

# FRONTLINE

PHYSICIAN

A Publication of the Indiana Academy of Family Physicians • Spring 2007

## Indiana Hosts Annual Ten-State Conference

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## A Roadmap to Maintenance of Certification for Family Physicians

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## Mark Your Calendars Now for Annual Meeting

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317.237.4237 • 317.237.4006  
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Web site: [www.in-afp.org](http://www.in-afp.org)

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# FRONTLINE PHYSICIAN

Volume 8 • Issue 1

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

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- 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



Windel Stracener, MD

## *Greetings!*

As I write this spring edition of my comments, I have watched the snow fall, the snow melt, and the snow and ice fall again. It hardly seems that spring can be on us so soon. Yet, as the spring comes, so do many of the other traditions of the season.

One such tradition is the long session at the Statehouse. This year has seen a great deal of legislation presented that has a bearing on our patients and our practices. The efforts of our staff and members have once again been exemplary. The issues that have been addressed have included Medicaid reimbursement, health care for the uninsured, scope of practice issues involving nurse practitioners and physician assistants, tobacco taxes and others that I am sure I have overlooked. We have wonderful dedicated folks who see that we are represented fairly and accurately at the Statehouse on these issues. However, there never seems to be an oversupply of help. If you are interested in expanding your role in the Academy and have special interest in legislative issues, contact us and let us put your talents to work.

Another tradition of the early spring is the Ten-State Conference, which our Academy hosted this year. This meeting was a rousing success. The keynote topic was change in medicine. The subtopic of this was learning to accept and even like change as a way of breeding successful and effective practice

styles for the future. This meeting will spur a great deal of discussion among the many physicians and leaders that were present. I have to take this opportunity to thank Deeda, Chris and the rest of the staff for all their hard work in making this such a great meeting.

Finally, as spring nears, I often find myself starting to plan for a summertime tradition that will follow. That, of course, is the Annual Scientific Assembly and Congress, which will be held this July in French Lick. Make your plans now to attend and participate in the all-member format at the Congress. As always, there will be a full slate of continuing education topics and social events. This is always a great time to renew old friendships and make new ones. If you have never been to this meeting, or you haven't been there for a while, take advantage of this year's meeting to start a new tradition or renew an old one. Either way, I think you will be glad you did.

Have a great spring, and I hope to see you all in French Lick.

## Mark Your Calendar

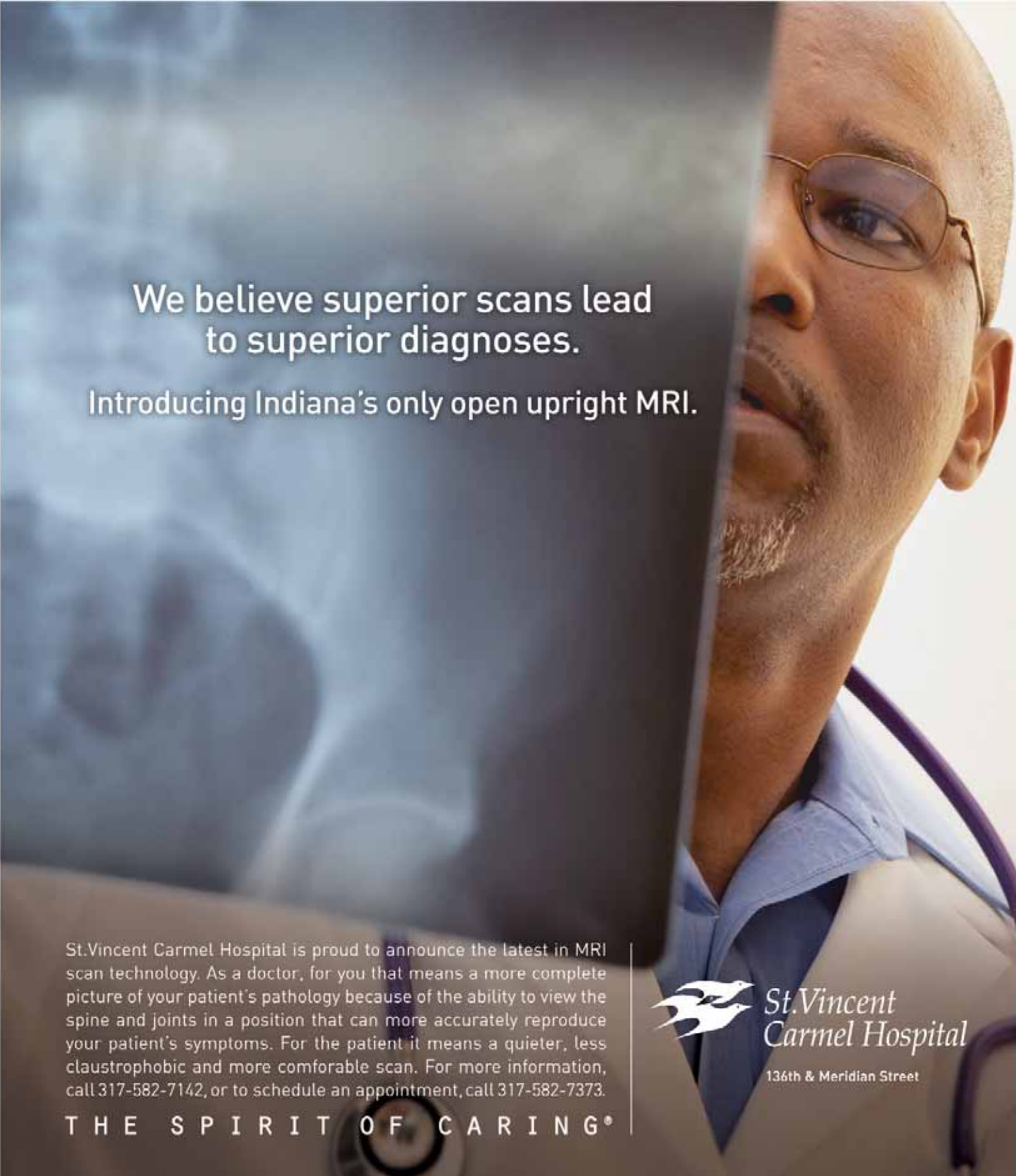
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# Indiana Hosts Annual

Family physician leaders from Connecticut, Illinois, Indiana, Kentucky, Michigan, Minnesota, New Jersey, New York, Ohio, Pennsylvania and Wisconsin gathered in Indianapolis February 9-11, 2007, to learn new leadership skills and explore issues related to family medicine. Our conference goal was to help further excellence in health care, particularly in family medicine, through idea sharing and networking. Attendees were able to take information and new skills back to their individual chapters, including updated AAFP knowledge from Jim King, MD, AAFP president-elect, and insights on health information technology from Ken Bertka, MD. Doug Kinser, JD, provided a review of national politics and health care trends, and Donna Valponi spoke on building stronger chapter relations with the AAFP. Michael Annison led three thought-provoking sessions on new trends, the challenges facing associations and future opportunities for family doctors, and the last conference speaker was Chuck Dietzen, MD, who gave an inspirational speech about his charity work. Exciting nighttime excursions to the NCAA Hall of Champions and the Indiana Medical History Museum rounded out a very successful conference.

