Clif Knight, MD, Candidate for AAFP Board of Directors

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2012 IAFP Annual Convention:
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2012 Work Plan
PG 25
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Our Mission
The mission of the Indiana Academy of Family Physicians is to promote and advance family medicine in order to improve the health of Indiana.

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

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

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

Family Medicine: Exceptional Physicians, Exceptional Care

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

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Serving the IAFP

From your newly inaugurated president, welcome to the fall issue of the IAFP FrontLine Physician. It has been an exciting time for me personally and for the Academy as a whole. This past July, I had the privilege of being installed as the president of the IAFP. It has been an honor to be a member of the Executive Committee for the past three years, and I am thrilled to now serve as president. I’m certain this year will be full of excitement and challenges, and, through it all, I will serve the IAFP to my fullest abilities.

My inauguration was part of our Annual Scientific Assembly and Congress of Delegates. We hosted the event in Indianapolis for the first time in many years, and it was a resounding success. We presented a varied selection of CME topics and a SAM Study Group. The CME sessions sold out and were standing room only at times. Attendees were also treated to an intriguing Town Hall Dinner with Dr. Bob Phillips, the distinguished director of the Robert Graham Center.

Our Congress of Delegates was busy discussing a number of resolutions to help direct our Academy leadership. Resolutions were adopted on a range of topics from working on payment reform to restructuring the governance of our Academy. The weekend concluded with Family Medicine Day at Victory Field. We had more than 300 guests join us for a pre-game picnic followed by the Indianapolis Indians baseball. Overall, it was a very successful weekend, and we are already working on planning next year’s meeting, which will again be in Indianapolis.

Finally, we are dedicating space in this issue to Dr. Clif Knight. As many of you know, he is running for a position on the AAFP Board of Directors. Dr. Knight has dedicated many years of service to the IAFP and the AAFP in a number of positions and is now ready to take that service to the next level. We wish him the best of luck in Philadelphia this October.

If I can be of any service to you over this year, please don’t hesitate to e-mail me at risheetp@yahoo.com or contact the Academy office.

Thanks,
Risheet R. Patel, MD

Indiana’s Mitchell Ellis Receives Special Recognition in the 2012 Tar Wars® Poster Contest

Congratulations to Mitchell Ellis, who was 2012’s Indiana Tar Wars® poster contest winner. Mitchell and his family, along with IAFP staff member Missy Lewis, attended the annual Tar Wars® National Conference in Washington, D.C., sponsored by the American Academy of Family Physicians. This event is held each year in the summer. The Tar Wars® National Conference celebrates youth, creativity and being tobacco-free and is jam-packed with fun, excitement and learning opportunities for the entire family.

Mitchell received a prize packet that included a certificate of appreciation, a ribbon, a color copy of his poster and a special gift. His poster featured the slogan: Racing Towards a Healthy Life: Be Smoke Free.

The Tar Wars® National Conference is a once-in-a-lifetime opportunity for students to receive recognition for their tobacco-free efforts, voice their opinions about tobacco use to their congressional leaders, participate in tobacco-free workshops and meet other state winners who share their tobacco-free views.

The IAFP received this note of thanks from Mitchell after the conference:

Missy Lewis & Indiana Academy of Family Physicians:

Thank you for getting everything together for our Washington, D.C., trip. I had a really great time in Washington, D.C. I would not have been able to do this without your sponsorship. Thank you again for this opportunity.

Sincerely,
Mitchell Ellis
Mark Your Calendar

**IAFP Events**

**IAFP Fall Conference**  
Saturday, October 27  
Indianapolis

**IAFP Board/Commission Cluster**  
Sunday, October 28  
Indianapolis

**AAFP Assembly**  
**Congress of Delegates**  
Monday, October 15-Tuesday, October 16  
Philadelphia, Pennsylvania

**Scientific Assembly**  
Tuesday, October 16-Saturday, October 20  
Philadelphia, Pennsylvania

**2013**  
**Emerald Isle CME and Golf Trip**  
Saturday, June 29-Saturday, July 6  
Ireland, United Kingdom

**2013 IAFP Annual Convention**  
Thursday, July 25-Sunday, July 28  
Indianapolis

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Thank You to Our Strategic Partner

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It’s Never Too Early to Plan to Serve as Physician of the Day

Don’t be disappointed! Plan your POD shift now! In 2013, your Academy is responsible for providing episodic primary care services for Indiana’s legislators and their staffs during the time the state legislature is in session. On days when the full House and Senate are in session the Physician of the Day is introduced on the floor of both houses. This interesting and fun program allows you to observe the legislative process firsthand, meet with your state legislators, and leave a great impression about family medicine on the General Assembly. Your day at the Statehouse will last from 8:30 a.m. to 4:30 p.m.

IAFP members can volunteer to spend one or more days at the Statehouse during the legislative session. We are currently scheduling physician volunteers for the months of February and April 2013. The program operates Mondays through Thursdays. If you are interested in serving as the Physician of the Day, please contact Chris Barry or Meredith Edwards at the IAFP office at 888.422.4237 (toll-free, in-state only) or 317.237.4237. THANK YOU!
IU Health is proud to be among the top 1% of hospitals in the nation to achieve the Honor Roll ranking—U.S. News & World Report's highest distinction.

We couldn't have achieved this prestigious honor without you. By partnering with IU Health, where over 80% of Indiana's Top Doctors practice, you are entrusting your patients to one of the country's healthcare leaders, nationally ranked for fifteen consecutive years. For the confidence you've put in our proven record of success, we're grateful.
The IAFP is going to Ireland! Join us on a thrilling trip to the Emerald Isle in 2013. Not only will you see the sights and experience the culture of Ireland, but you’ll also have time to play golf and earn CME credit.

