



Volume XCVIII • Number 4  
December 2011 • Indianapolis, Indiana

# Bulletin

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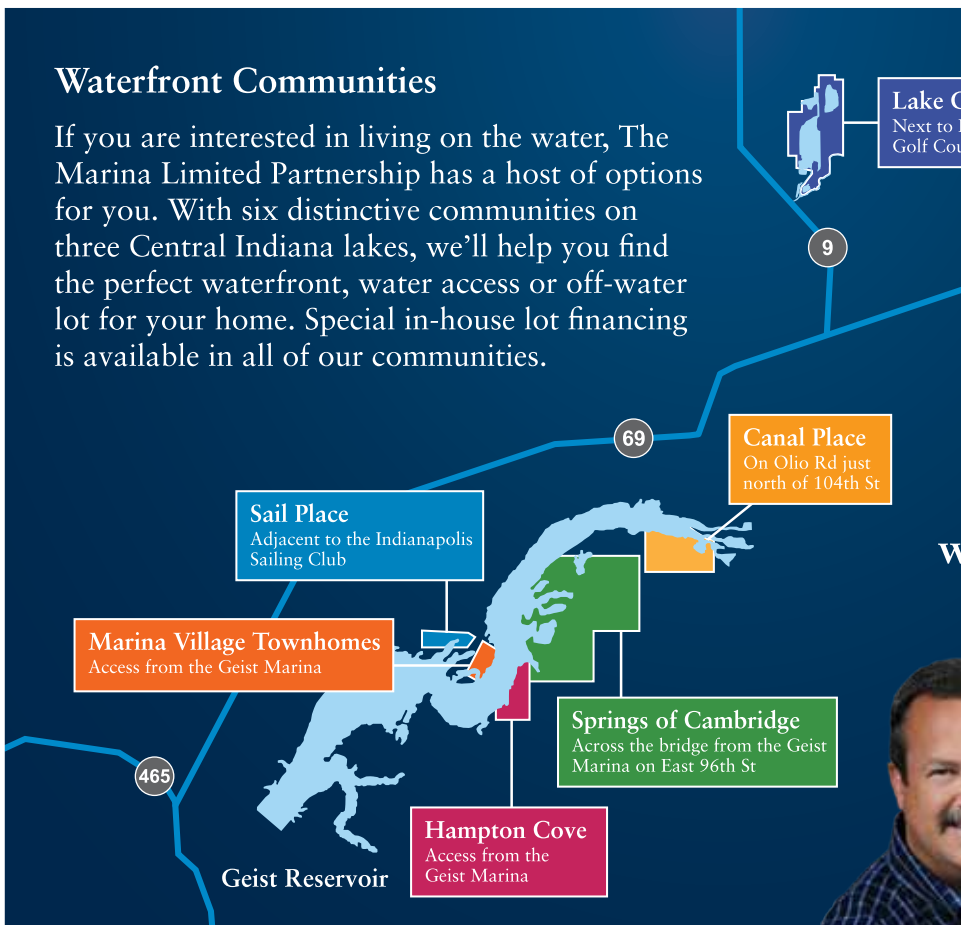
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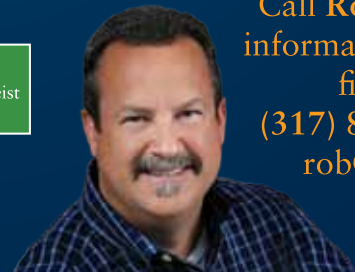
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We like to feature photographs or other artwork shared by IMS members on the cover of *The Bulletin*. Submit photographs, artwork, etc., to Beverly Hurt at the Society Office, [bhurt@imsonline.org](mailto:bhurt@imsonline.org).