## Acknowledgements

*The Indiana Academy of Family Physicians would like to give special recognition to the following supporters. The companies listed below have supported special events during the 2007 Ten-State Conference:*

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At the Ten-State Conference, each state chapter submits a detailed report on their activities during the previous year. The following is a copy of the report presented by the IAFP.

## Indiana Academy of Family Physicians Ten-State Report February 2007

### Governmental Affairs

This year marks a “long” session for the Indiana General Assembly. Not only must the legislature wade through more than 2,000 pieces of legislation, but this is also a budget year, in which the state’s biennial budget must be hashed out by *sine die* on April 29. The possibility of a special session would allow legislators to work on the budget through June 30, 2007. It is safe to say that this 2007 session of the Indiana General Assembly has been one of the most health care-intensive sessions in recent memory.

Looking back, the 2006 elections posed big changes for Indiana government. Democrats now control the House by a slim margin, while Sen. and President Pro-Tem Bob Garton (R) was defeated in the primary, after serving in the Senate since 1970 and as president pro-tem since 1980.

### Halftime Update

At the time of print for the spring issue of *FrontLine Physician*, the Indiana General Assembly had officially reached its halfway point on February 28, 2007, when all bills introduced had to pass their house of origin in order to continue on this session.

HB 1008, funding for the Governor’s Uninsured Plan, looked as if it was off to a good start when the House Public Health Committee voted unanimously for the plan, which included provisions for increased Medicaid physician reimbursement and an increase in the state’s tobacco tax of 55 cents. The bill took its first blow when the House Ways and Means Committee stripped out the physician reimbursement language and reduced the tobacco tax to 25 cents. The bill then failed to pass out of the House of Representatives on third reading by a vote of 44-52.

HB 1008 did not fail for want of policy consideration; rather, it failed due to external political factors. The House Democrats wanted it to be a bipartisan effort with at least 25 Republicans to vote for the governor’s initiative, but when it came down to it, the Rs just didn’t have the votes. There is a reasonable chance that the tobacco tax and uninsured piece can be reincarnated. The language could either be added to the state budget bill, or it could be added into a House bill by the Senate. SB 503, the Governor’s Uninsured Plan, will be debated within the next few weeks as announced by Rep. Charlie Brown, chair of the House Public Health Committee.

Speaking of the state budget, at the time of print, the state’s Medicaid program remains flat-lined in HB 1001, the House’s proposed state budget. Democrats passed the flat-lined Medicaid budget with the normal statement that “the governor and Budget Agency (or committee) have authority to increase based upon Medicaid usage” is in the House budget. If the flat-line continues through the process (which the IAFP does not expect), providers not only should not expect an increase, but also could expect some cuts. It is important to note that only once has there been a flat-line Medicaid budget. Whether to increase spending or make cuts would be a decision made by Medicaid. The budget, as drafted, would allow either. Conversations with House members tell us that they DO NOT expect Medicaid to remain flat-lined.

At time of print, the House’s proposed state budget did include the normal appropriation of more than \$2 million for the Medical Education Board, Family Practice Residency Fund.



# Ten-State Conference



Pictured from left to right: Tom Felger, MD; Fred Ridge, MD; Clif Knight, MD; Tom Kintanar, MD; AAFP President-Elect Jim King, MD; and Larry Allen, MD, at the Ten-State Conference

The political jockeying will continue through *sine die* on April 29. The IAFP will continue to urge legislators to NOT flat-line Medicaid, and we will also lobby legislators to reconsider the tobacco tax, the plan for the uninsured and the increased Medicaid physician reimbursement. Please call Allison Matters at the IAFP headquarters if you have any questions or concerns regarding this year's legislative session.

## Uninsured

Gov. Daniels has introduced a plan to expand coverage for the uninsured in Indiana. As proposed, the plan calls for at least a \$0.25 increase in tobacco tax to fund the project for the uninsured, as well as returning Indiana Tobacco Prevention and Cessation (ITPC) funding to the CDC minimum and providing funding for children's immunizations. The plan is a work in progress; aspects of the proposal include: providing the uninsured with Health Savings Accounts, allowing these individuals to take ownership of their health care, and inciting them to seek preventative care early. The IAFP is an active member of a grassroots coalition to support \$1 tobacco-tax increase, with relief going to health care initiatives and more uninsured. In particular, the IAFP is fighting for full funding of ITPC, with the rest to cover the uninsured and immunizations.

## Insurance

The Indiana Senate's Committee on Health and Provider Services is currently working through two important insurance issues facing Indiana physicians and patients. The committee has taken testimony on the assignment of benefits and prohibition of most-favored nations clauses. These issues are especially important to Indiana patients and

physicians, as Anthem Blue Cross and Blue Shield is headquartered just a block from the IAFP's office and now commands more than 30 percent of the insurance market in Indiana. Providers and patients alike feel the pressure from large insurers, and these two bills will serve to "level the playing field," so to speak. The IAFP has participated in task forces and summer study committees on both of the issues. We expect this to be an uphill battle, but the IAFP looks forward to continuing to work with all parties involved.

## Scope of Practice

The IAFP continues to struggle internally to come to agreement on our official policy towards the nurse practitioner and physician assistant's scopes of practice as it relates to the practice of family medicine. Per the direction of IAFP President Windel Stracener, MD, the IAFP will appoint a task force to examine the role of NPs and PAs in terms of the integrated practice model. The Indiana House's Committee on Public Health is currently reviewing legislation to afford physician assistants the right to prescriptive authority. It is the IAFP's understanding that Indiana is among the last states in the Union to allow such prescriptive authority.

