FRONTLINE PHYSICIAN

A Publication of the Indiana Academy of Family Physicians • Spring 2011

IAFP Attends Annual Ten State Conference

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Healthy Communities Collaborative Focuses on Cardiovascular Disease

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

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

Advocacy and Influence

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

Membership and Leadership Development

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

Education and Research

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

INDIANA ACADEMY OF FAMILY PHYSICIANS

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Jason Marker, MD

Digging Out After the "Blizzard"

As I write this, Indiana is in the midst of what some are calling a "blizzard." I guess, by meteorological definitions, it probably is, but for a busy family physician like me, it's a chance for my family to stay home in our pajamas for a day of getting caught up a little bit.

I remain confident that spring will eventually arrive, and we'll appreciate it all the more after the winter we've had this year. However, just as spring hits, the "blizzard" of activity within the IAFP is usually just beginning in earnest. Kevin and Deeda, assisted by the rest of our great staff in Indianapolis, are never busier than in the spring as they begin to ramp up for several big events in the near future.

We're just returning from our Ten State Meeting in Milwaukee (see article on page 12) and then in March, our Board of Directors will meet (now's the time to let us hear from you about anything on your mind). Later in the spring, IAFP leadership and staff members will be meeting with physicians in all of our geographic regions within Indiana and staying especially focused on the needs of our students and residents through those visits. Please plan to join us when you get your invitation! Finally, preparations for our Annual Meeting (July 22-24) in French Lick are already underway. The summer 2012 meeting will be in Indy at the new JW Marriott downtown, so this summer will be your last chance for a while to relax in the French Lick Springs Resort while getting awesome CME and taking part in the business of the Academy.

The second "blizzard" we deal with is the crazy whirlwind of activity that is the Indiana legislative session. Thanks to Doug and Meredith (our personal meteorologists to the State House), we have great relationships with lots of key legislators and are making sure that our priorities are being addressed. You can read the legislative update in this mailing and let them know your opinion on any of the issues up for debate. Make sure to communicate also with your own senators and representatives in Indianapolis — personal relationships with our elected officials are highly effective tools in the battle to be heard in the legislature. On a related note, making an early 2011 contribution to the IAFP Political Action Committee allows those funds to go to work for your agenda right away. Call 317.237.4237 to find out the best way to get your contribution where it can do the most good.

Well, it's cold and snowy right now, but who knows how it will be outside when this arrives in your mailbox? So, stay warm, stay cool, stay dry, don't get blown over — or whatever other weather-related salutation might be necessary to get through your day. I hope to see you at one of our upcoming events, and I wish you and your practice well in the meantime.

Jason Marker, MD

Mark Your Calendar

2011 Residents' Day/Research Forum
Friday, May 13, 2011
IUPUI Campus Center, downtown Indianapolis

2011 IAFP Annual Convention
Scientific Assembly and Congress of Delegates
July 21-24, 2011
French Lick, Indiana

IAFP Continuing Medical Education Alaska Cruise
August 6-13, 2011

AAFP Events 2011 highlights include:

AAFP Board of Directors
September 9-11, 2011
Orlando, Florida

AAFP Annual Scientific Assembly
September 14-17, 2011
Orlando, Florida

Member News

Marker Family Heads to Ecuador

IAFP president Jason Marker, MD, and his family of five are using their spring break to participate in a short-term mission trip to Ecuador!

Jason has been invited to give a series of lectures to the resident physicians of the Family Medicine Residency Program located in Ecuador's capital city, Quito. Dr. Roy Ringenberg is an acquaintance of Dr. Marker and is a faculty member of the residency program in the Hospital Vozandes. The Markers will be traveling with a group from St. Mark Missionary Church in Mishawaka, Indiana, and will also be serving the impoverished neighborhood of Carmen Bajo by assisting in the ongoing construction of a church and school there. An additional goal is to expand the English-language instruction of more than 120 children who participate in a daily Compassion International program.

The IAFP wishes Dr. Marker and his family a safe and productive trip!

Residents' Day/Research Forum

After last year's record number of abstracts submitted by family medicine residents from across Indiana, we are more excited than ever about our 2011 Residents' Day, being held for the first time at IUPUI's Campus Center in downtown Indianapolis.

This program gives family medicine residents (and IAFP members) from across Indiana the chance to exhibit case presentations, performance improvement or original research lectures to their peers, faculty members from residency programs and a panel of judges. Poster presentations are also included, and prizes are awarded at the end of the day.

The program is complimentary for all IAFP member residents.

In 2011, Residents' Day will be held on Friday, May 13, at the IUPUI Campus Center in downtown Indianapolis. Check our website for more details and information on submitting an abstract. Remember, **ALL** IAFP members can participate in this event.

Legislative Update

by Meredith Edwards

With Indiana making national news, the IAFP is sure you are aware how contentious negotiations have been this year in the Indiana House of Representatives. While the union and education-related legislation have been the hot topics in the news, the health bills introduced have also been controversial.

When the Indiana House of Representatives Democrats refused to return to the Statehouse, a number of pieces of legislation were left that had not received a full House vote. Originally, the deadline for bills to pass out of their first House was February 25, but the House Rules committee has voted to move the deadline. However, the Rules committee report still needs to be adopted by the full House with a quorum for new deadlines to go into effect.

The budget and midlevel provider scope of practice bills were left on the House calendar needing either a committee report adopted, amendments or a full House vote. The status of these bills is unknown as of press time. However, it is common practice for bills that die to be amended into other pieces of legislation during session.

