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about our cover

On our cover: The mission statement of your IMS recalls the purpose and celebration of the season. Experience the Joy of the Season in your own special way. Please take a few moments during this season of giving to support the Indianapolis Medical Society Foundation’s Project Health, which provides care for the working poor of Marion County. It is easy to donate, just visit www.imsonline.org and click on the “Donate” button on the right side of the page.

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If the altruism that was part of your original attraction to the practice of medicine is still intact, then I have a suggestion. It is time to rededicate ourselves and intensify our efforts to help our patients who smoke to stop smoking. As a pulmonologist, I spend most of my time treating the disastrous consequences of smoking. In Indiana, there is nowhere to go but up. We are always listed among the three worst states for smoking rates in the entire country. (We have also been criticized for our students’ performance on standardized tests and our rate of obesity, making us a state of cognitively challenged obese smokers.) Can we sit still for this sad state of affairs? Absolutely not!

Tobacco is the number one non-infectious cause of disease and mortality throughout the world. Roughly half of the 650 million people who smoke will eventually die of tobacco-related disease. Five million people die annually. More deaths result from smoking than all deaths from HIV, illegal drug use, motor vehicle accidents, suicides and murders combined. When it comes to saving lives, there is nothing like helping patients stop smoking. Smoking is the primary preventable cause of death in the United States. Smoking is responsible for about 20% of all deaths and results in roughly $100 billion in health care costs annually.

Not only is tobacco/nicotine dependence a deadly risk factor, it is a brain disorder in which nicotine binds to nicotinic cholinergic receptors in the brain which results in dopamine release, neuroadaptive changes, tolerance, and ultimately withdrawal symptoms when tobacco use is decreased or stopped. This makes quitting a proposition not dissimilar to walking away from heroin and other addictive substances and accounts for the 5% success rate (per attempt) of “cold turkey” smoking cessation. Quit rates are much higher (in the 30-50% range) when this physiologic dependence on nicotine is addressed with medication that reduces and stabilizes withdrawal symptoms.

There are a number of obstacles to improving our success with this stubborn problem. Smokers frequently do not utilize evidence-based approaches. Healthcare providers do not consistently offer and encourage smoking cessation treatments. We wax and wane in our optimism and confidence that we can seriously impact this plague. However, the opportunity to make a difference presents itself all the time. Roughly 70% of all smokers see a primary care physician each year. The addition of tobacco use to the vital signs in an office setting helps identify 80% or more of smokers. At least 75% of smokers have indicated they would quit if there was a painless and easy, almost automatically successful method available.

So what does work? Research supports the use of a positive, encouraging, empathic approach consistent with the principles of motivational interviewing in combination with pharmacotherapy. Counseling and support typically include asking the patient to set a quit date, encouraging them to tell others and ask for support, and to help the patient plan for anticipated obstacles and relapse triggers. It is important to discuss and encourage the use of medications such as varenicline (Chantix), combination nicotine replacement therapy, or bupropion. When using nicotine products, patients may have the option to start the nicotine replacement 2-3 weeks before the quit date. Flexibility, patient autonomy and preference are important concepts in smoking cessation. The alliance between the patient and the healthcare provider fosters the development of a positive relationship which can be a key to this process. Large doses of encouragement, emphasis on adherence to medication, and addressing fears and concerns about medications are critical. Patients have a tendency to stop the treatment prematurely, skip doses or underdose the medication and often complete less than 50% of the recommended counseling sessions. Noncompliance is a chronic problem, therefore follow-up and ongoing support and assistance provide accountability and improve outcomes.

Finally, I would like to mention some of the dedicated “champions” of this cause. Dr. Arden G. Christen has spent over 30 years conducting research and providing treatment at the IU Dental School, Fairbanks Hospital and other settings. Dr. Christen has seen thousands of patients for smoking cessation and has taught dental and medical students how to improve their outcomes with nicotine dependent patients. Dr. Stephen J. Jay, Professor of Medicine and past (founding) Chair of the Department of Public Health at IU Medical School has worked tirelessly for this cause. Dr. Richard D. Feldman has authored numerous articles to raise awareness and promote policy and legislative changes to advance this initiative. These men and others are outstanding role models who serve to remind us to remain passionate and dedicated to this cause. It is truly a matter of life and death.

