



# FRONTLINE

PHYSICIAN

A Publication of the Indiana Academy of Family Physicians  
SPRING 2005

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## FRONTLINE PHYSICIAN

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**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 medicine;
- 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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# President's MESSAGE



David Pepple, MD,  
President of Indiana  
Academy of Family  
Physicians

In my President's message for this issue of the *Frontline Physician*, I would like to discuss the issue of Political Action Committees, their impact and the more general issue of effective lobbying of legislators by us as individuals.

In the next several years, it is highly likely that major decisions will be made by officials in our federal government concerning the future of the Medicare program and physician reimbursement, Medicaid, the structure of a healthcare safety net, and implementation of electronic medical records technology. It goes almost without saying that these decisions will have a profound influence on the practices of family physicians.

The fact that the American Academy of Family Physicians is the largest physician organization in the nation without a Political Action Committee has been a concern for many of us for some time. Without a PAC, we feel the AAFP could miss considerable opportunities to significantly influence the decisions reached in the areas of health care policy that I have alluded to above.

With these concerns in mind, this was debated by the AAFP Congress of Delegates in Orlando last fall. After much testimony before the COD, it was the feeling of the Congress that being without a PAC was a major disadvantage for us, and this was corrected by the authorization of a federal PAC for family physicians.

The AAFP's decision was made after careful weighing of the evidence before it. A survey was done of members nationwide. It revealed that of the responders, 41% supported a PAC, 20% opposed a PAC and 34 % said they would be willing to contribute to a PAC. Thus, a fundraising goal of \$500,000 to \$750,000 per

two-year election cycle is attainable. These results contrasted with a similar survey done in 2000, in which only 17 % of the AAFP membership wanted a PAC and 30 % opposed one.

Numerous officers from chapters with state PAC's testified to the effectiveness of state-level PACs. Indiana has had a PAC for several years, and its effectiveness is evident. Certainly the members of the trial lawyer's associations and the chiropractor organizations have their PACs and have been highly effective in lobbying their interests.

At a somewhat more personal level lie our own activities as individual physician-citizens. We have a responsibility to try to influence our respective legislators on these health care issues. I recently attended a regional conference where a state senator gave a portion of a workshop designed to train us in effectively lobbying our state and nationally elected officials. This state senator detailed the most effective ways to lobby.

Most effective, he said, was a personal phone call from the doctor to his office. He said that if he received three phone calls from doctors on a health related bill, that number was significant and unusual. To receive five calls was huge!!!

The second most effective means of getting attention was a legible hand-written letter, he said. Third most effective was a typed letter on the doctor's letterhead. And fourth was an e-mail message.

He also discussed the mechanics of contact in his office, and the same holds true for other lawmaker's offices. He said, "I can't be there all the time. When you call, sometimes you must talk to one of my staff. Sometimes physicians

feel put off or offended that they end up talking to a 25-year-old political science major fresh out of college, who they perceive to be still wet behind the ears. But I have committee meetings to attend, a committee that I chair, lobbyists with whom I must meet, and a myriad of other duties that demand my time and attention. I simply can't be there in the office 100% of the time.

"Indeed, when I walk on the floor of the Senate, there are days when we may vote on as many as 20 or so bills of varying nature and importance. And when I walk on that floor, that 25-year-old political science major is at my side.

"I asked him, 'What do we hear from home about that health care bill?' If he says, 'Well, I've had four doctors call and three of them were in favor of it. You've read the seven hand-written letters, and six of those supported. There were 10 typed letters – eight in favor. And I tallied the 2,800 e-mails this week. Of the ones referring to this bill, 78 % were supportive.'"

"Now, how do you think I'm going to cast my vote?"

His point was that he is often influenced by a very small number of calls and letters. And the tallying of those communications from constituents was relayed to him by his 25-year-old legislative aide so that he could cast his vote in the way his constituents back home wished.

This serves to remind us that our opinions are heeded when properly conveyed to our legislative representatives. The house of medicine needs to stand united and be heard, and we all carry the responsibility to participate—both by financial support of our PAC's and individually to our elected representatives.





KEVIN P. SPEER, JD

## *Executive* Vice-President

### Gaining Perspective on Gainsharing

Generally, gainsharing is any incentive arrangement in which employees have the opportunity to share in gains that result from their creation of, or participation in, cost saving measures. This type of incentive program is not a new concept. In fact, gainsharing can be traced back to the 1930's where it was first introduced in the manufacturing sector to improve plant performance.

Within the health care arena, gainsharing has been utilized, mainly by hospitals, as a means to increase efficiency, quality, and profitability. Although gainsharing arrangements are specifically tailored to the particular goals of the parties, most take the form of an agreement between a hospital and group of physicians belonging to the medical staff. The agreement aligns the hospital's and physician's economic incentives with the goal of providing quality, cost effective care. The resulting cost savings are shared between the physician participants and the hospital, either through some combination of percentage payments, hourly fee or fixed fee. Gainsharing rewards physicians a portion of the savings realized from their restriction of wasteful use of hospital supplies and/or services. Most commonly, surgery specialties are targeted because waste is often more easily identified and that waste is proportionally more expensive.