## Hoosier Healthwise

The coming of 2007 marked a change in the state's Medicaid program. After an extensive RFS process, the state contracted with three managed-care organizations to supply all Medicaid care to Indiana patients via the Hoosier Healthwise Program. Recipients of the Hoosier Healthwise contract included MDWise, MHS and Anthem. The transition has proven problematic for some of our IAFP members. The

IAFP and its members will work with the administration to work out the kinks of this transition.

### Medicaid Reimbursement

There are two reimbursement plans on the table this session. This is especially important to Indiana physicians, as they have not received a Medicaid reimbursement increase since 1989. The chairman of the Senate Committee on Health and Provider Services has called this lack of increased payment “unconscionable” and, as a result, introduced a bill this year to increase physician reimbursement in Medicaid managed care programs, fee-for-service programs and demonstration projects by 10 percent in 2007 and 10 percent in 2008. Similarly, Secretary Roob of the Family Social Services Agency has introduced a plan to provide a one-time stipend to primary care providers in 2007, followed by a budgetary increase in the following two years. Both the chairman’s and FSSA’s initiatives are welcomed, as the IAFP, along with the rest of the health care community, have lobbied for increased payment throughout the years. The legislators still have to find the money, as the increase has a fiscal impact of \$60 million.

### Immunizations

Indiana senators have introduced a bill to mandate HPV vaccinations in school-age girls. The IAFP, along with many other health care groups, testified in support of the vaccination — assuming proper funding is available for the initiative. Much opposition met the vaccination proposal in committee, and the bill as amended now gives parents the choice to either opt in or opt out of the vaccination. The bill is still in its early stages, and we will continue to work with the senators and the state Department of Health on the issue.

### Public Policy

The IAFP continues to support and promote better public policy practices. Issues facing the 2007 legislative session include obesity and wellness initiatives, better school vending, use of seatbelt restraints, and prevention and cessation of tobacco use.

### Indiana Medical Licensing Board

The IAFP continued to represent its many members before the Indiana Medical Licensing Board. The MLB introduced an administrative rule to require accreditation for office-based surgery. Dr. Larry Allen, president-elect, participated in the Indiana State Medical Society’s Task Force to examine the issue and its impact on the physician community. After more than a year in the rule-drafting process, the IAFP, the Indiana Society of Anesthesiologists and ISMA were able to come to agreement on the matter. The conflict of interest ultimately hinged upon the requirement of accreditation for administering regional anesthesia, which was defined to include superficial peripheral nerve blocks so long as the amount of anesthetic exceeded the manufacturer’s recommended dosage. The IAFP conveyed to the MLB and ISA that anesthesia involving these nerve blocks is a routine part of the office practice of family medicine, and the designated threshold would serve as a tedious distinction in the office setting, as the manufacturer’s inserts did not contain coherent guidelines. The IAFP suggested that language be added to the rule to clarify the usage threshold as the maximum dosage per body weight. This change will allow family physicians to treat patients in their offices without violating the accreditation standards. The rule is currently in the final stages of drafting.

### Region Affairs

The IAFP has completed its governance restructuring. The previous 13 geographic districts have been streamlined into eight regional chapters. The restructuring was meant to lead to an increased involvement at the grassroots level, improved communications (particularly via e-mail and Web communication) and improved leadership identification and development. While we are early in the process, the IAFP is beginning to see its restructuring pay off. This spring marks the first regional meetings for the southern districts, in which they will elect new region directors.

Also new since last year’s Ten-State Conference, the IAFP held its first-ever All Member Congress of Delegates. This move allowed all members to vote and take the floor at the COD, better enabling them to participate in important IAFP policy-making decisions. We were happy to see many new faces at our COD and a slight increase in participation over years past. We hope, with further refinement of the restructuring, our attendance will continue to increase.

### Candidates for National Office

In 2006 Tom Kintanar, MD, ran for AAFP president-elect. This run marked the culminating point of his three years of service on the AAFP Board of Directors, and the IAFP worked mightily on the campaign. The campaign experience was invaluable to the IAFP, and, although Dr. Kintanar may have lost the race, he made the Indiana Academy proud with a standout speech and a run-off vote. Dr. Kintanar’s participation at the national level was truly a valuable asset to the IAFP. We offer heartfelt thanks for his leadership, dedication and continued support of our organization. The IAFP expects to have a candidate for the AAFP Board of Directors in 2008.

### Political Action Committee

The IAFP Political Action Committee raised more than \$5,000 this election cycle and contributed to key health and policy makers of the Indiana Legislature.

### Foundation

The Foundation continues to support Tar Wars, the Barnett Adopt-A-Student Program, the Conference on Practice Improvement Scholarship Program and the Historic Family Doctor’s Office at the Indiana Medical History Museum. Last year, the state tobacco prevention agency was able to offer a limited amount of funds for statewide grants. IAFP received a \$55,000 grant to grow Tar Wars in Indiana in an effort to expand involvement of family physicians in local smoke free air campaigns around the state. Also in 2006, three first-year medical students spent the summer with an IAFP preceptor as part of the Primary Care Scholars Consortium Summer Externship Program. Each student received a \$3,000 stipend, with funds raised from member donations, golf tournament revenue and a matching grant from the AAFP. Two residents received scholarships to attend the Conference on Practice Improvement.

A project that has been in the works for several years as a companion piece to our Historic Family Doctor’s Office is the *Family Practice Stories* book. This book will contain the stories of our senior members, many of whom are retired, and their experiences with family medicine during the years. We hope to publish this book and share it with the newest class of medical students each year. Currently, our student director has been conducting the interviews.



## **Students and Residents**

We continue to have a recruitment event for IUSM students each year. This year, we changed the format from a reception and dinner to just a reception. We increased the reception time and included more food and door prizes. Each of Indiana's residencies exhibited, along with a booth from the IAFP that provided information on the specialty of family medicine and AAFP/IAFP membership applications. Indiana does not collect dues from student members and pays the AAFP dues for those who apply.

With funding in part from the Foundation, the residency programs have collaborated in recent years to conduct "Procedure Day" for those students entering their third year of medical school. Each residency facilitates a procedural workshop for the students in an effort to prepare them for the clinical scenarios ahead of them. Procedure Day has attracted students of all inclinations during the last couple of years and has proven to be a great success.