IMS Bulletin, December 2011
Carpe Diem – Seize the Day!

Bernard J. Emkes, MD

When queried, many physicians and other providers say they do not like managed care – most often based on the prior auth requirements, along with the red tape and hassles of many of the health care processes. But when asked about – right patient, right care, right time, right reason, right cost, almost all agree this is the goal of health care. The former is the latter – but, of course, the devil is always in the details.

At issue is often this – While there are guidelines and protocols to assist in determining what to do and when to do it (Milliman Guidelines and InterQual Guidelines, among others), there must be exceptions and instances when the patient clearly does not fit a simple algorithm. Even the guideline developers recognize there are exceptions. Patients rarely have one disease, infrequently is there actually only one option for treatment and this is the exact variation that drives statisticians and health care analysts to drink, but is the very environment physicians work in every day.

Many disease processes lend themselves to protocols and that does breed some consistency. Better patient safety, better quality and improved outcomes are the result of less variation in care. But that same variation, unless controlled and managed by physicians is the exact reason for managed care rules, regulations and red tape.

I had a very interesting discussion with a case manager today. This happened to be a Peds case of a child with end stage and refractory cancer despite heroic attempts at cure. This happened to be a Peds case of a child with end stage and refractory cancer despite heroic attempts at cure. However, this child may not meet IP Hospice guidelines. So what are we to do to meet the needs of the patient, family, payer and employer? That is really what the health care reform debate is really about.

Value-based purchasing is about the value received for the services provided. As we implement or choose not to proceed to an ACO, this value equation will NOT go away. One thing will however change dramatically. Instead of the employer or the health plan being at risk for the cost of this care, more and more the physicians on our medical staff, and the Hospital will be absorbing these costs. This is a culture change that we will have to undergo as we evolve to more cost-effective treatment processes. Estimates are that 20% or more of health care costs are “waste,” but decisions about where those wastes exist, and the self-insured business (actual claim payer)? Probably not! What the child needs is more than likely Hospice over the next 2-3 months. We could change the status from acute care to Hospice in the same bed. That reduces our billing and revenue from this payer, yet probably is the right answer. Even then, the child may not meet IP Hospice guidelines. So what are we to do to meet the needs of the patient, family, payer and employer? That is really what the health care reform debate is really about.

Value-based purchasing is about the value received for the services provided. As we implement or choose not to proceed to an ACO, this value equation will NOT go away. One thing will however change dramatically. Instead of the employer or the health plan being at risk for the cost of this care, more and more the physicians on our medical staff, and the Hospital will be absorbing these costs. This is a culture change that we will have to undergo as we evolve to more cost-effective treatment processes. Estimates are that 20% or more of health care costs are “waste,” but decisions about where those wastes exist, and which sacred cows will be sacrificed is still an ongoing debate. Be sure of one thing – the more “we” are part of the solution the less “they” as outside forces will be dictating behaviors to us.
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The Center for Pain Management is one of Central Indiana’s most experienced medical practices focusing exclusively on treating patients who suffer from back, head, neck, joint or cancer-related pain.

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C. William Hanke, MD, was the Plenary Speaker at the 20th Congress of the European Academy of Dermatology Meeting, October 22, 2011, in Lisbon, Portugal. Dr. Hanke spoke on “Dermatodesign – State-of-the-Art 2011.”

Rick C. Sasso, MD, Indiana Spine Group, received his 10th US patent September 13, 2011. Dr. Sasso’s patent is “Instruments and techniques for guiding instruments to a spinal column.” This patent relates to anterior cervical disectomy and fusion procedures, as well as instrumentation to accurately and properly place artificial cervical disc replacements.

Dr. Sasso was the first author of an article, “Results of Cervical arthroplasty compared with anterior disecotomy and fusion: Four year clinical outcomes in a prospective, randomized controlled trial,” in the September issue of Journal of Bone and Joint Surgery.