The health care community's interest in cost saving programs like gainsharing was limited until Congress transformed hospital reimbursement with the passage of the Medicare Prospective Payment System ("PPS"). Under the PPS, hospital Medicare payments shifted from the reasonable cost basis for expenses incurred system to the diagnosis-related groupings ("DRG") system, which adjusts payment based on patient diagnoses. Currently, hospitals are

generally paid the same for any patient with a particular diagnosis, regardless of patient's actual cost to the facility.

As Congress forecasted, the cost of health care diminished with the implementation of the PPS/DRG system; likewise hospital reimbursement under Medicare part A weakened. Facing leaner times, hospitals began to focus more attention on cost savings programs. Gainsharing was seen as a logical option to improve profitability because it offered a means of controlling a significant portion of hospital expenditures, that is the over-utilization of hospital services and supplies. This over-utilization was and is difficult to curb because physicians are not often employees of the hospital, nor are they the most concerned with the hospital's bottom line. Given this unique relationship, hospitals lacked adequate leverage to temper physician over-utilization of costly resources.

This disconnect between the hospital financial viewpoint and that of its medical staff stems from the fact that while hospital reimbursement evolved, physician reimbursement remained the constant. Physicians are paid on fee-for-service basis; meaning physicians are not paid based on a patient's diagnosis but on the services rendered. The more care given, the greater the physician compensation; thus, physicians have had less incentive to use less resources. On the other hand, hospitals have been forced to focus on limiting utilization as a means of maintaining financial viability. Gainsharing was, at least initially, highly touted as a method by which hospitals could actually achieve physician participation in limiting over-utilization.

The enthusiasm surrounding gainsharing was quickly dampened by Congress's enactment of the Civil Monetary Penalty

("CMP") law. The CMP law imposes monetary penalties if a hospital "knowingly makes a payment, directly or indirectly, to a physician as an inducement to reduce or limit services" to either Medicare or Medicaid recipients. Monetary penalties aside, exclusion from the Medicare and Medicaid program, which is a possible sanction under the CMP law, would spell the death of most health care institutions. In spite of the risk of violating the CMP law, gainsharing arrangements were undertaken throughout the 80's and 90's. This risk taking behavior was born out of the limited enforcement of the CMP law by the Office of Inspector General ("OIG").

Early in 1999, the Internal Revenue Service ("IRS") seemed to offer its blessing of the gainsharing movement in a Private Letter Ruling. The IRS concluding that certain gainsharing arrangements would not be a violation of the tax-exemption laws. Shortly thereafter the IRS' ruling the OIG issued a special advisory bulletin in response to several advisory opinion requests. The OIG's bulletin was clear that most gainsharing arrangements between physicians and hospitals were illegal under the CMP law.

The OIG's staunch posture towards gainsharing arrangements was sharply objected to by those in the health care sector. Much of the criticism stemmed from the OIG's lack of parallel between its conclusions and the evidence presented. Less than two years later the OIG, in another Advisory Opinion, revised its previous stance. In its 2001 opinion, the OIG concluded that although a particular gainsharing arrangement was a technical violation of the law, it would, nonetheless, choose not to impose sanctions against the participants. The OIG highlighted the numerous limits and safeguards presented in

the proposal as a basis for its decision not to levy sanctions.

In its 2001 opinion, the OIG indicated that it still viewed gainsharing arrangements with much trepidation because of the risk posed to patient care. The OIG suggested that any entity considering such a program should be certain to account for the necessary safeguards. Recognizing that advisory opinions are fact sensitive and only applicable to the party seeking the opinion, the OIG offered that, at a minimum, a gainsharing arrangement should contain the following safeguards:

- Set in advance minimum utilization levels based on objective historical and clinical criteria;
- Establishment of maximum incentive payments and durational limits on the length of the program;
- Medical program review to ensure that quality of care is not adversely impacted;
- Full disclosure of the program to all impacted patients;
- Anti-discrimination policy to shield Medicare and Medicaid recipients from disproportionate treatment.