As of press time, the House Democrats remained in Urbana, Illinois. It is unknown at this time how far the House of Representatives deadlines will be pushed back if the House Democrats continue their boycott. The Senate is continuing with their normal deadline schedule and has begun committee hearings on House bills sent to the Senate.

The IAFP Commission on Legislative and Governmental Affairs (COL) met on January 26 to discuss all the introduced health-related legislation and determine appropriate action. The IAFP COL, which is comprised of family physicians from across the state with an interest in policy, had to consider more than 50 bills owing to the vast number of health-related bills that were introduced.

Below is the breakdown of key health legislation of which family physicians should be aware. If you have questions on IAFP advocacy, or are interested in participating in IAFP advocacy, please contact Meredith Edwards or Doug Kinser, JD, at 317.237.4237 or medwards@in-afp.org. For the most up-to-date information on legislative activity, please look for our electronic newsletter the *e-Frontline* in your e-mail inboxes.

2011 Budget

The IAFP can report that currently the family medicine residency funding remains in the budget, with the 15 percent cut that the governor required of all boards and agencies. The Indiana Tobacco Prevention and Cessation agency received a larger cut than other agencies, reducing their budget to $8.05 million.

Scope of Practice Issues

As the IAFP expected, many non-physician health care providers came to the legislature seeking scope of practice expansions. At this point in session, we know the bill allowing non-nurse midwives to perform home births will not be moving forward.

The physician assistants originally came forward with a bill that would have grossly expanded their scope of practice, however through negotiations between the IAFP, the State Medical Association and the Indiana Academy of Physician Assistants, the groups are working on a bill with compromises. Currently, House Bill 1298 gives supervising physicians up to 72 hours to review charts and allows supervising physicians to delegate to their physician assistants the prescription of schedule 2-5 controlled substances not to exceed a 30 day supply (current law is only seven days). The bill has passed out of committee and is currently awaiting a House vote.

Physical therapists are seeking direct access to patients this year. The current law in Indiana states that patients must have a referral before treatment by a physical therapist. House Bill 1151 would allow physical therapists to treat patients for 30 days before requiring a referral from a physician. The House Public Health Committee heard House Bill 1151 on February 16, and IAFP past president Teresa Lovins, MD, of Columbus, Indiana, testified in opposition of the bill, citing patient safety. The bill passed out of committee and is awaiting its committee report to be adopted by the full House.

Online Death Registry

Senate Bill 366 has been much anticipated by the IAFP. Among other provisions it will remove the criminal penalties associated with failing to sign a death certificate. New penalties will begin after 2012 but will be at the discretion of the Medical Licensing Board and likely fine based. With the introduction of the new online death registry, another problem was quickly discovered — medical residents were unable to sign any death certificates. At the urging of the family medicine residency directors in the state, the IAFP sought to have Senate Bill 366 amended to include a provision to allow all residents to sign death certificates. The bill was amended and has been passed out of the Senate.

Insurance and Payment
For the third year, legislation that would ban open-access clauses in insurance contracts was introduced. House Bill 1080 was heard in the House Insurance committee on January 26, where IAFP member Dr. Topper Doehring of Indianapolis testified on how open-access clauses prohibit physicians from having control over their practice. This year, the bill failed to move out of committee but may be studied this summer.

The Insurance committee also heard House Bill 1582, which would require physicians to give patients five provider options for any referral and the costs that patients could expect. The IAFP spoke to Rep. Heath VanNatter, the author of the bill, about our opposition. Rep. Heath VanNatter noted our concerns, and the bill was amended to form a study committee on this issue. The bill is awaiting a full House vote.

Criminal Background Checks
Sen. Pat Miller introduced Senate Bill 363, which would require national criminal background checks for certain professionals seeking their initial license to practice in Indiana. The list of included professionals is extensive and includes physicians, podiatrists, genetic counselors, nurses, pharmacists, chiropractors and massage therapists. The bill was passed out of the Senate.

Public Health
In the pubic health realm, bills concerning student concussions, the drug spice and texting while driving all look like they will pass out of both houses at this time. Senate Bill 57 makes possessing, dealing in, manufacturing or delivering a synthetic cannabinoid (commonly referred to as spice) equivalent to the same crimes for marijuana. Senate Bill 18 would prohibit the use of handheld electronic devices from being used to send or read e-mails or texts. Senate Bill 93 requires the Indiana Department of Education to create materials educating coaches, athletes and parents about the risks of head injuries and requires the evaluation of students with suspected head injuries.

Health Care Reform Implementation
The Federal Patient Protection and Affordable Care Act (PPACA) left much of its implementation to the states. Senate Bill 461 would prepare Indiana for implementation of health care reform, by decreasing income eligibility for the Healthy Indiana Plan (HIP) to 113 percent of the federal poverty level. The state plans to change HIP into an entitlement program in 2014 so it can function as Indiana's Medicaid expansion as required under PPACA. Currently, the state administration and CMS are in discussions about whether the state can keep personal patient contributions a part of the HIP program under the expansion. Senate Bill 461 also gives the Family and Social Services Agency the ability to alter Medicaid coverage to match the federal minimum benefits package, when that package is announced. The bill has passed out of the Senate.