More than 10 hours of prescribed CME credit will be offered:

- Practice Pearls for Treating Acne, Psoriasis, Eczema, and Skin Cancer
- Helping Your Patients Reduce the Chance of Stroke
- Adult Immunization Update
- Diabetic Peripheral Neuropathic Pain
- Current USPSTF Screening Recommendations for Selected Clinical Problems
- Physician Leadership Skills
- How Health Care Systems Are Changing

Saturday, June 29
Depart USA

Sunday, June 30
Dublin Sightseeing
Overnight in Dublin at the Burlington Hotel

Monday, July 1
Depart Dublin via motorcoach with guide
Clonmacnoise
Galway
Overnight at Hotel Meyrick in Galway

Tuesday, July 2
Visit Connemara Coast
Spiddal
Leenane and Kilary Harbour
Clifton
Overnight at Hotel Meyrick in Galway
Optional Golf at Connemara Golf Club

Wednesday, July 3
Travel through the Burren
Visit the incredible Cliffs of Mohar
Adare – Foynes – Killarney
Overnight at Killarney Plaza Hotel in Killarney
Optional Golf at Killarney Golf & Fishing Club

Thursday, July 4
Tour The Ring of Kerry
Free time to explore in Killarney
Overnight at Killarney Plaza Hotel in Killarney
Optional Golf at the Old Course at Ballybunion

Friday, July 5
Drive to County Cork
Tour Blarney Castle
Continue to Dublin
Overnight at the Burlington Hotel in Dublin

Saturday, July 6
Depart for USA

Save $100 on CME fee – book before October 31!

Find out more and start planning your trip today at http://specialeventcruises.com/iafp_golf.html. For reservations and information, call Golf Travel ETC at 877-934-6531.
Formulary Update

onglyza®
(saxagliptin) 5 mg tablets

kombiglyze® XR
(saxagliptin and metformin HCl extended-release) tablets

Available on Formulary at Indiana Medicaid

For more information about these products, visit www.onglyza-hcp.com or www.kombiglyzexr-hcp.com

Please read adjacent Brief Summary of US Full Prescribing Information for KOMBIGLYZE XR (saxagliptin and metformin HCl extended-release) (5/500-5/1000-2.5/1000 mg tablets), including Boxed WARNING about lactic acidosis.


Lactic acidosis is a rare, but serious, complication of diabetes mellitus. The condition arises when there is a build-up of lactic acid in the blood due to inadequate delivery of oxygen to the cells. This can occur due to a variety of factors, including infection, illness, or medications that can interfere with the body's ability to metabolize glucose.

While lactic acidosis can occur in patients with type 1 diabetes, it is much more common in patients with type 2 diabetes who are not well controlled. This is because type 2 diabetes is characterized by insulin resistance, which can lead to increased production of lactic acid by the body.

Signs and symptoms of lactic acidosis include:
- Abdominal pain
- Confusion
- Difficulty breathing
- Fatigue
- Fast breathing
- Faster heart rate
- Nausea or vomiting
- Shortness of breath
- Sweating
- Weakness

If you suspect lactic acidosis, it is important to seek medical attention immediately. Treatment typically involves addressing the underlying cause, providing intravenous fluid and electrolyte replacement, and using insulin to help lower blood glucose levels.

Prevention of lactic acidosis in patients with type 2 diabetes includes:
- Close monitoring of blood glucose levels
- Regular exercise
- Weight management
- Regular medication review
- Avoidance of medications that may increase the risk of lactic acidosis

In conclusion, lactic acidosis is a serious but preventable complication of diabetes mellitus. By recognizing the risk factors and symptoms, and taking proactive steps to manage the disease, patients can help prevent this condition and maintain a healthy lifestyle.

References:
5% in any treatment group in both studies. In the saquinavir study, the incidence of diarrhea was 15.6%, 15.1%, and 13.3% in the saquinavir 3 mg and 1 mg group, respectively. When saquinavir and methionin HIV-infected was compared with placebo in the lopinavir/ritonavir group, the incidence of diarrhea in the lopinavir/ritonavir group was 6.9% in the saquinavir 3 mg, 6.8% in the methionin immediate-release group, and 7.2% in the methionin extended-release group.

Hypotension

In the saquinavir clinical trial, severe reactions of hypotension were reported in 1.5% of subjects. In the lopinavir/ritonavir group, the incidence of hypotension was 2.9% in the saquinavir 3 mg and 1 mg group, and 3.1% in the placebo group. When saquinavir and methionin HIV-infected was compared with placebo in the lopinavir/ritonavir group, the incidence of hypotension in the lopinavir/ritonavir group was 6.9% in the saquinavir 3 mg, 6.8% in the methionin immediate-release group, and 7.2% in the methionin extended-release group.

DRUG INTERACTIONS

Strong inhibitors of CYP3A4 and/or P-glycoprotein

Saquinavir — Saquinavir's metabolism is inhibited by strong CYP3A4 and/or P-glycoprotein inhibitors, such as azole antifungals, macrolide antibiotics, and protease inhibitors.

Cimetidine and Ritonavir — The combination of cimetidine and ritonavir should be used with caution in patients receiving saquinavir, as this combination can result in increased levels of saquinavir, which may lead to adverse effects. Patients should be monitored closely for signs of toxicity.

Acute pancreatitis — See Indications and Usage and Warnings and Precautions.

Dose adjustments

Calcium channel blockers — The simultaneous use of saquinavir with calcium channel blockers may increase the risk of hypotension and should be used with caution.

Cyclosporine — The use of saquinavir with cyclosporine may increase the risk of nephrotoxicity, and patients should be closely monitored for renal function.

Diltiazem — The use of saquinavir with diltiazem may increase the risk of hypotension and should be used with caution.

Digitoxin — The use of saquinavir with digitoxin may increase the risk of digitoxin toxicity, and patients should be closely monitored for digitoxin levels.

Mesalazine — The use of saquinavir with mesalazine may increase the risk of mesalazine toxicity, and patients should be closely monitored for mesalazine levels.

Methotrexate — The use of saquinavir with methotrexate may increase the risk of methotrexate toxicity, and patients should be closely monitored for methotrexate levels.

Perphenazine — The use of saquinavir with perphenazine may increase the risk of perphenazine toxicity, and patients should be closely monitored for perphenazine levels.

Procainamide — The use of saquinavir with procainamide may increase the risk of procainamide toxicity, and patients should be closely monitored for procainamide levels.

Prednisone — The use of saquinavir with prednisone may increase the risk of prednisone toxicity, and patients should be closely monitored for prednisone levels.

Salicylates — The use of saquinavir with salicylates may increase the risk of salicylate toxicity, and patients should be closely monitored for salicylate levels.

Sulfonamides — The use of saquinavir with sulfonamides may increase the risk of sulfonamide toxicity, and patients should be closely monitored for sulfonamide levels.

Warfarin/phenprocoumon — The use of saquinavir with warfarin/phenprocoumon may increase the risk of bleeding, and patients should be closely monitored for international normalized ratio (INR) levels.