Beyond the CMP risk, hospitals must steer clear of any Stark or Anti-Kickback violations. Both laws offer exceptions or safe harbors which, if satisfied, minimize the risk of sanctions. The Fraud and Abuse/Anti-kickback Statute personal services and management contract safe harbor, and the personal services exception of the Stark law, contain similar requirements. Therefore, if a gainsharing agreement possesses the following, a hospital will limit its risk of violating either the Stark or Anti-Kickback statutes:

- The agreement is set out in writing, signed by the parties, and specifies the services encompassed by the program;
- The agreement covers all the services to be provided by the physician to the entity;
- The agreement specifies the schedule of such services;
- The term of the agreement is a minimum of one year;
- The aggregate compensation is consistent with fair market value negotiated through an arm's length transaction and it must not be made to take into account for the volume or value of referrals; and
- The aggregate services contracted for do not exceed those which are reasonably necessary to achieve a commercially reasonable legitimate business purpose

Because of the OIG's position that gainsharing arrangements pose, at least, some threat to the quality of patient care, such arrangements should be entered into only after thorough consideration and with the advice of counsel. If all recommended safeguards are implemented while accounting for the necessary safe harbor provisions, risk will be minimized. Depending on the nature of the arrangement, the only means to eliminate risk may be to seek an OIG advisory opinion.

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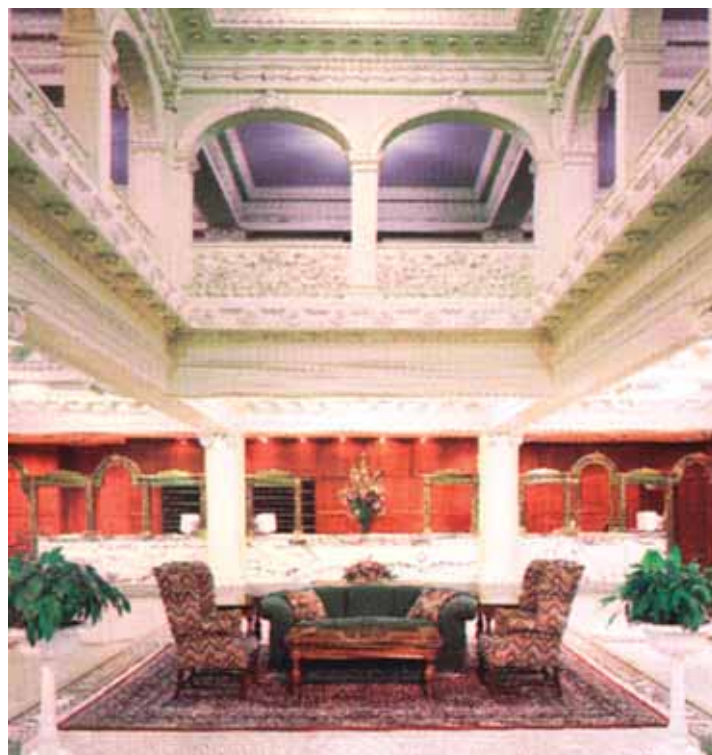
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# Mark Your Calendar for the **IAFP 57th Annual Meeting**

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**CME** 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 includes state and nationally known speakers.

Come to the IAFP Annual Meeting from July 20 to 24 at the French Lick Springs 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—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 Springs Resort is nestled in southern Indiana. Room rates for IAFP registrants are \$95 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.

For more information, call the IAFP headquarters office at (317) 237-4237 or at (888) 422-4237. You can also email us at [iafp@in-afp.org](mailto:iafp@in-afp.org).



## Family Medicine: The Essential Piece

INDIANA ACADEMY OF FAMILY PHYSICIANS  
57<sup>th</sup> ANNUAL MEETING



# Official Notice

## Indiana Academy of Family Physicians Congress of Delegates



NOTICE IS HEREBY given of the 57<sup>th</sup> Annual Scientific Assembly and Congress of Delegates of the Indiana Academy of Family Physicians to be held in French Lick, Indiana, July 20-24, 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 21 at 6 p.m. (first session) and Friday, July 22 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 in this publication. If you would like to write a resolution and need further information, please contact the IAFP office at (317) 237-4237.

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## Let Your Voice Be Heard: Submit Resolutions By June 20

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 21 and 22 in French Lick, Ind.

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 here to ensure that 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 20.

### 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 whereas 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.

The deadline for resolutions to be submitted is June 20th. Send resolutions to IAFP, Attn: EVP, 55 Monument Circle, Suite 400, Indianapolis, IN 46204 or to [iafp@in-afp.org](mailto:iafp@in-afp.org).

# Resolution **Template**

Title:

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Submitted by:

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WHEREAS,

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and

WHEREAS,

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WHEREAS,

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therefore be it

RESOLVED,

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and therefore be it further

RESOLVED,

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Fiscal Note: \$

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## IAFP Awards: Call for Nominations

Throughout the years, the Indiana Academy of Family Physicians has strived to better healthcare in Indiana. In recognition of the individual who works 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 an 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 14. 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. It 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 the education of 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. Additionally, he 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 past IAFP Executive Vice President, Jackie Schilling.