Indiana Academy Members and Staff Attend Ten State in Wisconsin

IAFP president Jason Marker, MD, was joined by IAFP leaders and staff members in a chilly Milwaukee, Wisconsin, this February for the Annual Ten State Conference. This is our opportunity to get together with our colleagues from surrounding states to share best practices, fellowship and updates on our chapter's activities. Part of the exciting program of events included a trip to the Harley-Davidson Museum.

Staff members Missy Lewis and Meredith Edwards presented a very well-received talk about our chapter's recent move to cloud-based computing. The presentation covered an overview and description of the cloud, its advantages over a traditional server-based office set-up and the various available online services such as applications, e-mail, group e-mails, documents and calendars. Due to the large number of questions and compliments Missy and Meredith received following this talk, it's clear that their presentation was of great interest and value to our colleagues from other chapters.

A copy of the report we provided to other states is reprinted here.

Jason Marker, MD, IAFP president, sits astride a Harley-Davidson motorcycle in Wisconsin. He is joined by (from left to right) Teresa Lovins, MD; Clif Knight, MD; Shelley Knight; Deanna Willis, MD; Risheet Patel, MD; Missy Lewis, CAE; Kevin Speer, JD; and Meredith Edwards.

Indiana Academy Ten State Report • February 2011

Government Affairs/Legislation

In 2010, the Indiana General Assembly held its short session, which lasts just three months. The 2011 session is the budget-writing session for the state and will last until the end of April. The IAFP will be watching the funding levels for the following: family medicine residencies, Indiana University Medical School, Medicaid and the Indiana Tobacco Prevention and Cessation Agency.

Early in January 2010, we hosted our second annual legislative breakfast. We had a shorter presentation by one of the new co-chairs for the IU Department of Family Medicine once again on the shortage at our legislative breakfast. We had ten legislators in attendance, and all stayed to spend time to talk with the physicians at the breakfast.

For 2011, our legislative breakfast will be in mid-March to provide emphasis during the final budget negotiations that family medicine residencies need to be funded and that Medicaid payments to primary care physicians cannot be cut. Our plan this year is to invite more medical students and family medicine residents to speak with the legislators that attend

2010 and 2011 Health Legislation…

Scope of Practice: A bill to allow for the practice of direct-entry midwives (non-nurse midwives) for home births was introduced in 2010 and 2011. It was not heard in committee in 2010, but the IAFP is maintaining a watchful eye in 2011. Several bills that would allow direct access to physical therapists have been filed in 2011, as have bills that would allow pharmacists to administer more immunizations.

Open-Access Clauses: The house of medicine sought legislation to prohibit "open-panel" or "open-access" clauses in contracts between physicians and insurers in 2010. These clauses require a physician to continue to take patients from a particular insurer or completely close their panel. In 2010, the open-access bill was passed out of committee but did not receive a House floor vote, and in 2011, we already have a committee hearing scheduled for the bill.

Smoking Ban in Public Places: The smokefree air bill failed to move forward in the second house in 2010, and we once again have a smokefree air bill in 2011. The bill is eligible for a second reading in the House, though we are not confident it will be heard in the Senate.

Indiana Tobacco Prevention and Cessation Agency: The Indiana chapter has been a longtime supporter of the work done by the Indiana Tobacco Prevention and Cessation Agency. In 2010, there was an imminent threat that the agency would be dismantled, but the agency was saved.

Medicaid Fraud Matters: In 2010, a troublesome bill was introduced that would have would have required a $50,000 surety bond from every Medicaid provider for the purpose of recouping fines for fraud, and it would have allowed the attorney general's office to seize medical records of physicians based on allegations of abandonment, without giving the physician a hearing. The IAFP worked with the author and the attorney general's office to remove these offending portions of the bill.

Region Affairs

In 2010, IAFP staff members visited all eight regions and, in each region, held meetings with the local family medicine residents during the day and a dinner for all the family physicians, residents and medical students in the area that night. The residency visits were very successful. At each residency, the IAFP staff gave an introductory presentation about the IAFP and answered questions from the residents about our advocacy and member services. The residency visits will definitely be continued, but the board has not determined the frequency of their occurrence.

Health Care Services Commission

In 2010, the Indiana Health Care Services Commission sent letters to CMS concerning the proposed physician fee schedule changes. By direction of the Congress of Delegates, the Indiana chapter wrote a letter to the Medical Licensing Board urging it to legalize expedited partner therapy for gonorrhea and chlamydia. The commission approved articles in the *FrontLine* magazine and *e-FrontLine* on how practices can compete better with retail clinics. When planning the PCMH sessions for the fall conference, the Commission on Health Care Services directed the staff to include a panel of physicians with innovative practices and a session on creating better access for patients.

PCMH

The Indiana chapter has been working with the Indiana chapter of the American Academy of Pediatrics and the department of health on a medical home grant. The grant was recently expanded to add another six family medicine practices. The practices receive support from a facilitator and a guided collaborative environment for transforming their practices.

The Indiana chapter offered a half-day of seminars on PCMH innovations during our free Fall Conference in 2010. Seminar topics included a panel of physicians, group visits, implementing walk-in appointments and EMR meaningful use.

Education

Following the success of 2010's educational events, we are planning a similar program of three major meetings this year — a Spring SAMs & CME event in Indianapolis in April, our Annual Convention in French Lick in July and another Fall Conference this November. Each of these events will feature prescribed CME credit and at least one MC-FP SAM Study Group, which continue

to be very popular with our members. In November, we were able to offer a Fall Conference free of charge to our members, which included a program of education on the PCMH, Hot Topic CME and a SAM Study Group. This was one of our highest-attended meetings in recent years. We chose to offer the meeting free of charge as a member service and have experienced a positive reaction from our members.