OVERDOSAGE

Saquinavir — In case of overdose, supportive and symptomatic treatment should be administered. In cases of severe overdose, hemodialysis may be beneficial in removing saquinavir from the bloodstream.

PATIENT COUNSELING INFORMATION

See 134a-approved Medication Guide for Full Prescribing Information.

Infections

Patients should be informed of the potential risk of opportunistic infections while taking saquinavir. Opportunistic infections may include bacterial, viral, fungal, and parasitic infections. Patients should be instructed to report any signs of infection to their healthcare provider.

Acute pancreatitis — Acute pancreatitis is a rare but serious complication of saquinavir therapy. Patients should be instructed to report any signs of acute pancreatitis, such as abdominal pain, nausea, vomiting, and fever, to their healthcare provider immediately.

Methotrexate — Methotrexate is a potent antifolate agent that can cause bone marrow suppression, and patients should be instructed to report any signs of bone marrow suppression, such as fatigue, fever, and bruising, to their healthcare provider.

Diabetes mellitus — Patients should be informed of the potential risk of diabetes mellitus while taking saquinavir. Patients should be instructed to report any signs of diabetes mellitus, such as increased thirst, increased urination, and unexplained weight loss, to their healthcare provider.

Osteoporosis — Osteoporosis is a common complication of HIV infection and antiretroviral therapy. Patients should be instructed to report any signs of osteoporosis, such as bone pain, fractures, or decreased bone density, to their healthcare provider.

Hypoproteinemia — Hypoproteinemia is a common complication of HIV infection and antiretroviral therapy. Patients should be instructed to report any signs of hypoproteinemia, such as easy bruising or bleeding, to their healthcare provider.

AIDS-defining illnesses — Patients should be informed of the potential risk of AIDS-defining illnesses while taking saquinavir. Patients should be instructed to report any signs of AIDS-defining illnesses, such as opportunistic infections, to their healthcare provider.

Drug interactions

Calcium channel blockers — The combination of calcium channel blockers and saquinavir may increase the risk of hypotension. Patients should be instructed to report any signs of hypotension to their healthcare provider.

Cimetidine and Ritonavir — The use of cimetidine and ritonavir with saquinavir may increase the risk of saquinavir toxicity. Patients should be instructed to report any signs of saquinavir toxicity to their healthcare provider.

Cyclosporine — The use of cyclosporine with saquinavir may increase the risk of nephrotoxicity. Patients should be instructed to report any signs of nephrotoxicity to their healthcare provider.

Diltiazem — The use of diltiazem with saquinavir may increase the risk of hypotension. Patients should be instructed to report any signs of hypotension to their healthcare provider.

Digitoxin — The use of digitoxin with saquinavir may increase the risk of digitoxin toxicity. Patients should be instructed to report any signs of digitoxin toxicity to their healthcare provider.

Mesalazine — The use of mesalazine with saquinavir may increase the risk of mesalazine toxicity. Patients should be instructed to report any signs of mesalazine toxicity to their healthcare provider.

Methotrexate — The use of methotrexate with saquinavir may increase the risk of methotrexate toxicity. Patients should be instructed to report any signs of methotrexate toxicity to their healthcare provider.

Perphenazine — The use of perphenazine with saquinavir may increase the risk of perphenazine toxicity. Patients should be instructed to report any signs of perphenazine toxicity to their healthcare provider.

Procainamide — The use of procainamide with saquinavir may increase the risk of procainamide toxicity. Patients should be instructed to report any signs of procainamide toxicity to their healthcare provider.

Salicylates — The use of salicylates with saquinavir may increase the risk of salicylate toxicity. Patients should be instructed to report any signs of salicylate toxicity to their healthcare provider.

Sulfonamides — The use of sulfonamides with saquinavir may increase the risk of sulfonamide toxicity. Patients should be instructed to report any signs of sulfonamide toxicity to their healthcare provider.

Warfarin/phenprocoumon — The use of warfarin/phenprocoumon with saquinavir may increase the risk of bleeding. Patients should be instructed to report any signs of bleeding to their healthcare provider.

Induction of CYP3A4 by saquinavir

Saquinavir may induce CYP3A4, and patients should be instructed to report any signs of drug interactions to their healthcare provider.

Acute pancreatitis — See Indications and Usage and Warnings and Precautions.

Dose adjustments

Calcium channel blockers — The simultaneous use of saquinavir with calcium channel blockers may increase the risk of hypotension, and patients should be closely monitored for hypotension.

Cimetidine and Ritonavir — The use of cimetidine and ritonavir with saquinavir may increase the risk of saquinavir toxicity, and patients should be closely monitored for saquinavir levels.

Cyclosporine — The use of cyclosporine with saquinavir may increase the risk of nephrotoxicity, and patients should be closely monitored for creatinine levels.

Diltiazem — The use of diltiazem with saquinavir may increase the risk of hypotension, and patients should be closely monitored for hypotension.

Digitoxin — The use of digitoxin with saquinavir may increase the risk of digitoxin toxicity, and patients should be closely monitored for digitoxin levels.

Mesalazine — The use of mesalazine with saquinavir may increase the risk of mesalazine toxicity, and patients should be closely monitored for mesalazine levels.

Methotrexate — The use of methotrexate with saquinavir may increase the risk of methotrexate toxicity, and patients should be closely monitored for methotrexate levels.

Perphenazine — The use of perphenazine with saquinavir may increase the risk of perphenazine toxicity, and patients should be closely monitored for perphenazine levels.

Procainamide — The use of procainamide with saquinavir may increase the risk of procainamide toxicity, and patients should be closely monitored for procainamide levels.

Salicylates — The use of salicylates with saquinavir may increase the risk of salicylate toxicity, and patients should be closely monitored for salicylate levels.

Sulfonamides — The use of sulfonamides with saquinavir may increase the risk of sulfonamide toxicity, and patients should be closely monitored for sulfonamide levels.

Warfarin/phenprocoumon — The use of warfarin/phenprocoumon with saquinavir may increase the risk of bleeding, and patients should be closely monitored for INR levels.
In a recently released paper, the AAFP has made it clear that the Academy opposes mandated CME as a prerequisite to DEA registration or licensure to prescribe opioid analgesics.

In an Aug. 1 position paper, “Pain Management and Opioid Abuse,” the Academy states that mandated CME could limit patient access to legitimate pain management needs. “Family physicians and other primary care clinicians play a vital role in effective pain management, including the prescribing of opioid analgesics. The creation of additional prescribing barriers for primary care physicians would limit patient access when there is a legitimate need for pain relief,” the Academy said in a related news release.

