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Indianapolis Medical Society 1848

Bulletin

ICD-10
October 1, 2014
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From left to right: Sandra Dolny, PA-C; Jocelyn Bush, MD; Edward Kowlowitz, MD; John Fitzgerald, MD; Alina M. Clavijo-Passik, PhD
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Bulletin

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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.

The Bulletin is your magazine. Share your views by submitting reprints of your published articles; articles written expressly for *The Bulletin*; quips; short stories; brief comments; ideas; cartoons, etc.

Remember the *Indianapolis Medical Society Foundation* when planning your will. *(Contribution form included in this issue.)* Unless otherwise specified, your contribution will be directed toward medical scholarships.

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in this issue

Special Features

Departments

about our cover

On our cover:
Happy New Year 2014!
Let us celebrate the possibilities.

Countdown to ICD-10. Be Ready!

ICD-10 Webinars and Special Events
are in the planning stages for 2014.

The first webinars will be in January.

Watch your eBulletin and email for dates, times and registration procedures.

President's Page

Mark M. Hamilton, MD

Romneycare vs. Obamacare 2.0

There's been no shortage of controversy over the rollout of the Affordable Care Act (aka Obamacare) and the individual mandate that comes with it. From the expensive and botched Healthcare.gov website to expanding Medicaid to millions of new patients across the country, it's difficult to predict what type of effect the law will have on doctors here in the Hoosier state.

Physicians across the nation are waiting to see how Obamacare affects their patients, the type of care they'll be able to provide, and how much that care will cost. Despite the uncertainty and the challenges inherent with the implementation the Affordable Care Act, we can look back to see what may lie ahead. Many of the same issues the nation is confronting today have already been met in Massachusetts.

It's been more than seven years since Massachusetts enacted its health care reform law under then Governor Mitt Romney. That means the state of Massachusetts has already served as a preliminary testing ground for widespread rollout of a mandated health care initiative. In fact, some of the main architects of the Massachusetts plan were instrumental in crafting President Obama's signature healthcare law.

According to a *Forbes* magazine report[1], three of Governor Romney's health care advisors met with senior White House officials a combined 12 times in 2009. One of those men, served as executive director of a Massachusetts advocacy organization called "Health Care for All."

One doesn't have to look very far to see that both programs share several common features. The first being an individual mandate, requiring everyone to buy health insurance or face a fine. The second is the establishment of a public marketplace where those without insurance can compare plans and purchase coverage. Both the state and federal laws also require payers to cover those with pre-existing conditions, and both make investments to improve wellness, prevention and public health.[2]

One key difference between the two is that the Massachusetts plan offers subsidies for those earning up to 300 percent of the federal policy level, while the ACA extends subsidies to those earning up to 400 percent of the federal poverty level.

And like the highly reported challenges we've seen with the rollout of Obamacare, the Massachusetts program required some tweaking in the years following the initial launch.

Massachusetts residents began to sign up for their new health insurance policies in January of 2007, and enrollment numbers were less than stellar. In the first month, only 123 people signed up for the new policies across the entire state of Massachusetts.[3]

Despite the initial problems, a majority of Massachusetts residents say they're satisfied with the coverage they have now. In fact, a recent poll by the Massachusetts Medical Society, a statewide physician group, found that:

"Eighty-four percent of residents expressed satisfaction with the care they received over the last year, including 56 percent who indicated they are 'very satisfied' and 28 percent who are 'somewhat satisfied,'" the survey report states. Seventy-three percent of residents reported that gaining access to health care they need is "not difficult," and for serious medical problems, 86 percent said the amount of time they needed to wait was not a problem.[4]

The statewide plan is widely seen as successful when examining how it was able to expand coverage to more people. The Massachusetts Medical Society survey also found:

- 439,000 more residents have gained health insurance coverage since 2006.
- Only 1.9% of Massachusetts residents are uninsured (U.S. average: 15.7%).
- Fewer adults have unmet health care needs due to cost (12% in 2009 vs. 16% in 2006), though patients with serious illness report that cost remains a barrier to care.
- 68% of Massachusetts adults support the state health reform law. 63% support the federal health reform law.
- Health reform in Massachusetts "had little negative impact on private sector employment in the state" relative to other states.
- Employer coverage has increased from 70% to 76% since 2005 (U.S. average: 60%). During the same time period, their financial contribution toward individual coverage has risen from 77% to 78%.