He also served as a faculty member at the American Academy of Orthopedic Surgeons annual spine course, “Spine Surgery: State of the Art Techniques and Science, held at the Rosemont Illinois center. He lectured on cervical spondylotic myelopathy.

Richard D. Feldman, MD, director of Medical Education and Residency Training was recognized at the 27th annual Tony and Mary Hulman Health Achievement Awards program, held Oct. 6 at the Indianapolis Westin Hotel. Dr. Feldman received the Lifetime Award for Distinguished Service in Years of Health Advancement Award during the 2011 Indiana Public Health Foundation award program.

David H. Moore, MD, is the latest recipient of the Healing Hands Award presented on October 26, 2011 by Franciscan St. Francis Health. With his colleagues and support staff looking on, Dr. Moore received the award at a ceremony at his office, Gynecologic Oncology Specialists.

Awarded quarterly, the Healing Hands Award was established in 2010. Its goal is to recognize St. Francis physicians for excellence in clinical skills, patient relations, research, stewardship and their reflection of the hospital’s health-care ministry, values and mission.

Jeffrey M. Rothenberg, MD, Clinical Associate Professor, Department of Obstetrics & Gynecology, IU School of Medicine, recently gave two talks at the District V ACOG meeting in Detroit – “GYN Care of the HIV+ Woman, and Bacterial Vaginosis, What is Old, What is New.”

Dr. Rothenberg also had a glass and metal sculpture in stalled in the lobby of the new Glick Eye Institute entitled Oculi on Campus.

Richard C. Rink, MD, IU Professor and Chief Pediatric Urology, was invited as Visiting Professor at the Alfred I. du Pont Hospital for Children, Wilmington, Delaware on October 19, 2011. He discussed “Lower Urinary Reconstruction in Children,” “Surgical Management in Children with Disorders of Sexual Development” and “Common Problems in Pediatric Urology.” On October 20, 2011, Dr. Rink was Visiting Professor at the Jefferson Medical School, Department of Urology in Philadelphia, Pennsylvania.

News from Goodman Campbell Brain & Spine...

Aaron A. Cohen-Gadol, MD, published the article, “The medial tentorial artery of Bernasconi-Cassinari: a comprehensive review of its anatomy and neurosurgical importance,” in the October issue of Acta neurochirurgica.

Troy D. Payner, MD, Thomas J. Leipzig, MD, John A. Scott, MD, Andrew J. DeNardo, MD, and Aaron A. Cohen-Gadol, MD, published the following article based on research conducted at Goodman Campbell Brain and Spine, “Trends over time in the management of 2253 patients with cerebral aneurysms: A single practice experience” in the journal, Surgical Neurology International.

Richard B. Rodgers, MD, and Eric M. Horn, MD, published the following articles, “Multi-level corpectomies and reconstruction via a single posterolateral approach” in Journal of Clinical Neuroscience; and “Sacral fractures following stand-alone L5-S1 anterior lumbar interbody fusion for isthmic spondylolisthesis” in Journal of Neurosurgery: Spine.

Michael B. Pritz, MD, published the article, “Geometry of Saccular, Side-branch Cerebral Aneurysms: Implications for Treatment” in the Journal of Stroke and Cerebrovascular Diseases.

Ronald L. Young, II, MD; Troy D. Payner, MD; and Aaron A. Cohen-Gadol, MD, published the results of their research study, “A Feasibility Trial of Concurrent Radiation, Temozolomide, and Bevacizumab Followed by Temozolomide and Bevacizumab for Resectable and Unresectable Glioblastoma Malform of the Brain” in the Proceedings of the 53rd Annual American Society of Radiation Oncology Meeting in October.
Are increased health insurance premiums strangled your practice’s budget?
Are reductions in health insurance benefits putting more stress on your employees?
Is your current health insurance coverage anniversary date in the near future?