### **Distinguished Public Service Award**

The Distinguished Public Service Award is presented to members in good standing who have distinguished themselves by rendering a community or public service. The service must be entirely separate from purely profession 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.*



## 2005 CALL FOR IAFP NOMINATIONS FOR OFFICERS

At least 90 days prior to the IAFP Annual Assembly each year, the Nominating Committee shall announce nominations as required by the Bylaws. These nominations shall be formally presented at the first meeting of the Congress of Delegates, which this year will be July 21 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 22.

Offices to be filled for 2005-2006 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 and are interested in submitting your name as a candidate, you must submit a letter of intent, a glossy black and white photo and curriculum vitae. This information must be received prior to April 14.

If you have questions, please contact Kevin Speer or Deeda Ferree at 317-237-4237.

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## Congratulations New AAFP Degree of Fellows!

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Established in 1971, the AAFP Degree of Fellow recognizes family physicians that have distinguished themselves through service to family medicine and ongoing professional development.

Criteria for receiving the Degree of Fellow consists of a minimum 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.

The following members have achieved this honor and those in bold have recently achieved this status. We applaud each member's effort to enhance their medical career with this distinguished degree.

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 Wallace M Adye, MD  
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 Kenneth James Ahler, MD  
 Robert Dennis Aiello, MD  
 Raphael Eugene Albert, MD  
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 Deborah Irene Allen, MD  
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 Garland D Anderson, MD  
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# Legislative Update

## Conservative Increase in Medicaid Spending

by Doug Kinser, JD

**F**or the past several years, I have worked with Laura Hahn in Government Relations. She left last July to become the Executive Director of the Arizona Academy of Family Physicians. In January, Zach Cattell assumed Laura's role. Zach has come to the Academy from the Indiana State Department of Health where he was Legislative Director. Zach served ISDH well and I look forward to working with him as the Academy's new Director of Legislative and District Affairs.

### Background

Organization Day was November 16 and party caucuses elected their leadership. Sen. Garton was elected President Pro-Tem, a position he has held since 1980. Rep. Bosma, formerly minority leader, is now Speaker of the House.

Bills were introduced beginning November 16 and concluded in January. This 2005 session is the "long" session because the biennial budget must be approved. Indiana's revenue shortfall remains a significant problem for all legislators. The January revenue shortfall was \$60 million. It remains difficult to see how Indiana can grow itself out of its budget problems. Passage of all legislation must occur by April 29 for the session to adjourn on time, and it is expected to end timely.

### 2005 Session

Just as he announced post-election, Gov. Daniels hit the ground running. His legislative agenda is aggressive and his call for change in the way state government runs is clear.

On January 18 Gov. Daniels defined his priorities in his first State of the State address before the General Assembly. As you would expect, his speech received positive support from Republican legislators and more tepid response from Democrat legislators. At the bill filing deadline, approximately 650 bills were introduced in the Senate and approximately 870 bills were introduced in the House. While the majority of bill topics are now known, it is still possible to amend new ideas into existing bills. The number of bills introduced is lower than in recent years.

Gov. Daniels's commitment to balancing the budget is clear. He proposed very limited spending increases and flat-lined the budget in most areas. Gov. Daniels proposed a one-year, 1% surcharge on adjusted gross incomes in excess of \$100,000 to help with the budget. While nobody in the General Assembly has supported it, it remains early in the process.

## Medicaid

Gov. Daniels is allowing a very conservative increase in Medicaid spending of 5% despite forecasts of 10% growth in Medicaid spending. Final decisions will not be made until the end of the session when the budget is finalized. It is expected that President Bush will recommend further cuts in the federal Medicaid budget.

FSSA Secretary Mitch Roob met with health care providers on January 12 to discuss the financial troubles of Medicaid. The current fiscal year shortfall for the program is currently at \$121 million. The Medicaid program must find \$17.2 million dollars in order to finish FY2005 at break-even. Secretary Roob announced that effective on February 15 an across-the-board 2% withhold to providers will be instituted. Secretary Roob described this move as a possible action in hopes that by February 15, the administration will find another way to make up this shortfall.

As of February 5, while there have been some discussions on eliminating the 2% withhold, nothing final has been released.

## Bill Update

The following bills may either affect a family physician's practice or are important to the Academy for policy considerations:

### **HB1103 Vaccination exemption and disclosure.**

Requires the state department of health to prepare and publish forms disclosing the risks and benefits of vaccines and to publish forms allowing an adult or a parent or guardian of a child to exempt the adult or the child from receiving a vaccine. Requires a health care provider to provide a copy of the appropriate forms to an adult and the parent or guardian of a child. Provides that a civil or criminal penalty may not be imposed on an adult or parent or guardian of a child who does not give consent to receive a vaccination.

This bill, and a companion bill, HB 1606, will not likely receive a hearing.