That doesn't mean the Massachusetts law is without its critics. The most vocal of them point out that the mandate has done very little to lower overall health care costs, something the ACA will likely struggle to do also. While the cost of providing healthcare hasn't necessarily dropped, it has leveled off somewhat over the past few years. The Massachusetts Medical Society survey[5] also found:

- Health care premium increases are moderating. Median premiums for individual coverage rose 4.4% in 2011, compared to 8.3% and 7.3% the previous two years.
- Year-to-year increases in spending on medical claims has fallen steadily from approximately 12% in 2003 to less than 5% in 2010.

In addition, malpractice issues were not addressed in the Massachusetts law nor Obamacare.

This is another major defect in both plans as we all know the enormous costs of medical liability and the corrosive effect it has on the practice of medicine.

Critics also point out that while more residents in Massachusetts have insurance coverage, the surge of new patients hasn't led to a drop in emergency room visits. In fact, the opposite is true.

Due to the surge in new patients across the state, many of the newly insured have struggled to find a doctor. Half the

Continued on page 19.

Special Feature

Dr. Joan Duwve MD MPH, Chief Medical Officer, Indiana State Dept. of Health

First Do No Harm:

The Indiana Healthcare Providers' Guide to the Safe and Effective Management of Chronic, Non-Terminal Pain

First Do No Harm: The Indiana Healthcare Providers' Guide to the Safe and Effective Management of Chronic, Non-Terminal Pain is a toolkit developed by healthcare providers for healthcare providers, based on expert opinion and recognized standards of care. The Toolkit was developed as an interactive compendium to the new Medical Licensing Board rule addressing opioid prescribing to patients with chronic, non-terminal pain to support healthcare providers who care for these patients. The Toolkit offers multiple modalities as options for the safe and responsible treatment of chronic pain, including prescriptions for opioids, when indicated, with a focus on patient safety and functional improvement.

The Toolkit is centered on ten recommendations that have been widely accepted by medical communities nationally. The Toolkit addresses each of the ten recommendations in unique chapters that offer significant detail, cite available evidence, and provide links to useful tools for healthcare professionals treating patients with chronic pain. A brief summary of those recommendations is provided below.

Ten Recommendations for the Safe and Effective Management of Chronic, Non-Terminal Pain:

1. Do your own evaluation. Healthcare providers assuming care for patients with chronic pain should take the time to perform a thorough history and targeted physical exam. Request and review available records from previous caregivers, order appropriate tests, and then attempt to establish a working diagnosis for the patient. Work with the patient to establish realistic functional therapeutic goals, and then tailor a treatment plan to achieve them.

2. Risk stratification for all. Performing a risk assessment on all patients protects both patients and providers. Risk stratification will help identify behaviors and historical facts that predict future aberrancy. Two important predictors for misuse of opioids are a prior history of substance abuse and mental illness. Identifying these patients and risk indicators at the outset of your therapeutic relationship can help create a beneficial treatment plan while minimizing the risk of harm. Multiple validated screening tools are available to help you stratify risk in your patients. These are identified in the Toolkit Section 3, Risk Stratification. Because risk varies over time, it is critical to repeat your risk stratification as appropriate.

3. Set functional goals with your patients that include achievable targets for pain management. Healthcare providers and patients alike often approach chronic pain with the goal of returning to a previous pain-free life. Although this seems like the most compassionate approach to chronic pain, it is an unattainable goal in the large majority of chronic pain patients. Focusing on the elusive elimination of pain as a target over the achievable improvements in function and quality of life sets up a hopeless, vicious cycle for both patient and provider. Patients engaged in their treatment and prescribed a multi-faceted treatment plan that balances steps to increase function with modalities to improve pain, without the expectation for complete resolution of symptoms, have the most significant improvements in quality of life.