This year, our annual Residents' Day/Research Forum will be held at Indiana University – Purdue University Indianapolis' Campus Center in downtown Indianapolis for the first time. We have pushed back the date of this event to allow more time for residents to complete their research, and we hope this change will encourage more students to attend for the day. We also decided to move our annual student interest reception and residency fair to the same day, in the evening, rather than in the fall. Attendance had declined in recent years, and many students felt that this was because fourth-year students were already too far into their search, but the younger students were not really ready to engage with the residencies. We hope that combining the events will draw in many more second- and third-year students.

Our 2010 Student Survival Skills Day, an event at which residents teach third-year students very basic skills just days before they begin clinical rotations, was held again in June. Unfortunately, attendance declined quite a bit — just over half of what it had been in recent years. With the changes to our student interest reception and residency fair, it is likely that we will not host Student Survival Skills Day in 2011 and will look for a new large event that will engage students during the next school year.

In August 2011, we will be hosting our third CME at Sea. Our physicians will be cruising from Seattle to Alaska on the Holland America *Westerdam* for a seven-day trip. During the trip, the IAFP will be offering more than 10 CME credits.

Our annual convention in French Lick, Indiana, continues its condensed schedule this year, aiming to provide a leaner meeting for our members so they could participate fully while spending less time out of the office. We have contracted with the brand-new JW Marriott in Indianapolis for 2012, which will be one of the very few meetings in the past decades not to be held at French Lick. This new facility is considered the gem of the $450 million Marriott Place development of five Marriott hotels connected to the Indiana Convention Center. The hotel boasts one of the largest Marriott ballrooms in the world and offers 104,000 square feet of meeting, banquet and exhibit space.

Communications

We have been working with Indianapolis-based SpinWeb to develop a new website and transition our office to cloud-based computing. Our new site will feature dedicated news and Twitter feeds, as well as improved calendars and ease in navigation. Over the next year, we will begin to integrate event management, financial transactions, online giving and electronic communications — eliminating the cost and confusion in having multiple providers with overlapping services.

In December, SpinWeb helped us move our e-mail, documents and calendars to Google, in an effort to cut costs and make it easier for staff to be productive while away from the office. All of our staff now enjoy the benefits of Gmail while keeping our branded domain. Electronic documents are now stored in "the cloud" using Google Docs — eliminating the need for costly servers and expensive IT support. Our staff can now work remotely and access all documents from any location with Internet access — smart phones included. This transition will allow us to better collaborate on documents, eliminate duplication of efforts and coordinate schedules.

IAFP continues to produce our magazine, *FrontLine Physician*, on a quarterly basis. Staff time is the only expense incurred, as we are able to print and mail the magazine at no cost, thanks to the advertising that the printer coordinates. Time-sensitive information is shared via e-mail in an *e-Frontline* (electronic newsletter) as needed, and more recently also via Twitter (@INFamDocs) and Facebook (facebook.com/InAFP). These social media efforts are slowly catching on with our membership, and we hope that integrating the Twitter feed into the new website will help.

Strategic Plan

Updating the strategic plan was one of our biggest undertakings in 2010. A summary of the plan was provided in the last issue of *FrontLine Physician* and will be available on the new website. Every effort has been made to plan board meetings that are focused on advancing the goals of the strategic plan.

Foundation

The IAFP Foundation is excited to be wrapping up the *Family Practice Stories Book* this year. The book is a compilation of interviews and stories of family medicine dating back to the middle of the 20th century. We hope to have the book completed and published by the end of 2011. While serious stock market concerns limited activity in the last couple of years, the Foundation has been able to continue supporting the IU Family Medicine Student Interest Group (FMSIG) by providing meals for FMSIG meetings. Among the topics that were addressed: "Practicing Medicine in a Rural Community," "Preparing for Residency Interviews" and "What Is Family Medicine?"

Staff

The Academy operates with a staff of four full-time employees and one part-time employee, in addition to the EVP.

Healthy Communities Collaborative Focuses on Cardiovascular Disease

The Indiana Academy of Family Physicians is excited to announce that we are working with the AAFP and the Wisconsin chapter on the first-ever Healthy Communities Collaborative Performance Improvement CME program. Supported by a grant from GSK, this program will help family physicians enhance the comprehensive care they provide to patients with cardiovascular disease, or CVD. The 18-month longitudinal curriculum is built on the Academy's existing performance improvement CME programs — Measuring, Evaluating and Translating Research Into Care, or METRIC, and the Quality Improvement Practice Enhancement Forum, or PEF — and will help 32 family medicine practice teams in Wisconsin and Indiana achieve practice-based improvements aimed at improving cardiovascular care.

Integrating Performance Improvement and Outcomes Assessment

According to an executive summary of the program, the AAFP HCC "integrates current best practices in QI (quality improvement), PI (performance improvement) CME and research evaluation to help participants achieve measurable, sustainable improvements in addressing learning needs and practice performance gaps when caring for patients with CVD and related health risk factors and comorbidities."