Our annual Residents' Day/Research Forum is still a very popular IAFP event, at which 80 to 100 residents hear 12 to 16 original research presentations and case presentations from their peers. We also elect resident officers at this meeting.

The National Conference of Family Medicine Residents and Medical Students is always a popular event for both residents and students. We had three members run for elected positions at the conference, and we had five apply for commission appointments in 2006. We also coordinated an effort to send students to the conference with funding from our residency programs. At home, we have offered students the opportunity to attend our annual meeting free of charge.

## **Campaign for Tobacco-Free Indiana**

The IAFP continues to convene the Campaign for Tobacco-Free Indiana, a coalition of statewide organizations that have an interest in legislative efforts regarding tobacco control. We work very closely with the Campaign for Tobacco-Free Kids, Americans for Nonsmokers' Rights and other statewide organizations on various policy issues throughout the year, especially smoke free air campaigns and efforts to restore funding to our state tobacco prevention agency. In 2006, Indiana was recognized for passing the second-most effective local smoke free air ordinances, surpassed only by our neighbors in Illinois. Last fall, Missy Lewis attended a national advocacy training in Atlanta as a guest of the Campaign for Tobacco-Free Kids and returned to Atlanta a month later to participate in a training at the CDC with four other team members from around the state. In Indiana, it is understood by many that family physicians and the IAFP are leaders in nearly all tobacco policy efforts.

## **Strategic Planning**

The Indiana Chapter held a Strategic Planning Retreat in October in Phoenix, Arizona. Members enjoyed the beauty and weather of Arizona while working hard to complete the first phase of a new strategic plan for the IAFP. Mickey Schaefer (past AAFP vice president) served as facilitator. At the end of the session, we had developed seven strategic objectives: 1) Practice Enhancement, 2) Medical Home, 3) Promote the Value of Family Medicine, 4) Education & Research, 5) Advocacy & Influence, 6) Workforce and 7) Membership/Leadership Development.



# IAFP Membership Update

## KEEP US INFORMED

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

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E-mail

To update, please call:

Amanda Bowling at the

IAFP: 888.422.4237

AAFP: 800.274.2237

## Membership Status Totals as of January 31, 2007

**Active** .....1,636

**Supporting (non-FP)** ..... 6

**Supporting CME (FP)** ..... 3

**Inactive** .....12

**Life** .....199

**Resident** .....256

**Student**.....213

**Total** .....2,325

## New Members

The Academy wishes to extend a warm welcome to our new members:

## Active

Edward Bush, MD  
Anderson

Gregory Eigner, MD  
Fort Wayne

Noel Wilkins, DO  
Bloomington

## Resident

Laura Cline, MD  
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Michael Shing, DO  
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## Students

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## IAFP Family Medicine Update — Our Exhibitors and Prize Winners

The Indiana Academy of Family Physicians would like to give a special recognition to the following companies that exhibited at the January 25-29 IAFP Family Medicine Update. When possible, please support these companies, and take the time to thank their representatives for their support of the IAFP educational activities.

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Stock Yards Bank & Trust  
St. Vincent Heart Center of Indiana  
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The Care Group, LLC  
The Indiana Hand Center  
Verathon Medical  
Wyeth Pharmaceuticals

The following physicians were winners in a prize drawing at the Update:

## Name

Ray Nicholson, MD  
Tom Kirkwood, MD  
Joy Anglea, MD  
Mark Sieb, MD

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# A Roadmap to Maintenance of Certification for Family Physicians

Editor's note: This article first appeared in the California Academy of Family Physicians' *California Family Physicians* magazine. We thank them for their permission to reproduce it for our members.

## Roadside Assistance: ABFM Support Center

2228 Young Drive  
Lexington, Kentucky 40505-4294  
Phone: 888.995.5700  
Fax: 859.335.7501  
E-mail: [help@theabfm.com](mailto:help@theabfm.com)

**THE MAINTENANCE OF CERTIFICATION PROGRAM** for Family Physicians (MC-FP), a mechanism for Board recertification for practicing family physicians, is now in its fourth year. Prior to 2003, recertification required possession of a full and unrestricted license, completion of 300 CME credits, and successful completion of a cognitive examination. Now, beginning with the 2003 recertification class, MC-FP will also require participation on an ongoing basis between examinations. The major objective of MC-FP is to provide opportunities for prospective professional development. IAFP will do its best to help members navigate the MC-FP process, but the best source for clarification and the latest updates is the American Board of Family Medicine (ABFM). This pullout guide is based on information for 2007 class members and beyond. Don't have time to read this now? Aren't recertifying this year? Tear out this quick reference guide, and file it somewhere for future use.

## MAJOR ATTRACTIONS: FOUR COMPONENTS

The MC-FP process is divided into four components that provide evidence of professional standing, lifelong learning, cognitive experience and performance in practice. Those marked with an asterisk (\*) are the same as the previous recertification process.

### PROFESSIONALISM

This is a measure of your professional standing. It includes information provided by both patients and other physicians and requires:

- Possession of a valid and unrestricted license in all states in which you maintain a license\*
- Peer review, via a process completed by phone or over the Internet, and introduced by ABFM and the American Board of Medical Specialties in 2005. This review will be required once during the seven- or 10-year cycle.
- Demonstration of patient satisfaction will also be required once during the cycle.

### SELF-ASSESSMENT AND LIFELONG LEARNING

This section focuses on specific areas of knowledge of your choice. The purpose is to enhance your knowledge and skills in areas that are of greatest use in your individual practice. Completion requires:

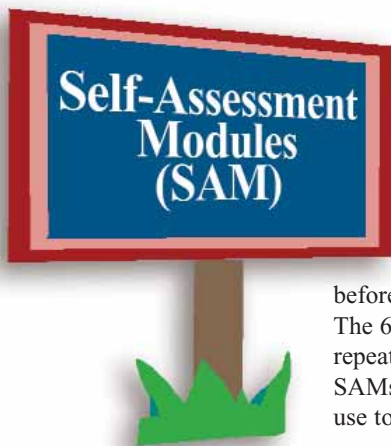
- 300 CME credits\*
- One Self-Assessment Module per year, for a total of six. These modules are accessed over the Internet and consist of two parts: 1) assessing cognitive knowledge with respect to a particular disease or problem, and 2) assessing your ability to apply that knowledge using patient-simulation technology developed by the ABFM. Diplomates may choose up to two modules from providers other than the ABFM, and the modules will also count toward your CME requirement.