If you answered yes to any of the above questions, consider the Indianapolis Medical Society members program for a discount on group health insurance through ADVANTAGE HEALTH SOLUTIONS, a local health plan owned by local providers. IMS physician practices and the IMS are benefiting from this discount and the move to ADVANTAGE.

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Vascular Surgery
University of Lagos, Nigeria, 1995

Livingston, Daniel S., MD
Resident – St. Vincent Hospital
Internal Medicine
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Spoljoric, Jason J., MD
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Carmel, 46032-4409
Anesthesiology, 2010
Indiana University, 2003

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Project Health

Carrie Jackson Logsdon, Director

Thank You,
Craig G. Herrman, MD!

Project Health’s Doctor of the Month is Craig G. Herrman, MD, JWM Neurology. He is originally from Richmond, Indiana, where his dad is a retired computer applications specialist who worked at Reid Memorial Hospital. His mother is an administrative assistant and his step-mother teaches newspaper and yearbook at Richmond High School. He has one older brother who works at Dick Hill & Son Heating and Air Conditioning. Dr. Herrman said it was great growing up in Richmond. He was on the tennis team and said Coach Gary Eagles was a mentor. “He always encouraged hard work.”

Dr. Herrman worked part-time for a veterinarian in high school and started Purdue with that in mind, but changed his mind in his second year. “I started getting into human biology and liked the fact that the patient could actually talk to you and give you symptoms. I liked studying how the brain worked and was fascinated by how one side works versus the other,” he said.

He met his wife at Purdue. She is a Physician’s Assistant and went to PA school at George Washington University while he was in medical school at the I.U. School of Medicine. Dr. Robert Pascuzzi, Chairman of the Dept. of Neurology, recommended that Dr. Herrman check out the Rochester neurology program. He and his soon-to-be wife then met up again in Rochester. They both worked at the same hospital while he was doing his residency. They married in his second year of residency. He also did a residency in Internal Medicine and then a Fellowship in neurophysiology, all at Rochester. “I really like all fields in neurology and now do a lot of work in Multiple Sclerosis. The patients are really fantastic and we’re doing a lot of research. We have about 20 ongoing trials in MS. We are working hard to find that one medicine that will work and make a huge difference in their lives.” Dr. Herrman is Board Certified in Neurology.

The Herrman family leads a very active life outside of medicine. They have a five year old son that loves super heroes and an eight year old girl who loves tennis. Dr. Herrman has been competing in triathlons, so he has been doing a lot of swimming, biking and running. The family loves to ski, so they go to Utah and Colorado each year and are members at Perfect North in Lawrenceburg. He recently traveled to London to present the results of a research study. “It was great in London, but it was only for 3 days, so we did more traveling than having a fun time.”

All of the JWM Neurology doctors have been very good to Project Health patients; it is difficult to say thank you enough. Happy Holidays to everyone!

Yes! I want to Help Project Health during this Holiday Season!

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14 IMS Bulletin, December 2011
**Acute & Chronic Back Pain**
**Cervical Spine (Neck) Pain & Related Headaches**
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**Sciatica / Radiculopathy**
**Spinal Facet Syndrome**
**Spinal Stenosis (Lumbar & Cervical)**
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- Discography
- Selective Endoscopic Discectomy (SED)
- IntraDiscal ElectroThermal Annuloplasty (IDET)
- Spinal Cord Stimulation

**See our NEW CARMEL LOCATION at 12289 HANCOCK ST.**
Special Feature  Susan Keane Baker

The Patient Preference No One Talks About

A key driver of patient loyalty is:

**People value experiences in which their unique preferences are identified and respected.**

What about a preference for a different physician, nurse, physical therapist, home care aide? Is everyone on your team knowledgeable about your philosophy and processes regarding switching to a different person?

A gastroenterologist told me that patients are assigned to a physician for the first visit and no switches are ever possible. I asked what she would do if her hair salon prohibited her from switching to a different stylist. “I’d go someplace else.” She could see the connection between her experience at the salon and her patients’ experiences at the practice, but she couldn’t change the policy.