### **HB1126 Immunity for 501(c)(3) organizations.**

Provides that employees, volunteers and volunteer directors of: (1) certain community mental retardation and other developmental disabilities centers; (2) certain rehabilitation centers; and (3) nonprofit organizations; are immune from civil liability arising from the performance of the duties of the employee, volunteer, or volunteer director if the employee, volunteer, or volunteer director exercises reasonable care in the performance of those duties.

Rep. Foley had a hearing in Judiciary on February 7. There will be amendments in committee.

### **HB1343 Student nutrition and physical activity.**

Requires school boards to establish a child nutrition and physical activity advisory committee to develop a local wellness policy that complies with certain federal requirements. Requires that foods and beverages sold to students outside the federal school meal programs must meet certain requirements. Provides that the requirements do not apply after school hours. Requires daily physical activity for elementary school students in public schools. Allows a school to continue a vending machine contract in existence before May 15, 2005. Rep. Becker had a hearing on February 8.

### **HB1415 Immunizations by pharmacists.**

Allows a physician to delegate a pharmacist to administer immunizations under a drug order or prescription. Requires the board of pharmacy to adopt rules concerning the qualifications, protocols and record keeping requirements of pharmacists who administer immunizations.

A hearing was scheduled on February 8 in the House. Sen. Riegsecker introduced SB 534 which has similar provisions.

### **HB1643 Health insurance claim filing and payment.**

Specifies certain requirements for provider submission and payment of claims under state employee health benefit plans, accident and sickness insurance policies, and health maintenance organization contracts. Repeals the law requiring use of certain billing codes for health maintenance organization claims filing and payment.

Rep. Ripley has not indicated whether there will be a hearing. It is a bill initiated by the insurance industry and is not satisfactory in its present form.

### **SB0225 Office based sedation standards.**

Requires the medical licensing board to adopt rules concerning office-based procedures that require certain levels of sedation. Makes a technical correction. (The introduced version of this bill was prepared by the commission on excellence in health care.)

SB 225 passed in the Senate unanimously. Rep. Becker will sponsor the bill.

### **SB0292 Limitation on Medicaid optional services.**

Allows the governor to: (1) limit; or (2) exclude; an optional Medicaid service from the state Medicaid plan by executive order if the governor determines that the state's fiscal situation requires the Medicaid limitation or exclusion.

There was a hearing, but it was not voted on. Sen. Miller indicated she would put forth an amendment that would define the optional services with some specificity.

### **SB0406 Prescribing of Ritalin.**

Limits a physician to prescribing methylphenidate (Ritalin) only in accordance with the Diagnostic and Statistical Manual of Mental Health Disorders, Fourth Edition (DSM-IV) and creates a Class B infraction for a violation.


There has not been a hearing on Sen. Miller's bill.

### **Master Tobacco Settlement**

The Master Tobacco Settlement was discussed in the House Ways and Means Committee February 8. There has been no indication from the Administration on its intention. The Academy will attend the hearing and is participating in public discussions on tobacco funding.

The session is moving quickly. The deadline for bills to be out of the first House is March 1. At that point, several bills will drop off our radar screen. Until then, all ideas remain possible. We remain vigilant. If you have questions or concerns during the session, please call Zach at (317) 237-4237 or me at (317) 977-1454.





# WHAT IS NEW IN REIMBURSEMENT ISSUES?

Joy Newby, LPN, CPC  
Newby Consulting, Inc.

Visit the IAFP Web site for new information on these topics and more! We encourage you to visit your Web site frequently for new and revised postings on practice management issues including coding and reimbursement tips. The latest postings are summarized below.

1. Health Professional Shortage Area (HPSA) and Physician Scarcity Area (PSA) – Family Physicians (FPs) should review this article to determine if the locations where you provide services are subject to Medicare bonus payments of 10 percent (HPSA), 5 % (PSA), or 15 % (both HPSA and PSA). This article contains the HPSA and PSA automatic bonus zip codes as well as those areas requiring physicians to self-designate by use of modifiers.

2. Influenza Demonstration Project – CMS is undertaking a demonstration project to measure the impact of providing coverage for certain antiviral drugs to treat and/or prevent influenza. The Influenza Treatment Demonstration provides

coverage to Medicare beneficiaries for Food and Drug Administration (FDA)-approved drugs for the treatment and targeted prevention of influenza. FPs should review this article for information on Medicare coverage of four new flu medications, including—where applicable—their generic equivalents. These medications are Amantadine Hydrochloride; Zanamivir, Inhalation Power Administered through Inhaler; Oseltamivir Phosphate, Oral; and Rimantadine Hydrochloride, Oral.

These drugs will be paid under a Centers for Medicare & Medicaid Services (CMS) Demonstration for dates of service through May 31.



3. Electronic Claims Filing Mandate – Medicare announces process to determine if those physicians/practices submitting paper claims meet one of the exceptions allowing submission of paper vs. electronic claims.