### COGNITIVE EXPERTISE

Successful completion of the ABFM examination is still required.\*

### PERFORMANCE IN PRACTICE

A Performance in Practice Module must be completed once during the seven- or 10-year cycle. Instead of focusing on recordkeeping (as past requirements may have), the PPM focuses on quality of care. PPM also contributes to the CME requirement.



Once in the MC-FM program, you are required to complete six SAMs and one Performance in Practice module during the cycle. Each SAM consists of a 60-question knowledge assessment and a simulated clinical encounter. You must complete the 60-question knowledge assessment with a satisfactory score

before beginning the simulated clinical encounter. The 60-question knowledge assessment can be repeated until a satisfactory score is achieved. SAMs also include extensive references you can use to discuss and answer questions.

The current SAMs are:

- Asthma
- Depression
- Heart Failure
- Coronary Heart Disease
- Diabetes
- Hypertension

## Toll Booths:

### Payment Options for the 2004, 2005 or 2006 classes

In an effort to provide the greatest flexibility for paying for MC-FP, the ABFM has designed three payment plans. The following plans are available to those who entered MC-FP in 2004, 2005 or 2006:

**PLAN I:** This single-payment plan allows you to make one payment for the total cost of MC-FP. It includes six SAMs, one PPM and the exam at the end of the seven-year cycle. There will be no additional payments required to fulfill the seven-year cycle of MC-FP requirements. This payment plan is available any time after entry into the MC-FP process. (This is Fast-Trak.)

**PLAN II:** This annual payment plan allows you to make seven equal payments and guarantees the total cost of MC-FP at a fixed rate. It includes six SAMs, one PPM and the exam at the end of the seven-year cycle. This plan is only available during the first year you are scheduled to start the MC-FP process.

**PLAN III:** This pay-as-you-go payment plan allows you to pay for each component of MC-FP (six SAMs, one PPM and the exam) as you take them. The fee for each component (including the examination) is not guaranteed and is expected to gradually increase during the seven-year cycle. (Throwing coins in the basket.)

**PAYMENT PLAN CHANGES:** Should you wish to move from Plan III to Plan II during your first year of participation, you may do so by paying the difference and then paying the appropriate annual payment for the next six years. If you wish to move from Plan III or Plan II to Plan I, you may do so at any time by paying the difference between your prior payments and the current Plan I fee.

If you choose one of the pre-payment plans, the pay-as-you-go fee for each component will be deducted from your payment(s) as you begin participation, and the remainder will be carried forward toward the cost of the examination at the end of the seven-year cycle.

# DETOUR

## DETOUR: THE 10

The schematic below illustrates how the 10-year option works for the 10-year opt-out class and beyond. In the 2003, 2004 or 2005 recertification

Note: You will retain your seven-year certificate until the 10-year requirements — at which time your certificate will

## CERTIFICATION/RECERTIFICATION

### STAGE 1

Completion of two Part II Modules and one

YES

### STAGE 2

Completion of additional two Part II Modules and one Part IV Module during the following three years

YES

### STAGE 3

Completion of additional Part II Modules and one Part IV Module prior to recertification exam

RECERTIFICATION EXAM  
AT YEAR 10

# OUR

## 10-YEAR OPTION

on works for members of the 2006 recertification  
ication class? Go to [www.theabfm.org](http://www.theabfm.org) for details.

l you successfully complete the Stage 1 AND Stage  
be extended to 10 years.

## RECERTIFICATION EXAMINATION

Part IV Module during the three-year period

**NO**

Completion of six Part II Modules  
and one Part IV Module prior to  
recertification exam

**RECERTIFICATION EXAM  
AT YEAR 7**

### PART II Modules

Self-Assessment Modules or other approved external provider module. In the six years preceding the exam, diplomates must complete an equivalent of 300 CME credits.

### PART IV Modules

Depending on your practice setting and whether you see patients in continuity, these component requirements differ.

Traditional practice setting: patients seen in continuity options include PPM, Methods in Medicine Modules, Patient Safety Module, a METRIC from the AAFP or other approved external provider module.

Nontraditional practice setting: patients not seen in continuity or not seen at all options include MIMMs or PSMs.



## ARE WE THERE YET? HOW MUCH FURTHER? AND OTHER CAR GAMES

**For those certifying or recertifying in 2007 and beyond, we have the answers to your frequently asked questions.**

### CAN ANYONE EXTEND HIS OR HER CERTIFICATE BY THREE YEARS?

All successful certification or recertification candidates will receive a seven-year certificate from the ABFM and will be required to participate in MC-FP. Any diplomate who is already participating in MC-FP (someone who certified or recertified since 2003) may earn an extension to his or her seven-year certificate. To earn the extension, you must successfully complete a combination of modules within a defined timeframe. The process has been sectioned into three-year stages with specific requirements that must be successfully completed by the end of each stage. The requirements for each stage are the completion of two Part II modules and one Part IV module.

If you have not yet entered MC-FP, you will after your next Board exam. At that time, you'll be eligible to earn the extension.

### WHICH MODULES DO I NEED TO TAKE?

If you are currently in MC-FP and working toward earning a three-year extension of your certificate, the requirements are two SAMs and one PPM module for a total of three modules for each three-year stage. You may complete these modules at your own pace, doing all in one year or one every year, but they all must be completed by the end of each three-year stage. A total of three stages, or nine modules, must be completed during the 10-year cycle in order to sit for your next recertification exam. If you fail to complete the requirements noted above for any stage, you will retain your original seven-year certificate.

To meet the requirements for the seven-year MC-FP cycle, and in order to be eligible to sit for your next recertification

exam, you will need to complete six Part II modules and one Part IV module.

### HOW DO I KNOW WHERE I AM IN THE PROCESS?

If you are currently participating in the MC-FP program, you may log in to your "Physician Portfolio" and "Track Your Progress" online at [www.theabfm.org](http://www.theabfm.org). Here, you can review the modules you have successfully completed and what you still need to complete to fulfill the requirements for MC-FP.

If you are certified or recertified in 2004, there is an alternative available in the first stage, as further discussed later in these directions (look for the \*).