She wanted to know how to make the policy sound like a benefit. The “which means that” technique is a simple way to take a feature and formulate a benefit. “Patients are assigned to a physician at the time of their first visit and no switching is allowed, which means that we will never ask you to switch to another physician.”

If your policies are more flexible, do you let patients know they can switch easily, and without guilt? Senior Help Services in Denton Texas asks and answers the switching question in the Frequently-Asked Questions section of their website:

**What if I want a different caregiver?**

*You’re the boss. You can always request somebody new; in fact, that’s one of the advantages of hiring a company over an individual. You leave the hiring and firing to us, and you get uninterrupted care.*

A client, whose hair always looks fabulous, recommended I try the Phillip Bruce Salon in Westport, Connecticut. (Thank you Anne!) As Bruce was doing my hair, we chatted about how they handle the sometimes emotion-laden request to try another stylist.

“As a team, we talk about this all the time. The bottom line? It’s about what the client wants, not what we want. Direct requests and indirect hints are most likely expressed at the front desk. Our receptionists know to listen for this and are prepared to say: ‘Most clients like to try someone different once in awhile- it happens all the time.’ If the client expresses anxiety about hurting the stylist’s feelings, the staff member suggests scheduling the next visit on the stylist’s regular day off.”

So, can your patients switch to another practitioner? If they can’t, have you scripted the reason(s) why and how your policy could benefit your patient? If there is a law in your state or country that prohibits certain requests for changes, let patients know upfront!

If patients can switch, is everyone on your team familiar with your policy and comfortable in responding to requests? And are patients reminded that a request to change will be cheerfully honored?


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These insurance plans have been specifically designed for ISMA members and their employees to provide the highest quality coverage at the lowest possible cost.

*Access is available through Medical Assurance of Indiana - ISMA’s endorsed professional liability carrier.
Delegates to the State Convention, September 14-16, 2012, Indianapolis JW Marriott

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Linda Feiwell Abels (2012)
Christopher D. Bojrab (2012)
Anne C. Clark (2013)
Steven A. Clark (2013)
Carolyn A. Cunningham (2013)
David C. Hall (2013)
Ronda A. Hamaker (2013)
Stephen R. Klapper (2013)
J. Mark Michael (2013)
J. Timothy Stack (2013)
Tim E. Taber (2013)

Mary D. Bush (2012)
Heidi M. Dunniway (2012)*
Robert J. Goulet, Jr. (2012)
C. William Hanke (2012)
Gerald T. Keener, Jr. (2012)
David H. Moore (2012)
Robert Michael Pearce (2012)
J. Scott Pittman (2012)
Bridget M. Sanders (2012)
John F. Schaefer, Jr. (2012)
H. Jeffery Whitaker (2012)

Alternate Delegates to the State Convention, September 14-16, 2012, Indianapolis JW Marriott

The year shown in parentheses indicates year in which the term expires following the conclusion of the ISMA Annual Convention.

Nancy R. Baird (2012)
Jennifer J. Bucki (2012)
Stephanie R. DuNlop (2012)
John Duplantier (2012)
Robert S. Flint (2012)
Norrisa N. Howard (2012)
Mark U. Kyker (2012)
Terry L. Layman (2012)
Patrick J. Loertscher (2012)
Mark R. Ogle (2012)
David M. Ratzman (2012)
Jeffrey M. Rothenberg (2012)
Beata E. Samuel (2012)
Steven Richard Smith (2012)
Abideen Yekinni (2012)

Robert J. Alonso (2013)
David S. Batt (2013)
Daniel J. Beckman (2013)
Craig S. Ciecurea (2013)
Marc E. Duerden (2013)
Brian W. Haag (2013)
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Andrew A. Johnstone (2013)
Jeffrey J. Kellams (2013)
Frank P. Lloyd, Jr. (2013)
Andrew L. Morrison (2013)
David L. Patterson (2013)
Kenny E. Stall (2013)
Ronald L. Young, II (2013)

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Philip W. Pryor (2014)
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Steven M. Samuels (2014)
Kenneth N. Wiesert (2014)
In early October, the U.S. Preventive Services Task Force (USPSTF) recommended healthy men no longer receive prostate-specific antigen (PSA) blood tests as part of routine cancer screening. The panel, chaired by a pediatrician, includes neither urologists nor oncologists. In 2009, this same task force suggested mammograms were unnecessary for women ages 40-49, and recommended against teaching women to do breast self-exams. Due to public outrage this recommendation was almost immediately retracted. After the widespread criticism regarding the breast cancer screening, the panel did not fully release its prostate cancer recommendations at that time, instead issuing a limited opinion on PSA screening for patients over 75.