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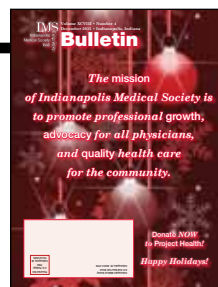
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## about our cover



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](http://www.imsonline.org) and click on the "Donate" button on the right side of the page.*

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### Seated Left to Right

Morgan Tharp II, M.D.  
Keith Logie, M.D.  
Andrew Greenspan, M.D.  
M.S. Murali, M.D.

### 1<sup>st</sup> Row Standing

Hillary Wu, M.D., Ph.D.  
Madelaine Sgroi, D.O.  
Melody Sands, APRN-BC  
Danielle Doyle, M.D.  
G. Irene Minor, M.D.  
Tracy Price, M.D.  
Elsayed Aly, M.D.

### Back Row

Paul DesRosiers, M.D.  
Sead Beganovic, M.D., Ph.D.  
Harold Longe, M.D.  
Thomas Whittaker, M.D.  
Bryce Lord, D.O.  
Jennifer Morgan, M.D.


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## *Can We Sit Still for this Sad State of Affairs?*

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

# Past President's Perspective



## *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 child is dying. The initial admission was for pain control and other medical management questions that required an IP stay to resolve. But the issue is that parents for whatever reason want the child to remain in the hospital rather than

die at home. So my question to the case manager was pretty simple – Do you in your heart feel this child needs acute care in an ongoing fashion? (Another way to think – does this child meet IP guidelines?) The answer was – no. And this child may have 2-3 months to live. So while the “job” of the case manager is to get approvals for ongoing IP care, and so far this has been successful, are we truly being honest with ourselves, the payer, 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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From left to right: Sandra Dolny, PA-C; Jocelyn Bush, MD; John Fitzgerald, MD; Edward Kowlowitz, MD; Alina M. Clavijo-Passik, PhD; Sheila Abebe, FNP, PhD  
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# Bulletin Board

**Douglass S. Hale, MD**, Urogynecology Associates, Director Female Pelvic Medicine and Reconstructive Surgery Fellowship, Associate Clinical Professor: IU Health/Methodist Hospital was named to the Board of Directors of the American Urogynecologic Society for a 3 year term at the 32nd Annual Scientific Meeting held in September 2011. He also gave a debate against Dr. Mark Walter of the Cleveland Clinic on the best surgical approach for apical pelvic organ prolapse.

**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 "Dermatosurgery – 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 discectomy 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 discectomy 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 myelopathy and moderated the session on cervical spondylotic myelopathy. He performed a demonstration of cervical disc replacement. Dr. Sasso taught the cadaver session on posterior cervical instrumentation techniques and anterior cervical exposures.

**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 installed 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



Aaron A. Cohen-Gadol, MD



Andrew J. DeNardo, MD



Richard D. Feldman, MD



Douglass S. Hale, MD



C. William Hanke, MD



Eric M. Horn, MD



Thomas J. Leipzig, MD



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Troy D. Payner, MD



Michael B. Pritz, MD



Richard C. Rink, MD



Richard B. Rodgers, MD



Jeffrey M. Rothenberg, MD



Rick C. Sasso, MD



John A. Scott, MD



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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 Malforme of the Brain" in the Proceedings of the 53rd Annual American Society of Radiation Oncology Meeting in October.

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## New Members

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University Vascular Surgery, PC  
1801 N. Senate Blvd.  
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46202-1228  
Ofc – 962-0280  
Fax – 962-0289  
1001 W. 10th St., #425-H  
46202-2859  
Ofc – 630-8288  
Surgery, 2009  
Vascular Surgery  
University of Lagos, Nigeria, 1995

**Livingston, Daniel S., MD**  
Resident – St. Vincent Hospital  
Internal Medicine  
Pecsi Orvostudományi Egyetem,  
Pecs, Hungary, 2010

**Spoljoric, Jason J., MD**  
Community Anesthesia Associates  
11460 N. Meridian St., #110  
Carmel, 46032-4409  
Anesthesiology, 2010  
Indiana University, 2003

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Take Your Best Shot contest will be judged by professional photographers from the Indianapolis area.