### I AM NOT A PRACTICING PHYSICIAN; DO I STILL NEED TO PARTICIPATE?

Yes, physicians who are administrators or who practice in settings that do not allow them to complete a PPM (e.g., urgent care or *locum tenens*) will still be required to participate in MC-FP. They will elect to complete a different type of Part IV activity. Options include a Methods in Medicine Module or the Patient Safety Module. The first MIMM will be on information management. The PSM is expected to be available in 2007. The ABFM will be adding more MIMM options in the future.

### ARE THE REQUIREMENTS THE SAME FOR EVERYONE?

The requirements are the same; however, your pathway to obtaining a three-year extension will vary somewhat, in terms of the combination of different types of modules, depending on whether or not you see patients in a clinical setting that will allow you to complete a PPM.





**IF I JUST WANT TO RETAIN OR QUALIFY FOR A SEVEN-YEAR CERTIFICATE, DO I HAVE TO COMPLETE THE MODULES?**

Yes. Participation in MC-FP is still a requirement for eligibility to sit for the recertification exam. You will still need to complete six Part II modules and one Part IV module prior to your next exam.

**IF I AM BEHIND IN COMPLETING MY MODULES, HOW CAN I CATCH UP?**

While three modules are required for every three-year stage, they may be completed at any time during that three-year stage. However, falling behind in either the first or second stage will automatically disqualify you from being granted the three-year extension necessary for a 10-year certificate.

**HOW MANY MODULES FROM EXTERNAL PROVIDERS CAN WE USE IN A 10-YEAR CYCLE?**

There is no limit on the number of modules you can take from external providers, but there will be no reimbursement of any fees that might be paid to those providers for their modules.

**DOES MC-FP REPLACE THE NEED FOR CME?**

No, the requirement of 300 CME credits in the six years immediately prior to the exam remains. But, remember, CME credit is awarded for completion of each of the modules associated with MC-FP.

**I OBTAINED MY FIRST CERTIFICATE IN 2004; HOW DO I EXTEND MY CERTIFICATE TO 2014 INSTEAD OF 2011?\***

Ready for this? It's complicated. You can extend your certificate if, by 2007, you complete either three Part II modules or two Part II modules and a Part IV module, followed by the completion of two Part II modules and a Part IV module by 2010. You would then be required to complete two more Part II modules and a Part IV module by 2014 in order to be eligible to sit for your next recertification exam in 2014.

**CAN I SIT FOR THE RECERTIFICATION EXAM EARLY?**

You may sit for the recertification exam early, but all the MC-FP requirements will have to be completed as if you were taking the exam in Year 7 or Year 10. In other words, you cannot participate in fewer modules than required by taking the exam early.

**AM I REQUIRED TO TAKE THE MODULES ON THE INTERNET?**

Yes, the module activities are only available as interactive Web applications. However, the knowledge assessment questions in the SAMs may be downloaded and printed for offline completion. You would then need to return to the online SAM to enter your questions.

Since CME credit is available for all modules, you may take as many modules as you wish; however, any modules taken in excess of the Stage requirements cannot be counted toward MC-FP credit in a subsequent Stage. And, a module cannot be re-taken for MC-FP credit unless a new, updated version of the same module has been created.

**Your Final Destination**

Still have questions about the MC-FP? Contact Deeda Ferree at 317.237.4237 or e-mail [dferree@in-afp.org](mailto:dferree@in-afp.org). Or, better yet, you can contact the ABFM directly at 859.269.5626 or visit their Web site at [www.theabfm.org](http://www.theabfm.org).

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# Mark Your Calendars Now!

## 2007 IAFP Annual Scientific Assembly and Congress of Delegates

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Plan on joining us for the 2007 IAFP Annual Meeting at the new French Lick Resort in beautiful southern Indiana. You won't want to miss this chance to experience how improved French Lick is after its multi-million-dollar renovation, with outstanding leisure and gaming opportunities. Mark your calendars now and stay tuned for more details.

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- All Member Congress of Delegates
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- All Member Party
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## OFFICIAL NOTICE FOR 2007 COD

### Indiana Academy of Family Physicians to Hold “All Member” Congress of Delegates

**NOTICE IS HEREBY GIVEN** for the 59th Indiana Academy of Family Physicians' Annual Scientific Assembly and Congress of Delegates to be held at the French Lick Resort, French Lick, Indiana, July 26 and 27, 2007. The first session of the 2007 Congress of Delegates will convene at 7:00 pm on Thursday, July 26, with the second session convening at 5:00 pm on Friday, July 27.

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.

#### **PURSUANT TO CHAPTER XI, SEC. 1. of the IAFP Bylaws:**

Subject to referendum, the control and administration of the Indiana Academy of Family Physicians shall be vested in a Congress of Delegates. **All active members, residents and students in attendance at the Congress of Delegates shall comprise the Congress.** The Congress of Delegates may, at any time, by a majority vote refer and submit to the members of the Academy defined questions affecting the policy or recommendations of this Academy which, in the opinion of the Congress of Delegates, are of immediate practical consequence to the members of the Academy and the public. The result of the referendum shall control the acts of the Academy and of its Board of Directors, officers, commissions, committees, agents and employees.



# 2007 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 26 and 27 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 26.

Offices to be filled for 2007-2008 are: president-elect, second vice president, speaker of the Congress of Delegates, vice speaker of the Congress of Delegates, one AAFP delegate (two-year term) and 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 13. If you have questions, please contact Kevin Speer or Deeda Ferree at 317.237.4237.



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# Let Your Voice Be Heard:

## Submit Resolutions by Monday, June 25, 2007

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 26 and 27 in French Lick, Indiana.

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 25.

### 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 25. Send resolutions to IAFP, Attn: EVP, 55 Monument Circle, Suite 400, Indianapolis, Indiana 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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therefore be it

RESOLVED,

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and therefore be it further

RESOLVED,

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Fiscal Note: \$

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Ensuring access to medicines requires that many organizations and individuals work together, including the government, insurers, healthcare providers, patients

and pharmaceutical manufacturers. Lilly continues to lead and support efforts to improve access to medications.

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# THANK YOU!