4. New Low Risk Diagnosis for Pap Smears (and Screening Pelvic Examinations) – Effective July 1, Medicare is establishing a separate processing edit for HCPCS code Q0091 (screening Pap Smear, obtaining, preparing, and sending cervical or vaginal smear to laboratory) to prevent incorrectly paying for claims submitted outside of the frequency standards.

5. TRICARE Update February 2005 – This article contains information about denied claims for those TRICARE enrollees who should have enrolled in Medicare Part B by January 1, 2005.

6. Provider Enrollment Fraud Alert – Is your staff giving your personal information over the telephone? See this article for information on how crooks are obtaining physician information to steal Medicare payments.

7. Anthem Advance Directive Requirements - Anthem's Midwest Physician Office Review program addresses advance directives during the pre-contractual review (when a provider applies for participation in Anthem's managed care network) and during the annual medical record review (random reviews of network providers). Anthem's physician office reviewer will ask to see a blank form or the format used by the office or may need to see an actual medical record.

## CORRECT CODING OF HEMORRHOIDECTOMY, BY SIMPLE LIGATURE

Medicare notified physicians of recent data analysis and Medical Review findings for CPT 46221 (Hemorrhoidectomy, by simple ligature (e.g., rubber band)) that indicated a high error rate in the utilization of this code. AdminaStar Federal's (ASF) reviews revealed physicians were billing CPT 46221 more than once per session for the same beneficiary.

When billing CPT 46221, you may only report one unit of service regardless of the number of hemorrhoids ligated during the session. The October 1997 CPT Assistant article states "Each session of rubber band ligation, regardless of the number of hemorrhoids, is coded once."

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# CMS, ASF Issue Fraud Alert for Physicians, Medical Offices

Unscrupulous persons are attempting to take advantage of you and the Medicare program. That's the message AdminaStar Federal (ASF) has passed along, prompted by the Centers for Medicare & Medicaid Services.

In a fraud alert, ASF said individuals representing themselves as Medicare fraud investigators or Medicare claims audit or enrollment personnel call physicians or their offices. They state that the Medicare computer system has malfunctioned and they need to update lost information.

They request by phone or fax:

- Copy of the physician's drivers license
- Copy of the physician's social security number
- Unique physician identification number
- Verification of education and practice location
- Copy of physician's medical license
- Copy of patients' charts for a specific time

The callers then falsify enrollment data using the physician's name and request a change to their location, telephone numbers and pay-to addresses.

CMS has suffered NO computer system malfunction. If you received such a contact, try to verify the caller's telephone number and immediately notify ASF at (866) 250-5665.

*Published on February 7, 2005 in ISMA Reports and reprinted with permission from the ISMA.*

## ABFM Moves to Online Registration



The American Board of Family Medicine is offering online registration for its 2005 certification, recertification and sports medicine exams. The online application process has streamlined registering for the examination. In many instances, the physicians can complete the entire process in minutes at a single sitting.

The online application process began in December and test center selection came online two weeks later. The online registration and test center selection applications can be accessed at [www.theabfm.org](http://www.theabfm.org). With the move to computer-based testing last year, the ABFM is now able to offer nine exam dates, including Saturdays, at more than 200 test centers throughout the United States, Puerto Rico and U.S. territories.

Diplomates are encouraged to visit the website to complete their applications as early as possible to increase the probability of selecting the test center of their choice. All eligible candidates for the 2005 exam can login to their Physician Portfolio and follow the "Online Application" link to access the application. Once an approved application has been completed, the Diplomate will then be able to choose a test center. The link to Test Center Selection is also found in the Physician Portfolio.

For more information, please contact the ABFM Help Desk at (877) 223-7437.



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# Get Involved With Your Organization Through these IAFP Activities

## **Write an article for the *FRONTLINE PHYSICIAN***

Have a special interest or view? Articles sent by Academy members will be considered for publication as "Guest Editorials".

## **Become a speaker at IAFP CME Events**

IAFP is always looking for family physicians to speak at our CME Activities. Let us know if you are interested in speaking at the Annual Scientific Assembly or Family Medicine Update.

## **Join an IAFP Commission**

The IAFP has five active Commissions; 1) Commission on Education & CME, 2) Commission on Legislation & Governmental Affairs, 3) Commission on Membership and Communications & 4) Commission on Health Care Services.

*For more information on any of these activities contact the IAFP office at [in-afp.org](mailto:in-afp.org) or call 317-237-4237.*



## New To IAFP

**Chris Barry** joined the Academy at the beginning of the year as an Administrative Assistant. He previously worked in Lafayette before moving to the Indianapolis area with his family in late 2004. He was born and raised in Manchester, England, and moved to Indiana about six years ago. In his spare time, he enjoys hanging out with his four-year-old son. He likes his work at the Academy and is looking forward to the Annual Meeting this summer.