The program's learning objectives note that family physicians who participate in the AAFP HCC will be better able to:

- Provide leadership to help their practices cooperate, collaborate, communicate and integrate care in teams to ensure that care for patients with CVD is continuous and reliable
- Apply quality improvement to understand and measure quality of care in terms of structure, process and outcomes in relation to patient and community needs, as well as design and test interventions to change processes and systems of care
- Provide patient-centered care and communication and counsel patients on how to reduce their risk of developing CVD and how to manage related conditions
- Conduct appropriate screenings on patients with coronary artery disease, or CAD, such as serum cholesterol tests, blood pressure and weight measurement, and provide recommended treatments, such as antiplatelet therapy

The program will use clinical performance measurement sets developed by the AMA Physician Consortium for Performance Improvement and endorsed by the nonprofit National Committee for Quality Assurance.

The planning and development phase began in January with recruitment of physician champions and program coordinators, and meetings with program faculty members and state chapter leaders. For more information, please visit www.aafp.org/hcc. To find out about program availability for practice teams or control practices, please contact us at 317.237.4237 or e-mail iafp@in-afp.org. We'll be sharing news about this important and ground-breaking program on an ongoing basis.

A Report of the Surgeon General:
How Tobacco Smoke Causes Disease

The Biology and Behavioral Basis for Smoking-Attributable Disease

In December, U.S. Surgeon General Regina Benjamin, MD — a family physician — released the 30th tobacco-related Surgeon General's report issued since 1964. It describes in detail the specific pathways by which tobacco smoke damages the human body. The scientific evidence supports the following conclusions:

The Changing Cigarette

- The evidence indicates that changing cigarette designs over the last five decades, including filtered, low-tar, and "light" variations, have not reduced overall disease risk among smokers and may have hindered prevention and cessation efforts.
- There is insufficient evidence to determine whether novel tobacco products reduce individual and population health risks.
- The overall health of the public could be harmed if the introduction of novel tobacco products encourages tobacco use among people who would otherwise be unlikely to use a tobacco product or delays cessation among persons who would otherwise quit using tobacco altogether.

Chemistry and Toxicology of Cigarette Smoke and Biomarkers of Exposure and Harm

- In spite of uncertainties concerning whether particular cigarette smoke constituents are responsible for specific adverse health outcomes, there is broad scientific agreement that several of the major classes of chemicals in the combustion emissions of burned tobacco are toxic and carcinogenic.
- The design characteristics of cigarettes, including ventilation features, filters, and paper porosity, have a significant influence on the levels of toxic and carcinogenic chemicals in the inhaled smoke.
- The different types of tobacco lamina (e.g., bright, burley, or oriental) that are combined to produce a specific tobacco blend have a significant influence on the levels of toxic and carcinogenic chemicals in the combustion emissions of burned tobacco.
- There is no available cigarette machine-smoking method that can be used to accurately predict doses of the chemical constituents of tobacco smoke received when using tobacco products.
- Tobacco-specific biomarkers (nicotine and its metabolites and the tobacco-specific nitrosamines) have been validated as quantitative measures of exposure to tobacco smoke among smokers of cigarettes of similar design who do not use other tobacco-containing products.
- Although biomarkers of potential harm exist for most tobacco-related diseases, many are not specific to tobacco and levels are also influenced by diet, occupation, or other lifestyle or environmental factors.

Nicotine Addiction: Past and Present

- Nicotine is the key chemical compound that causes and sustains the powerful addicting effects of commercial tobacco products.
- The powerful addicting effects of commercial tobacco products are mediated by diverse actions of nicotine at multiple types of nicotinic receptors in the brain.
- Evidence is suggestive that there may be psychosocial, biologic, and genetic determinants associated with different trajectories observed among population subgroups as they move from experimentation to heavy smoking.
- Inherited genetic variation in genes such as CYP2A6 contributes to the differing patterns of smoking behavior and smoking cessation.
- Evidence is consistent that individual differences in smoking histories and severity of withdrawal symptoms are related to successful recovery from nicotine addiction.

Cancer

- The doses of cigarette smoke carcinogens resulting from inhalation of tobacco smoke are reflected in levels of these carcinogens or their metabolites in the urine of smokers. Certain biomarkers are associated with exposure to specific cigarette smoke carcinogens, such as urinary metabolites of the tobacco-specific nitrosamine 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone and hemoglobin adducts of aromatic amines.
- The metabolic activation of cigarette smoke carcinogens by cytochrome P-450 enzymes has a direct effect on the formation of DNA adducts.
- There is consistent evidence that a combination of polymorphisms in the CYP1A1 and GSTM1 genes leads to higher DNA adduct levels in smokers and higher relative risks for lung cancer than in those smokers without this genetic profile.
- Carcinogen exposure and resulting DNA damage observed in smokers results directly in the numerous cytogenetic changes present in lung cancer.
- Smoking increases the frequency of DNA adducts of cigarette smoke carcinogens such as benzo[a]pyrene and tobacco-specific nitrosamines in the lung and other organs.
- Exposure to cigarette smoke carcinogens leads to DNA damage and subsequent mutations in TP53 and KRAS in lung cancer.
- There is consistent evidence that smoking leads to the presence of promoter methylation of key tumor suppressor genes such as P16 in lung cancer and other smoking-caused cancers.

- There is consistent evidence that smoke constituents such as nicotine and 4-(methylnitrosamino)-1-(3-pyridyl)-1-butanone can activate signal transduction pathways directly through receptor-mediated events, allowing the survival of damaged epithelial cells that would normally die.
- There is consistent evidence for an inherited susceptibility of lung cancer with some less common genotypes unrelated to a familial clustering of smoking behaviors.
- Smoking cessation remains the only proven strategy for reducing the pathogenic processes leading to cancer in that the specific contribution of many tobacco carcinogens, alone or in combination, to the development of cancer has not been identified.