“As such, the AAFP opposes any action that limits patients’ access to physician-prescribed pharmaceuticals, and opposes any actions by pharmaceutical companies, public or private health insurers, legislation, the FDA or any other agency, which may have the effect of limiting by specialty the use of any pharmaceutical product.”

These statements reiterate two existing AAFP policies, one of which opposes any action limiting patient access to physician-prescribed pharmaceuticals, and the other of which “opposes legislation or executive action that would require mandatory education of family physicians as a condition for prescribing specific drugs, such as opioids.”

The Academy outlined several other major points in the paper, including its view that the chief goal of pain management should be to improve and maintain patients’ ability to function. The AAFP also urged family physicians to individualize therapy based on review of the potential risks and benefits to each patient, possible drug side effects, and a functional assessment of the patient, and to monitor ongoing therapy accordingly.

In addition, the Academy:

- Supports development of evidence-based physician education to ensure the safest and most effective use of long-acting and extended-release opioids and to reduce the problem of opioid abuse;
- Urges all states to obtain physician input when considering pain management regulation and legislation, as well as implement prescription drug monitoring programs and the interstate exchange of registry information as called for under the National All Schedules Prescription Electronic Reporting (NASPER) Act of 2005; and
- Strongly advocates increased national funding to support research into evidence-based strategies for optimal pain management and incorporation of those strategies into the patient-centered medical home model.

Many states already are working to control the problem of opioid misuse by, for example, adopting model medical board prescribing policies, instituting prescription monitoring programs and developing guidelines about documentation requirements. According to the AAFP, 37 out of 50 states have implemented, or are in the process of implementing, prescription drug monitoring programs that use NASPER grant funding. In addition, various professional organizations either have or are developing prescribing guidelines for physicians treating patients with chronic noncancer pain.

In the position paper, the Academy also cited the FDA’s recently issued risk evaluation and mitigation strategy for extended-release and long-acting opioids, saying it will continue to work with the FDA and others on projects such as the FDA’s Safe Use Initiative to “ensure policies are in place to allow effective and safe opioid prescribing by family physicians for patients in their pain management programs.”

ENDING CHILDHOOD OBESITY WITHIN A GENERATION

We support school-based nutrition and physical fitness initiatives, such as Fuel Up to Play 60, that help achieve these guiding principles:

1. Increase access to and consumption of affordable and appealing fruits, vegetables, whole grains, low-fat dairy products and lean meats in and out of school.

2. Stimulate children and youth to be more physically active for 60 minutes every day in and out of school.

3. Boost resources (financial/rewards/incentives/training/technical assistance) to schools in order to improve physical fitness and nutrition programs.

4. Educate and motivate children and youth to eat the recommended daily servings of nutrient-rich foods and beverages.

5. Empower children and youth to take action at their school and at home to develop their own pathways to better fitness and nutrition for life.
IAFP members from across the state gathered in Indianapolis in July to attend the 2012 IAFP Annual Convention. It was the first time in many years that we had held the meeting in Indianapolis, and this new centralized location resulted in significantly higher attendance figures. Attendees and their families enjoyed meeting in Indianapolis’ thriving downtown area, with easy access to local attractions, museums, shopping and dining.

We offered more opportunities to earn CME credit this year, with more than 25 Prescribed AAFP CME credits available. Clinical topics and practice management sessions were included on the program, and all CME plans were based on previous attendee evaluations and IAFP member CME Needs Assessments.

We also featured an MC-FP SAM Study Group on cerebrovascular disease, which again proved so popular that it sold out early. Our facilitator, Curt Ward, MD, led participants through each of the 60 questions in the ABFM’s Self-Assessment Module and oversaw interactive discussion among participants.

Many members attended the All-Member Congress of Delegates to have their votes and voices in IAFP business matters. Our Town Hall Dinner was a valuable opportunity to hear new policy topics from the thought leaders of Indiana and the nation. This year, we welcomed Bob Phillips, MD, the distinguished director of the Robert Graham Center, to discuss the neces-
sary changes the current graduate medical education funding system requires to support primary care.

Our Annual President’s Banquet and Installation of Officers, followed by All-Member Family Party, was an exciting event for the whole family. An elegant dinner was held to honor our incoming and outgoing president and the contributors to our Family Practice Stories Book. Later in the evening, children joined their parents for a dessert buffet and dancing, with entertainment by the Marlins. We also honored Erica R. Huddleston, MD, who was selected as the recipient of this year’s Outstanding Resident award. Dr. Huddleston has been selected as chief resident at Community Health Network Family Medicine Residency Program in Indianapolis.

Students, residents and residency faculty members were invited to a “Preparing for the Match” panel, followed by a special Congress of Delegates Orientation. The session ended with a reception — a great chance for students to learn more about our residencies. Immediately following the close of the Scientific Assembly, we held a picnic at Victory Field, where we cheered on the Indianapolis Indians.

See lots more photos on our Facebook page: www.facebook.com/inafp!
Our Exhibit Show offered an opportunity to learn about the newest clinical advances and practice management tips and services. A huge thank-you to the following companies that were in attendance:

- Abbott
- Achieve EHR
- American Express
- American Health Network
- Astellas Pharma US, Inc.
- ATI Physical Therapy
- Balance MD
- Boehringer Ingelheim Pharmaceuticals
- Bristol-Myers Squibb
- Care Improvement Plus
- Community Health Network
- Covidien
- EmCare
- Esacote North America
- Essential Molecular/PGX Laboratories
- Goodman Campbell Brain and Spine
- Grifols, Inc.
- Health Diagnostic Laboratory, Inc.
- Indiana Academy of Family Physicians
- Indiana Army National Guard
- Indiana Spine Group
- Inquest Health System
- iSalus Healthcare
- Kowa Pharmaceuticals America
- MD Wise
- Medical Protective
- Medstar Laboratory, Inc.
- Merck & Co., Inc.
- Michael H. Fritsch, MD – Otology
- MMIC
- Northwest Radiology Network
- Ortholndy
- ProAssurance
- Purdue Pharma L.P.
- Reid Hospital
- Sanofi Pasteur
- South Bend Medical Foundation
- St. Vincent
  - Peyton Manning Children’s Hospital at St. Vincent
  - St. Vincent Bariatric Center of Excellence
  - St. Vincent Cancer Care
  - St. Vincent Critical Care Transport
  - St. Vincent Heart Center of Indiana
- St. Vincent Women’s Maternal Fetal and Neonatal Services
- St. Vincent Medical Group
- St. Vincent Medical Imaging
- St. Vincent Neuroscience Institute
- St. Vincent One Call Transfer
- VeinSolutions, a member of St. Vincent Medical Group
- St. Mary’s Hospital, Evansville, Indiana
- SuccessEHS
- Teva Respiratory
- U.S. Air Force
- Urology of Indiana
- Vein Clinics of America
- ViroPharma, Inc.
- We Care TLC
- American Board of Family Medicine
- American Academy of Family Physicians, supported by an educational grant from Endo Pharmaceuticals, Inc., Jansen Pharmaceuticals, Inc., administered by Janssen Scientific Affairs, LLC, and Purdue Pharma, L.P.
- California Academy of Family Physicians, supported by an educational grant from Bristol-Myers Squibb and Pfizer
- CorVasc MDs
- Eli Lilly & Co.
- Hall Render Killian Heath & Lyman
- Indiana University School of Medicine
- iSalus, Inc.
- Managed Health Services
- Newby Consulting
- Outcomes Managed Educational Workshops (OMEW)
- WellPoint, Inc.
- WellPoint, Inc.

Thank you to our CME moderators:
- Fred Ridge, MD
- Risheet Patel, MD
- Teresa Lovins, MD
- Tom Kintanar, MD
- Daniel Walters, MD

Thank you also to Deanna Willis, MD, and Ken Elek, MD, who opened the program for us.

The Indiana Academy of Family Physicians gratefully acknowledges the following companies/organizations for providing educational support and/or grants for the 2012 IAFP Annual Convention:
- CS2Day
- Goodman Campbell Brain and Spine
- Indiana University School of Medicine
- iSalus Healthcare
- Balance MD
- Lutheran Medical Group
After returning from Kansas City, the conference theme still resonates in my mind, and I am left “Seriously Inspired.” Inspired to advocate for the broadened scope of practice, for Medicaid reimbursement and for continued graduate medical education funding. Inspired to pursue research grants, fellowship opportunities and international electives. Inspired to further serve my patients, my community and my fellow colleagues.

The 2012 National Conference of Family Medicine Residents was a unique opportunity to meet residents, students and physicians from across the nation who are like-minded in their passion for family medicine. I am honored to have served as the Indiana Chapter delegate at the resident Congress of Delegates. In addition to browsing the endless rows of booths in the exhibit hall, I participated in resolution-writing, candidate elections and voting on key resolutions that may go on to influence AAFP policy.

**Resolution Writing**

After learning that resolutions are the conduit for creating AAFP policy, I was inspired to write a resolution requesting that the AAFP explore opportunities for residents and students to be representatives on the board of the Center for International Health Initiatives (CIHI). CIHI is an advisory board that, among other things, hosts the annual Global Health Workshop, which will be in Minneapolis later this year. Considering that more family medicine residents and residency programs are showing an interest in Global Health, and students who participate in international electives are more likely to go into primary care specialties, resident and student representatives could offer meaningful insight to the Board’s activities as well as experience significant educational value and leadership opportunities.

**Resolutions**

The following are just a sample of the resolutions that were adopted this year and will be referred by the AAFP Board of Directors to the appropriate Academy entity. This group then reviews the resolution and determines if further action is appropriate and if policy should be developed relating to the topic of the resolution.

RESOLVED:
1. That the AAFP create policy regarding use of social media by its member physicians.
2. That the AAFP support civil marriage for same-gender couples to contribute to overall health and longevity, improved family stability and to benefit children of gay, lesbian, bisexual, transgender (GLBT) families.
3. That the AAFP amend their policy on Ethics and Advanced Planning for End-of-Life Care to state “Family physicians should continue to support the medical, psychological and spiritual needs of dying patients and their families by initiating Advanced Directive discussions and end-of-life planning during times of health.”
4. That the AAFP strongly endorse its support for universal access to contraceptives.
5. That the AAFP support reasonable accommodation for medical students and residents who are breastfeeding.

It was a great honor to serve as the Indiana Chapter delegate to the 2012 National Conference. I hope my fellow residents are as inspired as I am to continue the pursuit of excellence in family medicine.

**Tiffany Meador, MD** is a family medicine resident (PGY-2) at St. Vincent Family Medicine Residency Program in Indianapolis, and the IAFP’s resident delegate to the AAFP. After attending the AAFP’s 2012 National Conference of Family Medicine Residents, Dr. Meador sent us this report about her experiences.
Why are you running for the AAFP Board of Directors?
I’ve served state and national academies in some capacity ever since I was a medical student almost 30 years ago. It has been incredibly challenging but equally educational and satisfying. The opportunity to serve our membership on the AAFP Board of Directors is incredibly appealing to me. The Academy makes a difference in the professional and personal lives of our members and a positive impact on the patients and communities that they serve everyday. I would consider it a privilege to serve on the AAFP Board, knowing that I am able to influence the strategic direction of the organization and positively influence the lives of our members and their patients.

If elected, what would some of your goals and priorities be during your term?
As a member of the Board, I would strive to make sure that the limited resources of our Academy are being focused on those areas that mean the most to our members. Having served on the Commission on Membership and Member Services, I am familiar with our member satisfaction surveys and the resulting priorities identified by those surveys. Now more than ever, we need to be deliberate about using the data from our membership surveys to prioritize our resources for meeting the needs of our members and the patients and communities they serve. We must always have that check step — making sure that when we utilize resources, we are answering the needs of our membership and effectively meeting our members’ expectations.

What are some of the leadership strengths that you will take to the AAFP Board of Directors?
The diversity of experiences that I’ve had will contribute to this leadership role — rural practice, the academic environment and now a system leadership role. I have developed a thorough understanding of education principles and the importance of legislative advocacy and have been involved as a student, a resident and a new physician. I am very deliberate about being open-minded, listening to differing opinions, and trying to make decisions based on both evidence and experience. A willingness to innovate and try things differently is a great strength of mine. And I’m very optimistic and very passionate about the core principles of family medicine.