Since the last time the task force considered this issue, there has been no additional research justifying this drastic change in prostate cancer screening recommendations. In fact, the most recently published study, the Goteborg Randomized Population-based Prostate Cancer Screening Trial from July 2010, found that with screening, deaths from prostate cancer dropped 44 percent over a 14-year period, compared with men who did not undergo screening.

**Prostate Cancer and PSA Testing**

Prostate Cancer is the most common solid organ cancer in men with approximately 250,000 men diagnosed each year. PSA testing detects abnormal rises in serum PSA that can be due to benign prostatic hyperplasia (BPH), inflammation or prostate cancer. A prostate biopsy is necessary to diagnose prostate cancer. Approximately 30-35% of men undergoing a prostate biopsy are found to have prostate cancer. Since 1994, even with screening, the incidence of prostate cancer has remained fairly stable, while simultaneously, the death rates from prostate cancer have declined by nearly 40 percent. Studies show we are now diagnosing prostate cancer at an earlier, lower stage. We’re not detecting more cancers – rather; we are catching prostate cancers earlier, and saving lives. Still, prostate cancer remains the second leading cause of cancer death in men in the United States (after only lung cancer); with the National Cancer Institute reporting that 33,720 men will die from this disease this year – more than one every 30 minutes.

**USPSTF Recommendation Puts Men at Risk**

 Particularly troubling is that the task force extrapolates risks of treatment onto screening. But PSA screening is not treatment, in fact, it does not even establish the diagnosis of prostate cancer; it is simply screening, a simple blood test performed at your doctor’s office. There are essentially no risks to the screening itself, and to suggest that patients not have the information needed to participate in decisions regarding their own health care because of concerns regarding treatment they may never receive is misguided. Once screened, men and their families, with appropriate medical consultation, decide for themselves what course to choose.

This recommendation needlessly puts into harm’s way the men who are most at risk; the underinsured, those who live in rural areas where health care is not readily available, those who have a family history of prostate cancer, and particularly African-American men (who have the highest incidence of and death rates from prostate cancer). The task force suggests no screening in asymptomatic men, but every urologist knows this is a tragic error; by the time prostate cancer has symptoms, it is generally too late to cure. Adoption of these recommendations will undo more than two decades of progress in patient education, and result in the needless deaths of thousands of men.

**Top Doctors Provide Widespread Support for PSA Screening**

The US News and World Report conducted an exclusive survey of more than 600 Urologists and internists who are recognized as Top Doctors by US News and Castle Connolly Medical Ltd. About 95% of the responding Urologists and 72% of the responding male internists, felt that doctors should continue to advise men starting at age 50 to have PSA screenings as part of a routine physical exam, contrary to the task force’s recommendation.

The American Urological Association (AUA), the American Association of Clinical Urologists (AACU) and the Large Urology Group Practice Association (LUGPA) oppose the panel’s recommendation and support continued routine PSA testing in men beginning at age 40 to detect prostate cancer at earlier stages.