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Randy Gehring, MD  
Peter Gianaris, MD  
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Shannon McCanna, MD  
James Miller, MD  
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Michael Pritz, MD, PhD  
Richard B. Rodgers, MD  
Carl Sartorius, MD  
Mitesh Shah, MD, FACS  
Scott Shapiro, MD, FACS  
Michael Turner, MD  
Thomas Witt, MD  
Robert Worth MD, PhD  
Ronald L. Young, II, MD

## Pediatric Neurosurgeons

Laurie Ackerman, MD  
Joel Boaz, MD  
Daniel Fulkerson, MD  
Jodi Smith, PhD, MD  
Michael Turner, MD  
Ronald L. Young, II, MD

## Interventional Neuroradiology

Andrew DeNardo, MD  
John Scott, MD

## Physical Medicine and Rehabilitation

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Nancy Lipson, MD

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Donald Layton, PhD



# 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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## The Patient Preference No One Talks About

A key driver of patient loyalty is:

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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?

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Gene Moneymaker

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?

Susan Keane Baker is a Connecticut-based author and speaker. To receive her free special report, “60 Ways to Make Your Organization More Patient-Friendly” visit the home page at [www.susanbaker.com](http://www.susanbaker.com).

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## Twenty Years of Progress Battling Prostate Cancer Hangs in the Balance

In early October, the U.S. Preventative 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.

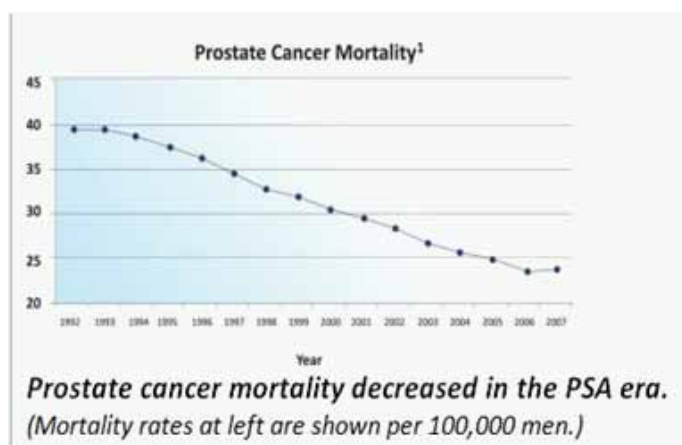
This recommendation needlessly puts into harm's way the men who are most at risk; the underinsured, those who live in rural areas where health care is not readily available, those who have a family history of prostate cancer, and particularly African-American men (who have the highest incidence of and 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

## Community Health Network

### Community Hospital East

First  
Wednesday Critical Care Conference  
Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Second  
Wednesday Medical Grand Rounds  
Medical Staff Conf. Room, 12:00 - 1:00 p.m.

Third  
Wednesday Neuro Grand Rounds  
Medical Staff Conf. Room, 12:00 - 1:00 p.m.  
Months of January, March, May, July, September, November

### Community Hospital South

Fourth  
Thursday Medical Grand Rounds  
Conf. Rooms A & B, 7:30 - 8:30 a.m.

### Community Hospital North

First  
Wednesday Pediatric Grand Rounds  
Multi Services Rooms 1, 2 and 3  
7250 Clearvista Dr. 7:30 - 8:30 a.m.

First  
Friday North Forum  
Reilly Board Room; 12:00 - 1:00 p.m.

### Community Heart & Vascular/ Indiana Heart Hospital

First  
Wednesday Disease Management Conference:  
rotates CHF & EP Case Presentations  
TIHH MCV Boardroom Videoconference to  
CHVp South Conf. Rm. 7:00 - 8:00 a.m.

Third  
Wednesday Ken Stanley CV Conference  
TIHH MCV Boardroom Videoconference to  
CHVp South Conf. Rm. 7:00 - 8:00 a.m.