4. Utilize evidence-based treatments, including non-opioid options initially, where possible. Developing a treatment plan for patients with chronic pain might feel overwhelming, especially after a thorough patient evaluation and review of records. It may seem easier to send the patient off with opioid-containing pain medications. Starting opioid-containing medications before initiating a trial of non-pharmaceutical pain management or other first-line pain medications sets up the expectation that opioids will be the cornerstone of therapy, and may make it more challenging to engage the patient in alternative modalities in the future. Chronic pain is complex and usually requires multiple interventions for safe and effective management and progress toward functional improvement. Appendix A of the Toolkit is a flowchart designed to guide healthcare providers as they navigate the available options to treat patients with chronic pain.

5. Discuss the potential risks and benefits of opioid treatment for chronic pain, as well as expectations related to prescription requests and proper medication use. Extend the practice of informed consent to decision-making regarding opioid use as treatment for chronic pain. Patients must be aware of the risks of chronic opioid use as well as the potential benefits. Treatment agreements that itemize risk, benefit, patient expectations and patient responsibilities are considered a "Best Practice" for opioid prescribing. Alerting women of child-bearing years to the risk of neonatal abstinence syndrome is mandatory.

6. When prescribing opioid medications for patients, periodic scheduled visits are required. Like patients with other chronic medical conditions with a high risk of complications, patients on chronic opioid therapy need to be followed at least every 4 months. Patients working to achieve optimal management and those at higher risk due to comorbidities or high doses of opioid medications should be seen and evaluated more frequently.

7. Remember the 5 A's when managing your chronic pain patients with opioids: Assess **Affect**, ask about **Activities of Daily Living**, provide **Analgesia** in order to assist patients in meeting their functional goals, minimize **Adverse effects** of treatment, and monitor patients for **Aberrant drug use behaviors**.

8. Use INSPECT, Indiana's prescription drug monitoring program. INSPECT provides an objective record of controlled substances prescribed to patients, and the healthcare providers who prescribed them. Assuring that new chronic pain patients aren't already receiving controlled substances from another prescriber is an easy way to screen for overdose risk and aberrant behavior before

Continued on page 19

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Bulletin Board

Robert A. Malinzak, MD, performed a single hip replacement for a Solsberry, Indiana, patient on December 5th as a part of the Operation Walk USA-sponsored program at the Center for Hip and Knee Surgery at Franciscan St. Francis Health, Mooresville. The Center donated the surgery, hospital and staff. The implanted device was donated by Biomet of Warsaw, Indiana.

Edward B. Aull, MD, presented at the 11th ADDISS International ADHD Conference in Liverpool, England in October 2013. He spoke on, "Now that DSM-V Allows that Patients with Autism Spectrum Disorders can be Comorbid with ADHD, What are the Problems with Medication Treatment?" His second presentation was "Medication Adjustment in the Treatment of ADHD when the Diagnosis is or could be Asperger's Syndrome."

Dr. Aull also presented at CHADD 25th Annual International Conference in Washington, DC, in November 2013. He spoke on "Now that DSM-V Allows that Patients with Autism Spectrum Disorders can be Comorbid with ADHD, What are the Problems with Medication Treatment?" This was Dr. Aull's 16th appearance as a speaker at the international meeting.

Mark Holbreich, MD, an Indianapolis allergist, conducted a workshop on eosinophilic esophagitis at the Annual meeting of the American College of Allergy in Baltimore. In addition Dr. Holbreich's research on the prevalence of allergic disease in Indiana's Amish population was featured in a cover story for the Sunday Review of the *New York Times* for Sunday November 10th.

Michael H. Fritsch, MD, Professor, an Otologist-Neurotologist, gave two one-hour peer-reviewed lectures evaluated and ranked in the top ten percent of all lectures at the national annual meeting of the American Academy of Otolaryngology in Vancouver, BC, Canada, on "Incisionless Otoplasty" and "Salivary Endoscopy for Salivary ductal stones."

Medical oncologist/hematologist, **William M. Dugan, Jr., MD,** has opened an office at 8091 Township Line Road and is practicing with his nephew, urologist, **James A. Dugan, MD**. Practicing together as family members honors the memory of Dr. William Dugan's late brother, IMS Physician Member, John R. Dugan, MD, who is also James' father. Dr. Dugan has special interests in prostate cancer and sees adult patients with all types of medical oncology/hematology conditions.