The Board of Trustees of the Indiana Academy of Family Physicians Foundation would like to thank the individuals and organizations that donated to the Foundation in 2006. Your generosity has provided the Foundation with critical resources needed to fulfill its mission:

*“...to enhance the health care delivered to the people of Indiana by developing and providing research, education and charitable resources for the promotion and support of the specialty of family practice in Indiana.”*

## FOUNDER'S CLUB MEMBERS

Founder's Club members have committed to giving \$2,500 to the IAFP Foundation during a five-year period. Members noted with a check mark (✓) have completed their commitment. The Board would also like to acknowledge that most of these individuals continue to give after completing their commitment.

Deborah I. Allen, MD ✓  
Dr. Jennifer & Lee Bigelow  
Kenneth Bobb, MD ✓  
Douglas Boss, MD  
Bruce Burton, MD ✓  
Kalen A. Carty, MD  
Clarence G. Clarkson, MD ✓  
Dr. Robert & Donna Clutter ✓  
Dianna L. Dowdy, MD  
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Fred Haggerty, MD ✓  
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Richard Juergens, MD ✓  
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Edward L. Langston, MD ✓  
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Jason Marker, MD

Debra R. McClain, MD ✓  
Robert Mouser, MD ✓  
Raymond W. Nicholson, MD ✓  
Frederick Ridge, MD ✓  
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Paul Siebenmorgen, MD ✓  
Kevin Speer, JD (IAFP EVP)  
Daniel A. Walters, MD ✓  
Deanna R. Willis, MD, MBA

## PLANNED GIVING CONTRIBUTORS

Ralph E. Barnett, MD  
Deeda Ferree  
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### 2006 CONTRIBUTORS

#### Gold Level (\$1,000-\$2,499)

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Windel Stracener, MD  
Drs. Curt and Kristy Ward

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Allison Matters  
Debra McClain, MD  
J. Christopher Sartore, MD  
Grace L. Walker, MD



*Did you miss your chance in 2006? Make your 2007 contribution to the IAFP Foundation now!*

# Ask and Act CME Webcasts

The AAFP's tobacco cessation program, "Ask and Act," encourages family physicians to ASK about the tobacco use habits of all of their patients, then to ACT on that information. The following CME opportunities are available online this spring. Remember, patients are more likely to try to quit smoking when their physicians suggest that they should.

**Become a Tobacco-Aware Practice: Using an Organizational and Team-Based Approach** – April 11, 2007, at 1 p.m. EDT. Enroll today and learn how to structure your office to identify tobacco users, and streamline your efforts to help them quit. This webcast is for your entire practice team.

**Conduct and Get Paid for Tobacco Cessation Group Visits** – May 16, 2007, at 1 p.m. EDT. Enroll today and learn how to enhance quality of care and productivity, improve patient satisfaction and decrease the overall cost of providing care through group visits.

**Beyond the Guidelines: Advances in Tobacco Cessation Treatment and Payment** – View this webcast to learn about evidence-based treatment, effective counseling strategies and reimbursement. Available for up to 2.0 Prescribed CME credits through April 24, 2008.

Visit: <http://www.aafp.org/online/en/home/clinical/publichealth/tobacco/cme/webcasts.html> for more details.

## Congratulations, Fort Wayne!

The city of Fort Wayne made history on January 23, 2007. On this evening, the Fort Wayne City Council approved a comprehensive smoke-free air ordinance, rescinding its previous ordinance that allowed for smoking rooms, which we now know to be ineffective at protecting the health of employees and patrons. The new measure applies to all public places, including restaurants, bars, bowling centers and private clubs. Fort Wayne's initial ordinance had been in effect since 1999 after going all the way to the state Supreme Court. At the time, this was a model ordinance, and one of the first of its kind in the Midwest. Since then, we have uncovered much research proving that walls and ventilation systems are not effective means of eliminating or blocking secondhand smoke.

Many municipalities and states across the country have enacted similar legislation during the years, but Fort Wayne was one of the first — and certainly the largest — to ever go back and strengthen an

ordinance we now know to be so flawed. This is a landmark decision, and we hope this will lead the way for other Indiana towns that have enacted ineffective laws to revisit the issue in the near future.



"The citizens of Fort Wayne should be proud to know that they will soon be waking up in a healthier community, thanks to the passage of this ordinance," said Karla Sneegas, executive director of the Indiana Tobacco Prevention & Cessation Agency. "This is a historic move forward, as Fort Wayne now has the distinction of being Indiana's largest city with a comprehensive smoke-free air ordinance."

The new ordinance will take effect June 1. Fort Wayne becomes the 30th municipality in Indiana to adopt a smoke free air ordinance. With its passage, more than 40 percent of the state's population is protected by an ordinance, compared to just 3 percent in 2000.



*It's your passion.*



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# Coding and Billing Update

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

## **2007 Coding Changes Impact Family Physicians – Lesion Destruction**

CPT 2007 includes hundreds of coding changes effective with dates of service on or after January 1, 2007. Due to changes in the descriptions, family physicians need to revise their reporting of 17000, 17003 and 17004 used to report the destruction of lesions.

For many years, physicians reported these codes for the destruction of benign or premalignant lesions. The 2007 change requires codes 17000, 17003 and 17004 to be used for reporting the destruction of only *pre-malignant lesions*. Codes 17110 and 17111 are used to report *benign lesions* other than skin tags or cutaneous vascular lesions.

## **Medicare Coverage for Ultrasound Screening for Abdominal Aortic Aneurysm**

§5112 of the Deficit Reduction Act of 2005 amended the Social Security Act to provide coverage under Part B of the Medicare program for a one-time ultrasound screening for abdominal aortic aneurysms (AAA).

Effective for services furnished on or after January 1, 2007, payment may be made for a one-time ultrasound screening for AAA for beneficiaries who meet the following criteria:

1. Receives a referral for such an ultrasound screening as a result of an initial preventive physical examination;
2. Receives such ultrasound screening from a provider or supplier who is authorized to provide covered diagnostic services;
3. Has not been previously furnished such an ultrasound screening under the Medicare program; and
4. Is included in at least one of the following risk categories:
  - a. Has a family history of abdominal aortic aneurysm, or
  - b. Is a man age 65 to 75 who has smoked at least 100 cigarettes in his lifetime.

Please note: this test must be ordered during an initial preventive physical examination, also known as the “Welcome to Medicare Physical.” This means Medicare will not pay for this test unless the patient is in the first six months of his or her Medicare Part B coverage.