**Professional Guidance and Patient Choice**

Successful prostate cancer treatment depends on early detection of the disease offered by PSA testing. Testing and treatment decisions should be determined between patients and their own doctor. The USPSTF recommendation opens the door for government and third-party payers to stop covering this lifesaving benefit. Massive public outcry saved breast cancer screening for women, and studies show that screening efficiency for prostate cancer is similar to that for breast cancer. Those of us concerned with men’s health must make our voices heard to prevent these premature and ill-advised recommendations from ever being enforced.
CME & Conferences

Indiana University School of Medicine/Indiana University Health

IU – Methodist – Riley
Dec. 5 Improving Chronic Obstructive Pulmonary Disease (COPD) Management in the Primary Care Setting in Indiana
Landsbaum Center for Health Education Auditorium Terre Haute, Indiana

Dec. 14 Improving Chronic Obstructive Pulmonary Disease (COPD) Management in the Primary Care Setting in Indiana
University Place Conference Center, Indianapolis

2012
Feb. 25 Review and Interpretation of the 2011 San Antonio Breast Cancer Symposium
University Place Conference Center, Indianapolis

May 4 15th Annual IU Gastroenterology/Hepatology Update
University Place Conference Center, Indianapolis

July 20 Review and Interpretation of the 2012 ASCO Meeting
University Place Conference Center, Indianapolis

Course dates and locations are subject to change. For more information, please visit http://cme.medicine.iu.edu or call 317-274-0104.

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December
6 IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg
14 Senior/Inactive Luncheon Meeting, Noon, Society,
Guest speaker: Jeff Rasley, J.D., I.U. School of Law,
Christian Theological Seminary, Master of Divinity
“Philanthro-Trekking the Nepal Himalayas”
20 Executive Committee Dinner, with Spouses/Guests

For more information, contact Valerie Brown, (317) 355-5381.
Structural Differences: ICD-9-CM -vs- ICD-10-CM

From Octo-mom to Nonuplets!

Diagnosis coding will go from 3-5 characters in ICD-9-CM to 3-7 characters in ICD-10-CM. While many components of the code in ICD-10-CM remain the same as ICD-9-CM the user will note differences in ICD-10-CM structure, code composition, and level of detail.

Just like ICD-9-CM, all of the codes with the same first three characters have common traits. Each character beyond the first three adds more specificity.

Let’s look at the ICD-10-CM example of S04.02xA Injury of optic chiasm initial encounter

S04.02xA Injury of optic chiasm initial encounter

The first character of the ICD-10-CM code is an alpha character. The first character is always an alpha character which is very helpful when it comes to distinguishing the alpha characters I and O from the numeric 1 and 0. The alpha letters I and O are only used in the first character position and this character is always an alpha letter. The letter “U” is not used in ICD-10-CM and has been reserved by the World Health Organization (WHO) for the provisional assignment of new diseases of uncertain etiology (U00-U49) and for bacterial agents resistant to antibiotics (U80-U89).

The twenty one chapters of ICD-10-CM will be identified by the first alpha character as follows:

<table>
<thead>
<tr>
<th>A00-B99 Certain Infections &amp; Parasitic Diseases</th>
<th>L00-L99 Diseases of the Skin &amp; Subcutaneous Tissue</th>
</tr>
</thead>
<tbody>
<tr>
<td>C00-D49 Neoplasms</td>
<td>M00-M99 Diseases of the Musculoskeletal System</td>
</tr>
<tr>
<td>D50-D89 Diseases of the Blood &amp; Blood-forming</td>
<td>N00-N99 Diseases of the Genitourinary System</td>
</tr>
<tr>
<td>Organs &amp; Certain Disorders involving Organs &amp;</td>
<td></td>
</tr>
<tr>
<td>Certain Disorders involving the Immune Mechanism</td>
<td></td>
</tr>
<tr>
<td>E00-E89 Endocrine, Nutritional &amp; Metabolic</td>
<td>Q00-Q99 Congenital Malformations, Deformations &amp;</td>
</tr>
<tr>
<td>Diseases</td>
<td>Chromosomal Abnormalities</td>
</tr>
<tr>
<td>F01-F99 Mental &amp; Behavioral Disorders</td>
<td>R00-R99 Symptoms, Signs &amp; Abnormal Clinical &amp;</td>
</tr>
<tr>
<td></td>
<td>Laboratory Findings, Not elsewhere Classified</td>
</tr>
<tr>
<td>G00-G99 Diseases of the Nervous System</td>
<td>S00-T88 Injury, Poisoning &amp; Certain Other</td>
</tr>
<tr>
<td></td>
<td>Consequences of External Causes</td>
</tr>
<tr>
<td>H00-H59 Diseases of the Eye &amp; Adnexa</td>
<td>R00-R99 Symptoms, Signs &amp; Abnormal Clinical &amp;</td>
</tr>
<tr>
<td></td>
<td>Laboratory Findings, Not elsewhere Classified</td>
</tr>
<tr>
<td>H60-H95 Diseases of the Ear and Mastoid Process</td>
<td>S00-T88 Injury, Poisoning &amp; Certain Other</td>
</tr>
<tr>
<td></td>
<td>Consequences of External Causes</td>
</tr>
<tr>
<td>I00-I99 Diseases of the Circulatory System</td>
<td>V00-Y99 External Causes of Morbidity</td>
</tr>
<tr>
<td>J00-J99 Diseases of the Respiratory System</td>
<td></td>
</tr>
<tr>
<td>K00-K94 Diseases of the Digestive System</td>
<td></td>
</tr>
</tbody>
</table>