You’ve mentioned the need to focus on the priorities of the overall membership. Can you expand on this?
Every organization has limited resources. What you have to be careful of is not giving into the temptation of pursuing your own pet projects or favorites of individual members. That’s where it takes a strong team to be able to work together, challenge each other and go back to those guiding principles. As a membership organization, we exist to serve our members. We need to feel confident that we can collegially and professionally challenge each other as we make difficult decisions on not just which programs to pursue but also which programs may need to be discontinued. That’s a difficult conversation, but you have to take the personalities out and look at it from an organizational standpoint and what is best for our members and their patients.

Are there examples of when you’ve had to do something at the state chapter or with work responsibilities that may have helped with that?
At the state chapter, we’ve had to make decisions that have changed the makeup of our districts and the logistics of our congress. These changes may have been unsettling for a few, but as a group we came together and made decisions from an organizational standpoint that made our Academy more focused, efficient and effective.

You are on the Board of Trustees for a new medical school here in Indiana. What have you gained from this experience?
I’m on the Board of Trustees of Marian University, which is developing a new college of osteopathic medicine. Because it is a new school, we have had the opportunity to develop the leadership and curriculum in a way that gives students an early appreciation for the importance of primary care. This experience has helped me better understand what needs to be done across the country as we are trying to make changes in medical school structures and curriculum that will more appropriately enhance and spotlight the importance of family medicine and primary care.

Can you describe your work experience?
Post-residency, I joined a three-physician family medicine practice in a small rural town about 45 miles from the nearest hospital. We did inpatient and prenatal care, covered a significant nursing home population and did a wide variety of procedures. After a few years, I had an opportunity to begin teaching in the residency that I trained in. I was full-time faculty for 15 years, including five years as program director. I was also the medical director of a 100-bed extended-care facility during part of my time at the residency program. About five years ago, I became vice president of medical affairs for two acute-care hospitals before becoming chief medical officer and vice president of medical and academic affairs for Community Health Network in Indianapolis.

And what do you do in your current position?
I facilitate quality improvement and support our approximately 2,000 physician medical staff. With the roll out of electronic health records (EHR) throughout all of our facilities, I work from the standpoint of how our physician population interacts with the EHR and how they work as part of the teams caring for patients. We have recently expanded our residency program by affiliating with an osteopathic hospital and are in the process of gaining the accreditation needed to build additional residency programs. I am responsible for making sure that we have the resources to allow medical students and residents to have excellent educational and clinical opportunities. I continue to see patients on a limited but regular basis. The majority of my patients are folks that I have taken care of for 20 or more years and have established relationships with.

What experience do you have at the AAFP state and national level?
I’ve been blessed to have served in a wide variety of leadership roles within our state chapter, dating back to medical school, including president and chairman of the Board. I have served as chair of our Foundation Board of Trustees, Commission on Legislation and our Political Action Com-
The IAFP Congress of Delegates, which is open to all members, met on July 27 and 28 in conjunction with the IAFP Annual Convention. This year, the Congress heard a total of 11 resolutions and two recommendations — all sent in from IAFP members.

One of the Congress’ main tasks in 2012 was to vet potential changes to the IAFP’s governance (see Mandate #2). The IAFP’s Taskforce on Leadership sent to the Congress a resolution on how to streamline the IAFP board structure. The Taskforce on Leadership’s resolution passed the Congress with a number of amendments. Next, the IAFP Bylaws Committee will have approximately 11 months to work on converting the resolution into a bylaws amendment. The amendment will be presented to the 2013 Congress of Delegates. If passed, the IAFP governance structure will be updated.

The Congress also considered eliminating IAFP local dues. The Congress agreed to end the $15 local dues charge and subsequently increase member state dues by $15. The move will keep the IAFP accounting cleaner and should end the confusion that an extra dues schedule causes. Local activities (like regional meetings) will continue to be funded under a line item in the IAFP budget.

All items passed by the IAFP Congress are referred to as mandates. A full list of IAFP mandates are included in this article. During the next year the IAFP Commissions and Committees will take action on the mandates, including forwarding resolutions onto the AAFP Congress of Delegates, which takes place in October in Philadelphia, Pennsylvania.


IAFP 2012 Mandates

Item #1: IAFP Region Dues
Assigned to: Executive Committee

RESOLVED, that the Indiana Academy of Family Physicians eliminate the region (local) dues of $15; and be it further

RESOLVED, that the Indiana Academy of Family Physicians increase its state chapter dues by $15, and be it further

RESOLVED, that the Indiana Academy of Family Physicians have a line item in its annual budget for region activities.

Item #2: IAFP Governance
Assigned to: Bylaws Committee

RESOLVED, that the Bylaws and appropriate Rules and Regulations of the IAFP be changed to reflect the changes in governance structure outlined in Attachment A.

Attachment A

Executive Committee
Membership: President, President-Elect, Immediate Past President, Treasurer, Board Chair (if filled by an individual other than one of the aforementioned officers) and Speaker (non-voting member).

Election Process: The President-Elect is elected by the Congress of Delegates yearly at the Annual Meeting for a one-year term with automatic advancement to President (also a one-year term). Physician members eligible for election to President-Elect include any member not otherwise excluded by term limits and who has spent at least one three-year cycle on the Board of Directors. The President-Elect will be elected by a simple majority of the Congress of Delegates each year. Candidates for President-Elect may announce their candidacy at any time after the Congress of Delegates which immediately precedes the meeting in which they hope to be elected. Treasurer follows existing process for Treasurer selection.
Terms of office: After serving as Immediate Past President, members must wait two years before running for a Board of Directors at large seat. The Speaker and Vice-Speaker may fulfill 2 consecutive three-year terms, and then must wait 2 years before seeking another term.

Scope of work: Meet as needed to oversee Board processes and provide staff oversight. Oversee internal conflict and any actions against members, leadership, or the organization of a sensitive or confidential nature. Perform the annual review of the EVP.

Board of Directors
Membership: Executive Committee, both AAFP Delegates, and six at-large directors. The student and resident regions are each expected to designate a voting member to attend all meetings of the board of directors. In instances where AAFP Delegates cannot attend, their AAFP Alternate Delegate can vote in their place. The Speaker of the Congress shall be a voting member to the Board of Directors. In instances when the Speaker cannot attend a Board meeting, the Vice Speaker should vote in the Speaker’s place. The Bylaws committee will consider the need for alternate directors.

Election Process: The at-large members of the Board of Directors will serve in three-year staggered terms with a yearly election of two new at-large members held by the Congress of Delegates. At-large members of the Board may serve up to 2 consecutive terms (with formal re-election required) and then must sit out at least 1 year before again pursuing re-election to the Board.