Cardiovascular Diseases

- There is a nonlinear dose response between exposure to tobacco smoke and cardiovascular risk, with a sharp increase at low levels of exposure (including exposures from secondhand smoke or infrequent cigarette smoking) and a shallower dose-response relationship as the number of cigarettes smoked per day increases.
- Cigarette smoking leads to endothelial injury and dysfunction in both coronary and peripheral arteries. There is consistent evidence that oxidizing chemicals and nicotine are responsible for endothelial dysfunction.
- Tobacco smoke exposure leads to an increased risk of thrombosis, a major factor in the pathogenesis of smoking-induced cardiovascular events.
- Cigarette smoking produces a chronic inflammatory state that contributes to the atherogenic disease processes and elevates levels of biomarkers of inflammation, known powerful predictors of cardiovascular events.
- Cigarette smoking produces an atherogenic lipid profile, primarily due to an increase in triglycerides and a decrease in high-density lipoprotein cholesterol.
- Smoking cessation reduces the risk of cardiovascular morbidity and mortality for smokers with or without coronary heart disease.
- The use of nicotine or other medications to facilitate smoking cessation in people with known cardiovascular disease produces far less risk than the risk of continued smoking.
- The evidence to date does not establish that a reduction of cigarette consumption (that is, smoking fewer cigarettes per day) reduces the risks of cardiovascular disease.
- Cigarette smoking produces insulin resistance and chronic inflammation, which can accelerate macrovascular and microvascular complications, including nephropathy.

Pulmonary Diseases

- Oxidative stress from exposure to tobacco smoke has a role in the pathogenetic process leading to chronic obstructive pulmonary disease.
- Protease-antiprotease imbalance has a role in the pathogenesis of emphysema.
- Inherited genetic variation in genes such as SERPINA3 is involved in the pathogenesis of tobacco-caused chronic obstructive pulmonary disease.
- Smoking cessation remains the only proven strategy for reducing the pathogenetic processes leading to chronic obstructive pulmonary disease.

Reproductive and Developmental Effects

- There is consistent evidence that links smoking in men to chromosome changes or DNA damage in sperm (germ cells), affecting male fertility, pregnancy viability, and anomalies in offspring.
- There is consistent evidence for association of periconceptional smoking to cleft lip with or without cleft palate.
- There is consistent evidence that increases in follicle-stimulating hormone levels and decreases in estrogen and progesterone are associated with cigarette smoking in women, at least in part due to effects of nicotine on the endocrine system.
- There is consistent evidence that maternal smoking leads to transient increases in maternal heart rate and blood pressure (primarily diastolic), probably mediated by the release of norepinephrine and epinephrine into the circulatory system.
- There is consistent evidence that links maternal smoking to interference in the physiological transformation of spiral arteries and thickening of the villous membrane in forming the placenta; placental problems could lead to fetal loss, preterm delivery, or low birth weight.
- There is consistent evidence of the presence of histopathologic changes in the fetus from maternal smoking, particularly in the lung and brain.
- There is consistent evidence that suggests smoking leads to immunosuppressive effects, including dysregulation of the inflammatory response, that may lead to miscarriage and preterm delivery.
- There is consistent evidence that suggests a role for polycyclic aromatic hydrocarbons from tobacco smoke in the adverse effects of maternal smoking on a variety of reproductive and developmental endpoints.
- There is consistent evidence that tobacco smoke exposure leads to diminished oviductal functioning, which could impair fertilization.
- There is consistent evidence that links prenatal smoke exposure and genetic variations in metabolizing enzymes such as GSTT1 with increased risk of adverse pregnancy outcomes such as lowered birth weight and reduced gestation.
- There is consistent evidence that genetic polymorphisms, such as variants in transforming growth factor-alpha, modify the risks of oral clefting in offspring related to maternal smoking.
- There is consistent evidence that carbon monoxide leads to birth weight deficits and may play a role in neurologic deficits (cognitive and neurobehavioral endpoints) in the offspring of smokers.

The complete report can be found at: www.surgeongeneral.gov.

Coding and Billing Update

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

Influenza Vaccine – Medicare

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

Medicare tracks utilization of the influenza vaccine and administration by "influenza virus season," not by calendar year. This means a Medicare beneficiary could have more than one influenza vaccine/administration in a calendar year and still have coverage for both services. For example, a beneficiary receives an influenza virus vaccination in January 2011, and another influenza virus vaccination is given in November 2011. Medicare pays for both services because the immunizations were performed in separate influenza seasons.

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

The administration code for influenza vaccines is G0008 (administration of influenza virus vaccine). The Indiana 2011 payment allowance is $22.24 (G0008).