**Zach Cattell** is the IAFP's Director of Legislative and District Affairs. During his career, Zach has been active in health and human service policy and in politics. Before joining the IAFP, Zach served as the Legislative Director for the Indiana State Department of Health. He has also worked in Washington, D.C. as a policy analyst for former Gov. Jim Hodges of South Carolina. In the political arena, Zach has served as a field director for state representatives in Pennsylvania and is also active in Indiana. Zach earned a degree in Political Science from West Chester University of Pennsylvania, and is currently working on obtaining a law degree at Indiana University School of Law, Indianapolis. Zach and his wife, Rebecca, live in Indianapolis.

**Christie Sutton** has joined the Indiana Academy of Family Physicians as our new receptionist/clerk. Currently, Christie attends Ivy Tech State College. She will obtain a degree in accounting this spring. She enjoys the outdoors, reading and spending time with friends, her husband and two boys. Christie is planning to attend the University of Indianapolis this fall to further advance her education.

# Exhibitors for the 2005 Family Medicine Update

The Indiana Academy of Family Physicians would like to give special recognition to the following exhibitors. The companies listed below supported the IAFP Family Medicine Update.

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Biosound Esaote  
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Clarian Health – Cardiovascular Services  
Clarian Health Partners – Women's Heart Advantage  
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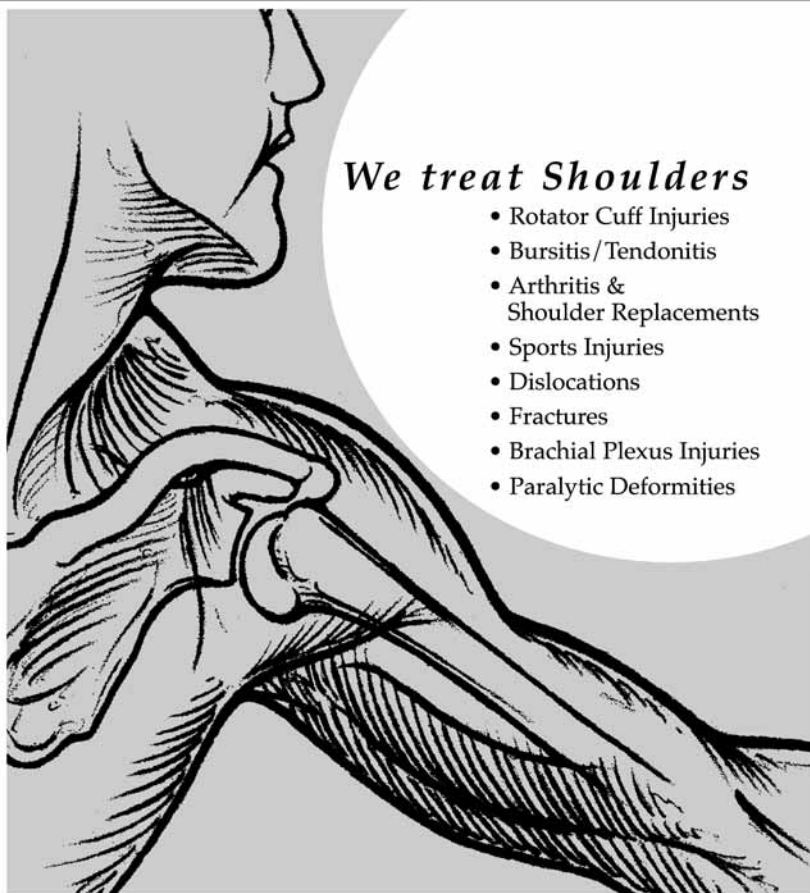


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# Foundation News

## 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 2004. 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 Medicine 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 also like to acknowledge that many of these individuals give to the Foundation in addition to their Founder's Club commitment. Members who have done so in 2004 are noted with a diamond (◆).

Deborah I. Allen, MD ✓◆  
Dr. Jennifer & Lee Bigelow  
Kenneth Bobb, MD ✓  
Bruce Burton, MD ✓◆  
Kalen A. Carty, MD  
Clarence G. Clarkson, MD ✓◆  
Dr. Robert & Donna Clutter ✓◆  
Dianna L. Dowdy, MD  
Richard D. Feldman, MD ✓◆

Thomas A. Felger, MD ✓◆  
Fred Haggerty, MD ✓  
Alvin J. Haley, MD ✓  
John L. Haste, MD ✓◆  
Jack W. Higgins, MD ✓  
Worthe S. Holt, MD ◆  
Richard Juergens, MD ✓  
Thomas Kintanar, MD ✓◆  
H. Clifton Knight, MD ✓◆  
Teresa Lovins, MD ✓◆  
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Raymond W. Nicholson, MD ✓◆  
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Kevin Speer, JD (IAFP EVP)  
Daniel A. Walters, MD ✓◆  
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### PLANNED GIVING CONTRIBUTORS

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# Lewis Accepts New IAFP Position While Tackling Tobacco Issues

Tar Wars®

The IAFP has appointed Missy Lewis director of its Foundation. She began this new endeavor in January and is additionally holding onto her tobacco-related responsibilities.