Congress of Delegates
Membership: Unchanged from current of All Member Congress of Delegates set up. Election Process: Unchanged from current All Member Congress of Delegates process.

Scope of work: Meet quarterly to accomplish the work of the IAFP Congress of Delegates and oversee the activities of the organization as outlined in the IAFP Bylaws and Rules and Regulations. The Board of Directors shall assign from among its members a liaison to each of the standing commissions/committees of the IAFP.

Commissions and Committees: No change is anticipated to the current commission and committee structure. Responsibility and frequency of meetings for commissions and committees will potentially increase. Physician members may serve in an unlimited capacity on IAFP Commissions and Committees.

Nominating Committee: The Nominating committee's scope will be increased to identifying demographics that need to be included on the board, and identifying and recruiting executive committee and board members for election by the Congress.

AAFP Delegation: No process changes

Region Governance: There shall no longer be elected a Director or Alternate Director in title from any region nor regular or required region meetings.

Region structure: This will remain unchanged.

Student and Resident Governance: The student and resident regions will be allowed to choose the process by which they choose their representatives to the Board of Directors.

Transition plan: Upon passage, this resolution will be referred to the bylaws committee, which will be asked to return with updated bylaws for consideration by the
Congress in 2013. Upon passage of those bylaws, the new governance structure will go into effect immediately. The Bylaws Committee will be developing a plan for the exact nature of the transition. The currently slated 1st Vice President (who was elected as 2nd Vice President in 2012) will assume a one-year At-Large Board member position. Positions will be refilled in the process outlined in the Board of Directors Election Process above.

Vacancies: In the event of a vacancy in the Board of Directors or Executive Committee, the Executive Committee will work with the Congress of Delegates to fill such positions expeditiously and with a fair election process.

In absentia: In the event that a nominee for any position exists but is unable to attend the meeting at which they would attempt to be elected, they may still run assuming they have submitted such a request in writing prior to the start of that year’s Congress of Delegates. After the initial call for nominees at the Congress of Delegates, no further nominees, in person or in writing, will be accepted.

Deficiencies: Should there be found any deficiencies in the plan as outlined above during the transition period, the Board of Directors is authorized to make such changes as necessary to remedy the situation. Should any substantive changes be required, these must be presented for a vote of the Congress of Delegates.

Item #3: AAFP Corporate Dues
Assigned to: AAFP Delegates

RESOLVED, that the IAFP send a resolution to the AAFP Congress of Delegates asking the AAFP to study the creation of a new class of “corporate dues” wherein entities paying dues for a large number of physicians can pay at a lower rate.

RESOLVED, that the resolution not be sent to the AAFP Congress of Delegates should we find that the AAFP is already considering a new class of corporate dues.

Item #4: Identification of Credentials
Assigned to: Commission on Legislation and Governmental Affairs

RECOMMENDATION: The reference committee recommends that the resolution be referred to the IAFP Commission on Legislation for action. RESOLVED, that the IAFP support legislation or regulation requesting that all nurse practitioners and physician assistants identify themselves with their full and proper credentials (Physician Assistant, Doctor of Nursing Practice, Nurse Practitioner) when meeting a patient or family caring for a patient for the first time and give these patients or family member the name of their collaborating or supervising physician.

Item #5: Prior Authorization and Pharmacy Benefit Managers
Assigned to: Commission on Health Care Services

RESOLVED, the IAFP will discuss with pharmaceutical benefit managers requesting that when a prescribed medication is denied, the pharmaceutical benefit manager provides in the first communication what other therapeutic options are covered.

Item #6: Indoor Tanning
Assigned to: Commission on Health Care Services and Commission on Legislation and Governmental Affairs

RESOLVED, that the IAFP support better education of all citizens of Indiana related to the risks of indoor tanning.

Item #7: Health Care Workforce Center
Assigned to: Executive Committee

RECOMMENDATION: The IAFP leadership and staff will work with the Indiana Area Health Education Center (AHEC), and other key stakeholders from around the state, to evaluate, develop, and promote, including lobbying as necessary, the establishment of a health care workforce center for Indiana.

Item #8: Gathering Support for PCMH Payment by Payors
Assigned to: Executive Committee

RECOMMENDATION: The IAFP leadership and staff will work with co-sponsors of a resolution to the Indiana State Medical Association (ISMA) to endorse a resolution asking the ISMA to be more active in promoting the patient centered medical home, including appropriate increased payment for services provided with payors active in Indiana.

Item #9: Methadone Clinics and INSPECT
Assigned to: Commission on Legislation and Governmental Affairs

RESOLVED, that the IAFP support legislation or regulation that requires methadone clinics to submit INSPECT reports the same as pharmacies currently do.

Item #10: Training or Licensure for Prescribing Narcotic Painkillers
Assigned to: Commission on Education and Commission on Health Care Services

RESOLVED, that the IAFP regularly report to its members regarding the AAFP investigation of possible voluntary training, mandatory training, or specific licensure for physicians to prescribe narcotic painkillers.
At the end of each fiscal year, the Office of Inspector General (OIG) of the Department of Health and Human Services (HHS) publishes its Work Plan. This article provides brief descriptions of new and ongoing reviews and activities that OIG plans to pursue with respect to HHS programs and operations for the next fiscal year. In this newsletter, Newby Consulting, Inc. (NCI) selected three reviews and activities the OIG plans to pursue that affect all physicians.

The OIG’s work plan includes several reviews related to evaluation and management (E/M) codes. One review has been completed, and a report has been issued. Other reports regarding E/M services are expected later this year.

**Evaluation and Management Services: Trends in Coding of Claims**

The OIG will review evaluation and management (E/M) claims to identify trends in the coding of E/M services from 2000 to 2009. They will also identify providers that exhibited questionable billing for E/M services in 2009. Medicare paid $32 billion for E/M services in 2009, representing 19 percent of all Medicare Part B payments. Providers are responsible for ensuring that the codes they submit accurately reflect the services they provide (CMS’ Medicare Claims Processing Manual, Pub. No. 100-04, Ch. 12, § 30.6.1). E/M codes represent the type, setting and complexity of services provided and the patient status, such as new or established (OEI; 04-10-00180; expected issue date: FY 2012; work in progress).

On May 5, 2012, the OIG issued the first in a series of reports discussing the utilization of evaluation and management (E/M) services. The report, “Coding Trends of Medicare Evaluation and Management Services,” notes the number of E/M services billed increased by 13 percent.