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

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

90658 – Influenza Virus Vaccine, Split Virus, When Administered to Individuals 3 Years of Age and Older, for Intramuscular Use – Dates of Service September 1, 2010, through December 31, 2010

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

90658 – No Longer Valid for Billing Medicare Beneficiaries

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

CPT Code	Payment Allowance	Description
Q2035	Payment to be determined by National Government Services (NGS)	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Afluria)
Q2036	$7.439, rounded to $7.44	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (FluLaval)
Q2037	$13.253, rounded to $13.25	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluvirin)
Q2038	$12.593, rounded to $12.59	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (Fluzone)
Q2039	Payment to be determined by NGS	Influenza virus vaccine, split virus, when administered to individuals 3 years of age and older, for intramuscular use (not otherwise specified)

Additional Payment Allowances for Other Influenza Vaccines

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

CPT Code	Payment Allowance	Description
90655	$12.398, rounded to $12.40	Influenza virus vaccine, split virus, preservative free, when administered to children 6-35 months of age, for intramuscular use
90656	$12.375, rounded to $12.38	Influenza virus vaccine, split virus, preservative free, when administered to individuals 3 years and older, for intramuscular use
90657	$6.297, rounded to $6.30	Influenza virus vaccine, split virus, when administered to children 6-35 months of age, for intramuscular use
90660	$22.316, rounded to $22.32	Influenza virus vaccine, live, for intranasal use (e.g. FluMist)
90662	$29.213, rounded to $29.21	Influenza virus vaccine, split virus, preservative free, enhanced immunogenicity via increased antigen content, for intramuscular use (e.g., Fluzone High-Dose)

New Immunization Administration Codes for 2011

**The following codes are not recognized by Indiana Medicare and/or Indiana Medicaid for reimbursement purposes.

CPT 2011 made several code changes for the administration of vaccines and toxoids. Codes 90465 through 90468 have been deleted. Physicians are instructed to use 90460, 90461 and 90471-90474.

- 90460 – Immunization administration through 18 years of age via any route of administration, with counseling by physician or other qualified health care professional; first vaccine/toxoid component
- 90461 – Each additional vaccine/toxoid component (list separately in addition to code for primary procedure)
- 90471 – Immunization administration (includes percutaneous, intradermal, subcutaneous, or intramuscular injections); one vaccine (single or combination vaccine/toxoid) (do not report 90471 in conjunction with 90473)
- 90472 – Each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)
  - (Use 90472 in conjunction with 90471 or 90473)
- 90473 – Immunization administration by intranasal or oral route; one vaccine (single or combination vaccine/toxoid)
- 90474 – Each additional vaccine (single or combination vaccine/toxoid) (list separately in addition to code for primary procedure)

Administration codes 90460, 90461 and 90471-90474 are reported in addition to the vaccine and toxoid code(s) 90476-90749.

Codes 90460 and 90461 are only used when the physician or qualified health care professional provides face-to-face counseling of the patient and family during the administration of a vaccine. For immunization administration of any vaccine that is not accompanied by face-to-face physician or qualified health care professional counseling to the patient/family, or for administration of vaccines to patients over 18 years of age, report codes 90471-90474.

If a significant separately identifiable evaluation and management service (e.g., office or other outpatient services, preventive medicine services) is performed, the appropriate E/M service code should be reported in addition to the vaccine and toxoid administration codes.

Immunization Administration with Counseling by Physician/Other Qualified Health Care Professional Through 18 Years of Age

Physicians and nonphysician practitioners will use 90460 for each vaccine administered. For vaccines with multiple components (combination vaccines), physicians will report 90460 for the initial component and 90461 for each additional component in a given vaccine.

Detailed descriptions for 90460 and 90461 are included in *CPT Changes 2011: An Insider's View*, published by the American Medical Association.

Clarifications

90460-90461 require (must meet ALL):

- 18 years of age or younger
- Physician or other qualified health care professional personally provides counseling – according to information verbally presented during the American Medical Association's 2011 *CPT* Coding Symposium, the term "qualified health care professional" does not include ancillary personnel, e.g., RN, LPN, MA
- Documentation of service provided by physician or other qualified health care professional (not all-inclusive)
- Risk/benefit counseling for each component with presentation of the Vaccine Information Statement. This information includes both the risk of contracting the preventable disease as well as the social concerns related to school mandates for the vaccine component
- Answering the parent's questions about side effects and safety
- Instructions given to parent regarding anticipated or possible side effects detailing the care plan for signs/symptoms, which should include information on when the physician/nonphysician provider should be notified of the signs/symptoms
- Required documentation for each vaccine
  - Lot number in both medical record and statewide vaccine registry

The key to correctly reporting these new administration codes is knowing whether the vaccine being administered has a single or multiple components.

- Rotavirus has one component – Code
  - 90460 X 1 unit
  - 90681 (rotavirus vaccine, human, attenuated, two-dose schedule, live, for oral use)
- Example: DTaP – Code
  - 90460 X 1 unit
  - 90461 X 2 units
  - 90700 X 1 unit (DTaP vaccine)

Coding for Immunizations Administered to a 2-Month-Old Infant

Counseling is provided by the physician or qualified health professional for each component of each vaccine and all other requirements for using 90460-90461 have been met. The coding is as follows:

Immunization	Administration Code(s)	Vaccine Code
Rotavirus	90460	90681
DTaP	90460, 90461 X 2	90700
Hepatitis B and hemophilus influenza type b	90460, 90461	90748
Pneumococcal conjugate vaccine, 13 valent	90460	90670
Inactivated poliovirus	90460	90713

Physicians should continue to use the existing codes 90471-90474 when all the requirements for 90460-90461 are not met:

Immunization	Administration Code(s)	Vaccine Code
Rotavirus	90471	90681
DTaP	90472	90700
Hepatitis B and hemophilus influenza type b	90472	90748
Pneumococcal conjugate vaccine, 13 valent	90472	90670
Inactivated poliovirus	90472	90713

IAFP Members

Plan Now for the IAFP Annual Convention This July!