Fourth  
Wednesday Imaging Conference:  
rotates Cath & Echo Case Presentations  
TIHH MCV Boardroom Videoconference to  
CHVp South Conf. Rm. 7:00 - 8:00 a.m.

### Cancer Conferences 2011

#### Community Hospital East:

First  
Tuesday East General Cancer Conference  
Medical Staff Conf. Room, 12:00 to 1:00 p.m.

Second  
Wednesday East Chest Cancer Conference  
Cancer Registry Conf. Room, LL 22,  
7:00 to 8:00 a.m.

#### Community Hospital North

First & Third  
Tuesday North Multidisciplinary Breast Conference  
8040 Clearvista Parkway, Suite 500, 7:00 - 8:00 a.m.

Third  
Wednesday North General Cancer Conference  
Reilly Board Room, 12:00 to 1:00 p.m.

Fourth  
Wednesday North Chest Cancer Conference  
Reilly Board Room, 7:00 to 8:00 a.m.

#### Community Hospital South

Second  
Monday South Chest Conference (site specific-lung)  
Education Center Rooms 5&6, 7:00 - 8:00 a.m.

First  
Wednesday South Multidisciplinary  
Breast Cancer Conference  
Community Breast Care Center South,  
533 E. County Line Rd., Ste. 101, 8:00 - 9:00 a.m.

Third  
Wednesday South General Cancer Conference  
President's Board Room, 12:00 to 1:00 p.m.

#### North Cancer Pavilion

Third  
Wednesday Melanoma Cancer Conference  
CHN Cancer Pavilion Conf. Rm., 7:30 to 8:30 a.m.

For more information, contact Valerie Brown, (317) 355-5381.

## 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

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## JWM Neurology

Saturday, March 10, 2012  
"Neurology Connection 2012" Seminar for Physicians

This half-day course covers 9 topics relative to neurologic conditions and sleep disorders. For more information contact JWM Neurology at 317-308-2828 ext., 1604.

## Indianapolis Medical Society

### 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

Please send submissions for the Bulletin Board, CME and the Bulletin to [mhadley@imsonline.org](mailto:mhadley@imsonline.org) by the first of the month preceding publication. Inclusion is on a space available basis and limited to members in good standing of the IMS.

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## 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

S 0 4 . 0 2 x A

#### 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:

<b>A00-B99</b> Certain Infections & Parasitic Diseases	<b>L00-L99</b> Diseases of the Skin & Subcutaneous Tissue
<b>C00-D49</b> Neoplasms	<b>M00-M99</b> Diseases of the Musculoskeletal System
<b>D50-D89</b> Diseases of the Blood & Blood-forming Organs & Certain Disorders involving Organs & Certain Disorders involving the Immune Mechanism	<b>N00-N99</b> Diseases of the Genitourinary System
<b>E00-E89</b> Endocrine, Nutritional & Metabolic Diseases	<b>O00-O9a</b> Pregnancy childbirth & the Puerperium
<b>F01-F99</b> Mental & Behavioral Disorders	<b>P00-P96</b> Certain Conditions Originating in the Perinatal Period
<b>G00-G99</b> Diseases of the Nervous System	<b>Q00-Q99</b> Congenital Malformations, Deformations & Chromosomal Abnormalities
<b>H00-H59</b> Diseases of the Eye & Adnexa	<b>R00-R99</b> Symptoms, Signs & Abnormal Clinical & Laboratory Findings, Not elsewhere Classified
<b>H60-H95</b> Diseases of the Ear and Mastoid Process	<b>S00-T88</b> Injury, Poisoning & Certain Other Consequences of External Causes
<b>I00-I99</b> Diseases of the Circulatory System	<b>V00-Y99</b> External Causes of Morbidity
<b>J00-J99</b> Diseases of the Respiratory System	<b>Z00-Z99</b> Factors Influencing Health Status & Contact With Health Services
<b>K00-K94</b> Diseases of the Digestive System	

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 7<sup>th</sup> 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?**

IMS

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# 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  
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