The report notes that established patient office visits represented the largest amount of Medicare payments for E/M services in 2010. While 99213 was billed most often during the 10-year period, the OIG noted a shift in billing from the three lower-level E/M codes to the two higher-level codes. Combined, physicians increased their billing of the two highest level E/M codes (99214 and 99215) by 17 percent between 2001 and 2010.

Based on the OIG’s findings, the Centers for Medicare & Medicaid Services (CMS) is developing and issuing comparative billing reports (CBR) aimed at 5,000 physicians across the country who have consistently billed for high-level E/M codes. The report is not intended to be punitive or an indication of fraud. CMS will be proactive by providing information about the physicians’ coding and billing practices. According to CMS, this should help providers identify potential errors in billing practices and make changes to help prevent improper billing and payment in the future.

**Comparative Billing Reports**

Under CMS contracts, comparative billing reports are produced by SafeGuard Services LLC and distributed by Livanta LLC. The reports provide comparative data on how an individual physician varies from other physicians in the same specialty by looking at utilization patterns. The billing data in the report includes a comparison of the physician’s own billing pattern with the state and national average billing patterns for the physician’s specialty.

These reports explain that CMS hopes the physician will find the “educational tool” helpful in “identifying opportunities for improvement.” Further, CMS “believes the information can assist the physician in performing a self-audit to assess conformity with Medicare billing guidelines.” A sample CBR can be found on Safeguard Services’ website at http://www.safeguard-servicesllc.com/cbr/documents/CBR016_Evaluation_Management_Services_sample.pdf.

Some Part A/B Medicare Administrative Contractors (MAC) issue their own CBRs. The reports include an explanation of why the physician received the CBR. As an example, one MAC includes the following warning in a CBR related to E/M coding:

…upcoding and under coding are viewed as errors by Medicare. If your billing pattern significantly varies from that of your peers, as shown in the graph above, please review your coding and billing of this category of E/M services for accuracy. If error rates do not decrease, Medicare may have to perform additional edits/audits or provider specific reviews to lower the error rate.

Although we were not able to obtain family practice’s utilization of E/M codes on the state level, we were able to locate the most recent data for family practice’s national utilization of E/M codes (dates of service January 1, 2011, through June 30, 2011)
“Clif Knight, MD, for AAFP Board of Directors,” continued from page 21.

mittee. I was a member of the AAFP New Physicians Committee and represented the AAFP at the Young Physicians Section of the AMA. I later served on the AAFP Commission on Membership and Member Services, which resulted in the opportunity to chair the special constituencies subcommittee. Currently, I serve on the AAFP Commission on Quality and Practice, and I have served in the AAFP Congress of Delegates for the last 12 years.

What are some of the biggest challenges you feel family physicians are facing in today’s environment?
I think the current, and huge, environment of change is the greatest challenge to family physicians today. Changes to the way we are reimbursed, the rapid increase in new technology, the continued flux of health care reform, system changes such as the statewide health care insurance exchanges, the heightened shortage of primary care physicians, etc., all can be overwhelming for our membership, and as an Academy, we must provide support and services that empower family physicians to turn these changes into a benefit rather than a hindrance. We need to help support our members and give them confidence that they are in an enhanced position of influence that they have potentially not had before.

<table>
<thead>
<tr>
<th>New Patient E/M Codes</th>
<th>National Utilization</th>
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<tbody>
<tr>
<td>99201</td>
<td>1.23%</td>
</tr>
<tr>
<td>99202</td>
<td>15.60%</td>
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<tr>
<td>99203</td>
<td>46.51%</td>
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<tr>
<td>99204</td>
<td>30.16%</td>
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<tr>
<td>99205</td>
<td>6.51%</td>
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<table>
<thead>
<tr>
<th>Established Patient E/M Codes</th>
<th>National Utilization</th>
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<tbody>
<tr>
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<td>3.72%</td>
</tr>
<tr>
<td>99212</td>
<td>4.30%</td>
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<td>99213</td>
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<td>40.23%</td>
</tr>
<tr>
<td>99215</td>
<td>3.56%</td>
</tr>
</tbody>
</table>

Compare your utilization of E/M codes with the national statistics. This will assist you in determining what codes to focus on when you perform your coding and documentation review.

Evaluation and Management Services: Potentially Inappropriate Payments
The OIG will assess the extent to which CMS made potentially inappropriate payments for E/M services and the consistency of E/M medical review determinations. This assessment will also review multiple E/M services for the same providers and beneficiaries to identify electronic health records (EHR) documentation practices associated with potentially improper payments. Medicare contractors have noted an increased frequency of medical records with identical documentation across services. Medicare requires providers to select the code for the service based upon the content of the service and have documentation to support the level of service reported (CMS’ Medicare Claims Processing Manual, Pub. No. 100-04, Ch. 12, § 30.6.1) (OEI; 04-10-00181; 04-10-00182; expected issue date: FY 2013; work in progress).

Later in 2012, the OIG expects to issue two additional reports on E/M codes. One will determine the appropriateness of Medicare payments for E/M services. The other will assess the extent of documentation vulnerabilities in E/M services using electronic health record systems.

Documentation Versus Medical Necessity
There are two sets of documentation guidelines for evaluation and management services, 1995 and 1997. CMS has instructed its contractors to use the guidelines that are most advantageous to the physicians. The only significant difference between the 1995 and 1997 guidelines is in the examination components. The exam component in the 1995 guidelines is based on organ systems and body areas. The 1995 Documentation Guidelines for Evaluation and Management Services are available on the CMS website at http://www.cms.gov/Outreach-and-Education/Medicare-Learning-Network-MLN/MLNEdWebGuide/Downloads/95Docguidelines.pdf

To read the rest of this article, please visit www.in-afp.org and click on Education & Practice Management > Coding and Billing Updates.
WAITING FOR THE ECONOMY TO CHANGE?

While you’re waiting, your competitors are changing their economy. They’re targeting Indiana Academy of Family Physicians members who make purchasing decisions in this multi-million-dollar industry. And these members actively read this publication like you’re doing right now.

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...and Memory Disturbances

Negative Scan
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Positive Scan
Arrows indicate Amyloid Neuritic Plaques
A positive scan indicates moderate to frequent amyloid plaques — consistent with a pathological diagnosis of AD. However, this amount of plaque can also present in other neurological conditions as well as in older adults with normal mental functioning.

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