We're headed back to French Lick this summer for another Annual Convention. Featuring the shorter schedule that was successful for the past couple of years, this meeting enables you to participate fully in the activities of your Academy while spending less time out of your office. Haven't visited French Lick since its renovation? You won't believe the changes that have taken place! This is a great opportunity to bring the whole family for a vacation close to home, as well as benefit from education, fellowship and networking opportunities.

- Hot topic CME planned by family physicians for family physicians — Topics will include major depressive disorder, asthma, new drugs update, diabetes, coding and billing, musculoskeletal medicine, dermatology and much more!
- MC-FP SAM Study Group on maternity care
- All-Member Congress of Delegates
- Exhibit Show

Location: French Lick Resort, featuring world-class golf, pools, spas, youth activities and more!

Check your mail for more information coming soon, or check our website: www.in-afp.org.

See you in French Lick!

IAFP Alaskan CME Cruise

The Indiana Academy of Family Physicians is extremely pleased to invite you to join us onboard Holland America Line's vista-class luxury ship, the *MS Westerdam*, as it sails the inside passage on the IAFP Alaskan CME Cruise — August 6-13, 2011.

More than 10 hours of approved CME, planned by the IAFP, will be offered. Timely topics, which have been identified on the IAFP CME needs assessment, include dermatology, chronic pain management and treatments, new recommendations for preventative care services, neurology – movement disorder, how to improve payment in your practice, physician leadership in the new year model and more. Speakers include family medicine leaders Clif Knight, MD; Fred Ridge, MD; Risheet Patel, MD; Kevin Speer, JD; and health care attorney, Doug Kinser, JD. All CME sessions will be held while the ship is at sea … not detracting time from when the ship is docked or inside the Hubbard Glacier Park.

The IAFP's last CME Cruise to Alaska, held in 2004, was an exciting trip that was exceptionally received by all attendees. Comments from attendees included:

"The Cruise was an unforgettable experience full of unbelievably spectacular experiences, especially the time spent in Glacier Bay."

"We had been wanting to take an Alaskan Cruise for sometime. The IAFP did all the legwork to find the best cruise line, itinerary, cost, etc. and also provide an excellent CME that we needed. All we had to do was call, register, pack and enjoy! Thanks so much for the wonderful opportunity!"

"Holland America provided the best accommodations, food and service we have experienced during a vacation! Great way to get CME while still having time to enjoy a very special vacation with my wife."

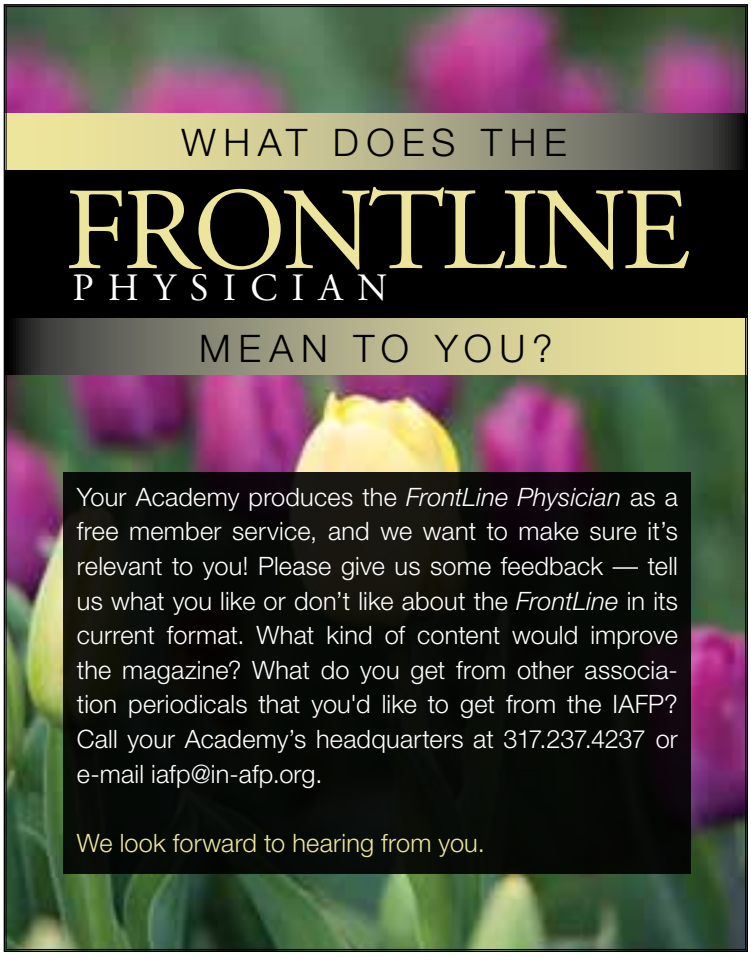
"Wow, every American needs to see Alaska."

"Our first Cruise … won't be our last. Was a wonderful trip and enjoyed being with other family physicians. CME topics were great and the speakers were excellent."

"My favorite part of this trip — everything!"

More info can be found at www.specialeventcruises.com/iafp_2011.html. Call Special Event Cruises at 800.422.0711 to book your cruise. Attendees do not have to register for the CME to attend the cruise, however, you must book your cruise with Special Event Cruises to register and attend the CME.

Cabins for this cruise are selling fast, so remember the sooner you book the better cabin selection available. All deposits are fully refunded for cancellations received prior to May 13, 2011.



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