The second character is always numeric. Character 3 through 7 can be alpha or numeric. There will always be at least 3 characters and the decimal is placed after the first three characters. The alpha characters are not case sensitive.

New to the coder in ICD-10-CM is the use of the “x” placeholder. The ICD-10-CM utilizes a placeholder character “x.” The “x” is used as a placeholder in certain codes to allow for future expansion. In our example of S04.02xA Injury of optic chiasm initial encounter, because this code requires the seventh digit to identify the encounter, the placeholder “x” is used as a placeholder in the sixth character.

Certain ICD-10-CM categories have applicable seventh characters. The applicable seventh character may be required for all codes within the category or as the notes in the Tabular List instruct. The seventh character must always be the seventh character in the data field. If a code that requires a 7th character is not 5 or 6 characters, a placeholder “x” must be used to fill in the empty characters.

Seventh characters identify different things in different chapters. In the musculoskeletal chapter the seventh character may identify the encounter for fracture; initial, subsequent, sequela and may even include the type of healing. Some seventh character requirements in the Musculoskeletal Chapter also identify open or closed fracture.

In the Pregnancy, Childbirth and the Puerperium chapter the seventh character may identify single and multiple gestations. The number of gestations goes up to 9.

That means that in ICD-10-CM we can code the offspring of Octo-mom and still have room for Nonuplets! Will ICD-11-CM bring Decuplets?

Are you ready for ICD-10? The time to begin preparation for clinical documentation improvement is now. Do not waste the opportunity to improve on current diagnosis documentation in ICD-9-CM. Learning how to improve your documentation now will make the transition into ICD-10-CM much easier.

Certified ICD-10 instructors with ICDExpert.net are here to help with your transition to ICD-10! For additional information on ICD-10 implementation or an evaluation of your ICD-10 readiness as well as training for you and your staff, please visit our website at www.icdexpert.net or call us at 877-413-ICD-10.
In Memoriam

John Lewis Searight, MD
1929 - 2011

John L. Searight, MD, 81, of Indianapolis, passed away November 5, 2011. He was born on November 23, 1929 in Logansport, Cass County, Indiana.

Dr. Searight graduated from Purdue University with a degree in Agriculture and graduated from Indiana University School of Medicine in 1962. He interned at Indianapolis General Hospital from July 1962 - July 1963. He began his family practice in 1963 on the east side of Indianapolis, retiring in 1995.

Dr. Searight was also the doctor for the Marion County Children's Guardian Home for over 30 years.

He served in the U.S. Air Force from July 1948 - July 1949.

Dr. Searight was a member of Phi Chi. He served the Indianapolis Medical Society as an Alternate Delegate to the ISMA in the 1910, 1981 and 1982 conventions.

Please take a moment to honor your colleagues and mentors by giving generously to the Indianapolis Medical Society Foundation in their name.

Your tax deductible contributions will help the IMSF help the citizens of Marion County and your colleagues in need.

Call the Society at 639-3406 for donation information.

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