## **Member Wants to Know**

A member writes: “I have been told I can only report 99214 once every four months for the same patient. Is this true? What if I see the patient for two different ‘emergencies’ within the four-months timeframe? What about a patient in ‘fragile’ health (i.e., out-of-control diabetic with hypertension and neuropathy) who needs to be seen monthly until he or she is stable?”

This is a great question! Evaluation and management (E/M) codes should not have any frequency restrictions. The main concern is medical necessity for the level of care. When selecting the level of care, please keep the following in mind.

*Medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT code. It would not be medically necessary or appropriate to bill a higher level of evaluation and management service when a lower level of service is warranted. The volume of documentation should not be the primary influence upon which a specific level of service is billed; however, the documentation should support the level of service reported.*

Don’t forget, the service should be documented while it is provided or as soon as possible after it is provided in order to maintain an accurate medical record.

Have a coding question you want to share with other members? Send it to the IAFP to get the answer. Selected questions will be published in *e-Frontline* or in the quarterly *FrontLine Physician*.

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TIP #9

## Know their approach to protecting physicians.



There is a big difference in operating philosophy among medical malpractice carriers. With some, defense against claims may be half-hearted at best. Many good physicians have been hurt by frivolous lawsuits when their good work went undefended in favor of quick-fix settlements. Clearly, this does not serve you or the profession well.

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# Indiana Physicians Receive Honorary Degree of Fellow from the AAFP

Several Indiana family physicians have achieved the Degree of Fellow of the American Academy of Family Physicians. The degree was conferred on almost 300 family physicians during a convocation on Saturday, September 30, 2006, in conjunction with the AAFP annual meeting in Washington, D.C.

Established in 1971, the AAFP Degree of Fellow recognizes family physicians who have distinguished themselves among their colleagues, as well as in their communities, by their service to family medicine, by their advancement of health care to the American people, and by their professional development through medical education and research. The 2006 fellowship class brings the total number of AAFP Fellows to more than 29,000 nationwide.

Criteria for receiving the AAFP Degree of Fellow consist of a minimum of six years of membership in the organization, extensive CME, participation in public service programs outside medical practice, conducting original research, and serving as a teacher in family medicine.

## Congratulations to:

Christopher Doehring, MD  
Renee Galen, MD  
Vipin Jain, MD  
Jeffrey Schoonover, MD  
Jerome Sneed, MD

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## FLP Tips

### Medications to **Avoid** for the Elderly

Medications can be the most effective and economical therapy to manage and prevent illness. However, inappropriate and ineffective medication use results in patient morbidity and mortality and the need for additional health care services. A landmark study in 1995 estimated that for every \$1 spent on medications, another \$1 was spent to resolve medication-related problems.<sup>1</sup> In 2001, the cost of medication-related problems had nearly doubled.<sup>2</sup> Medication problems or errors among older adults lead to a high rate of emergency department visits and hospital admissions.<sup>3</sup> Clearly, the management of therapeutic drugs can be improved.

Many medications can cause confusion, sedation, syncope, extrapyramidal side effects and/or toxicity in the elderly population. The following medications have safer or more efficacious alternatives and should be avoided in the elderly.<sup>4</sup>

Amiodarone (Cordarone)  
Amitriptyline (Elavil)  
Amobarbital (Amytal)\*  
Butabarbital (Butisol Sodium)\*  
Carisoprodol (Soma)  
Chlordiazepoxide (Librium)  
Chlorpropamide (Diabenese)  
Chlorzoxazone (Paraflex)  
Cyclobenzaprine (Flexeril)  
Diazepam (Valium)  
Disopyramide (Norpace)  
Fluoxetine (Prozac) (dosed daily)  
Flurazepam (Dalmane)  
Gatafloxacin (Tequin)

Indomethacin (Indocin)  
Ketorolac (Toradol)  
Meperidine (Demerol)  
Mephobarbital (Mebaral)\*  
Meprobamate (Miltown, Equanil)  
Mesoridazine (Serentil)  
Metaxalone (Skelaxin)  
Methocarbamol (Robaxin)  
Methohexital (Brevital Sodium)\*  
Methyldopa (Aldomet)  
Methyldopa/hydrochlorothiazide (Aldoril)  
Methyltestosterone (Android, Virilon, Testrad)  
Naproxen (Naprosyn, Avaprox, Aleve)  
(Doses greater than 200mg every 12 hours)

Nifedipine (Procardia, Adalat) (Short-acting only — doesn't apply to XL)  
Nitrofurantoin (Macrobid, Macrochantin)  
Orphenadrine (Norflex)  
Pentazocine (Talwin)  
Pentobarbital (Nembutal)\*  
Secobarbital (Seconal)\*  
Thiopental (Pentothal)\*  
Thioridazine (Mellaril)  
Ticlopidine (Ticlid)  
Trimethobenzamide (Tigan)

\* Except when used to control seizure

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1. Johnson, JA, Bootman JL. Drug-related morbidity and mortality: a cost of illness model. Arch Intern Med. 1995;155:1949-56
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3. Budnitz, DS; Pollock, DA, Weidenbach, KN, et al. National surveillance of emergency department visits for outpatient adverse drug events. JAMA 296:1858-1866 2006.
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This material originally appeared in Iowa Family Physician.



# National Provider Identifier Deadline Reminder

The purpose of the National Provider Identifier (NPI) is to uniquely identify a health care provider in standard transactions, such as health care claims. NPIs may also be used to identify health care providers on prescriptions, in internal files to link proprietary provider identification numbers and other information, in coordination of benefits between health plans, in patient medical record systems, in program integrity files and in other ways. HIPAA requires that covered entities use NPIs in standard transactions by the compliance dates. You are a covered entity if you conduct any electronic transaction with federal health programs.

The compliance date for all covered entities except small health plans is May 23, 2007. The compliance date for small health plans is May 23, 2008. As of the compliance dates, the NPI will be the only health care provider identifier that can be used for identification purposes in standard transactions by covered entities. That means, as of May 23, 2007, all physicians must submit the NPI number on their claims. Failure to do so may mean the inability to claim and receive payment for services rendered on or after that date. It is important to begin submitting the NPI now, while there is time to correct any problems within the billing system or clearinghouse. Members should submit both their current provider identification (legacy) numbers and their NPI at this time.

Members who want more information on the NPI and how to obtain one can access that information at the AAFP's Web site: <http://aafp.org/online/en/home/practicemgt/regulatorycompliance/hipaa/natlproviderid.html>.



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