ms. Kathleen Hertzer
Bloomington, IN

Mr. Mark Hubbard
Carmel, IN

Ms. Sandra King
Indianapolis, IN

Ms. Nikkia Lassere
Indianapolis, IN

Mr. Brenda LeRoy
McCordsville, IN

Ms. Sarah Ligler
Indianapolis, IN

Ms. Adrianne Lona
Indianapolis, IN

Ms. Clarenda Love
Avon, IN

Ms. Jennifer Maya
Portage, IN

Ms. Allison Meadows
Indianapolis, IN

Mr. Keith Miller
Terre Haute, IN

Ms. Rachel Miller
Indianapolis, IN

Ms. Dinorah Milner
Fort Wayne, IN

Ms. Tracy Murray
Indianapolis, IN

Mr. Michael Nannenga
Indianapolis, IN

Mr. Justin Park
Bloomington, IN

Mr. Hiren Patel
Indianapolis, IN

Mr. Dan Riethmiller
Indianapolis, IN

Ms. LeeAnn Ruf
Evansville, IN

Mr. Hahns Shin
Indianapolis, IN

Mr. Andrew Terrell
Bloomington, IN

Ms. Claire Uebbing
Mishawaka, IN

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