Lewis is ready for her new job. “The position gives me a little more insight into family medicine. Now I’ll have more of an opportunity to work with the other physicians and students outside of tobacco,” says Lewis.

In the three years she has been with the Academy, Lewis already has proven herself as extremely valuable to the IAFP through her work at the Academy. She joined the IAFP in 2002 after completing her master’s thesis on the attitudes and intentions of college students when faced with the proposal of smoke-free bars.

Her background has helped the Academy in its efforts to stop youth smoking. “This definitely laid the foundation for my work in tobacco control and especially for my involvement with Smoke Free Indy,” Lewis explains about her Masters in Health Promotion from Purdue University.

While at the IAFP, Lewis has been quite active. She has coordinated Tar Wars®, is on the steering committee for Smoke Free Indy and represents the Academy on the Indiana Cancer Consortium and the Medicine and Public Health Initiative.

Additionally, she’s been selected as one of 10 Tar Wars® Program Advisors for 2003 to 2005. “We meet regularly to provide directions for Tar Wars® and plan for future program expansion,” says Lewis, who is a Certified Health Education Specialist.

While with the IAFP she also has been trained as a facilitator for Teens Against Tobacco Use (TATU), Tobacco Awareness & Prevention/Tobacco Education Group (TAP/TEG) and various tobacco cessation programs. “I serve on a statewide secondhand smoke task force and have taken leadership of the newly named Campaign for Tobacco Free Indiana, which is directly related to our work with the Campaign for Tobacco Free Kids.”

This is a vocation that gives Lewis much satisfaction. “I enjoy working on the tobacco issues because I’ve been able to see results in what I’ve done in the last two and a half years. In the Tar Wars® program, we have increased participation among the schools, and we’re reaching more than 22,000 kids versus 15,000 when I started. We’ve also seen a huge increase in the number of posters we receive for the poster contest.”

Missy also leads a full personal life. “In my free time, I am the Collegiate Chapter Director/Advisor for my sorority (Delta Zeta) at Purdue, serve on the Board of Directors of the Purdue Association of Indianapolis, am a member of the Indianapolis League of Women Voters and began taking classes at Butler with the hopes of earning my MBA in the next couple of years.”

# 2005 Calendar



## Faculty Development Workshop

March 2, 2005

Airport Holiday Inn, Indianapolis

## Residents' Day/Research Forum

March 3, 2005

Airport Holiday Inn, Indianapolis

## Board of Directors/ Commission/Committee Cluster Meeting

April 17, 2004

Indianapolis

## AAFP Annual Leadership Forum

May 6-7, 2005

## IAFP Annual Scientific Assembly

July 20-24, 2004

French Lick Springs Resort, French  
Lick

## Board of Directors Meetings

July 20, 2005

French Lick, Indiana

July 24, 2005

French Lick, Indiana

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# IAFP Membership Update

## MEMBERSHIP STATUS TOTALS AS OF 1/31/05

**Active: 1581**  
**Supporting: 3**  
**Inactive: 19**  
**Life: 196**  
**Resident: 256**  
**Student: 279**

## KEEP US INFORMED

Members, please be sure to keep all of your contact information up to date with the AAFP and the IAFP.

This includes:  
 Your address  
 Phone/Fax  
 Email Address

To update, please call:  
 Amanda Bowling @ IAFP: (888) 422-4237  
 AAFP: (800) 274-2237

## Active

Rachael Ross, MD  
 Chesterton

Joseph Hix, MD  
 Elkhart

Lisa Roeder, MD  
 Granger

Norma Will, MD  
 Evansville

Ronald Perkins, MD  
 Evansville

## Residents

Aisha Hashmat, MD  
 Gary

Faiz Khan, MD  
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Roland Walker, MD  
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Saima Butt, MD  
 Muncie

Snigdha Volety, MD  
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Samuel Gbenro, MD  
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Mr. Ross Haynes  
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# Neuroscience Symposium

June 10-11, 2005

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The conference will be held at the Omni Severin Hotel, 40 W. Jackson Place, Indianapolis, IN

**Keynote speaker:** Anthony J. Furlan, MD  
Neurologist, Cerebrovascular Center,  
Cleveland Clinic

**Program Topics:**


- tPA in Rural Settings
- Finding the Future Now, Research at the Indiana Neuroscience Institute
- Clear Thought on Dementia: Vascular vs. Aging
- Less is More, Minimally Invasive Spine Procedures
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- Get it Straight: Vertebroplasty

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