News from Northwest Radiology Network, PC …

Joseph C. George, MD, a board certified radiologist with Northwest Radiology Network and Medical Director of Medical Imaging at St. Vincent Heart Center of Indiana was recently notified that he is now a 'Diplomat of the Certification Board of Cardiovascular Computed Tomography.' The mission of the CBCCT is to promote and enhance patient care by defining the domain of cardiovascular computed tomography and identifying the requisite knowledge and skills for quality practice through a certification program that fosters excellence and encourages continual learning.

Richard L. Hallett, MD, board certified Northwest Radiology Network Diagnostic Radiologist with a Certificate of Advanced Proficiency, Cardiac CT, recently co-authored three presentations at the XXIV Congress of the International Society on Thrombosis and Hemostasis in Amsterdam, The Netherlands. Titles of the presentations were: (1)"Splenic Infarction in a Teenager Associated with Oral Contraceptives, Elevated Lipoprotein A and Median Arcuate Ligament Syndrome," (2)"A Case of Extensive Recalcitrant IVC Thrombosis in a Teenager with Behcet Disease, Elevated Lipoprotein a, and Median Arcuate Ligament Syndrome," and (3)"Successful Anticoagulation with Concomitant Factor VIII Replacement in a Severe Hemophilia A Patient Suffering from a Life Threatening Thrombotic Event."


Edward B. Aull, MD


Aaron A. Cohen-Gadol, MD


James A. Dugan, MD


William M. Dugan, Jr., MD


Michael H. Fritsch, MD


Joseph C. George, MD


Richard L. Hallett, MD


Mark Holbreich, MD


Thomas J. Leipzig, MD


Robert A. Malinzak, MD


Troy D. Payner, MD

News from Goodman Campbell Brain and Spine …

Thomas J. Leipzig, MD, was Course Faculty (Oct. 19, 2013) for Practical Didactic: All, course PC05: Neurosurgery Board Review, The course provided an in-depth review of likely oral board questions and topics.

Aaron A. Cohen-Gadol, MD, was Faculty, Luncheon Seminar, Tumors (Oct. 21, 2013), M11: "Surgical Management of Meningiomas" and was a presenter, General Scientific Session III (Oct. 22, 2013), "Operative Pearls: Expanding Operative Corridor for Difficult-to-Reach Tumors."

Troy D. Payner, MD, was a member of the Course Faculty (19 Oct. 2013), Practical was Course Faculty (Oct. 19, 2013) for Practical Didactic course: Socioeconomics, PC22: "Negotiation Tactics from the Experts – Getting the Best Deal" (Hospital Negotiations), Course taught the critical tools needed to effectively negotiate with hospital administration.

The following articles were published by IMS Members, Dr. Cohen-Gadol, "Recognition and evaluation of nontraumatic subarachnoid hemorrhage and ruptured cerebral aneurysm." *Am Fam Physician* 2013 Oct. 1;88(7):451-6. [PMID:24134085]

Dr. Payner, Dr. Leipzig, and Dr. Cohen-Gadol, "Incidence, Epidemiology, and Treatment of Aneurysmal Subarachnoid Hemorrhage in 12 Midwest Communities." *J Stroke Cerebrovasc* Dis 2013 Oct. 19. doi:pii: S1052-3057(13)00384-4. 10.1016/j.jstrokecerebrovasdis.2013.09.010. Epub ahead of print. [PMID:24144595]

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Indiana University, 2009

Desai, Roshani J., MD
Indpls. Gastroenterology & Hepatology
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Ofc – 865-2955*
Fax – 865-2954
Internal Medicine, 2009
Gastroenterology
University of Missouri, 2006

Hill, Adam B., MD
Riley Hospital
705 Riley Hospital Dr., #1601
46202-5109
Pediatrics, 2012
Pediatric Hematology/Oncology
Indiana University, 2007

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In Memoriam

Victor John Vollrath, MD
1916 - 2013

Victor J. Vollrath, MD, 97, a lifelong Indianapolis resident and local family practitioner for nearly sixty years, died November 10, 2013 in Indianapolis.

Dr. Vollrath was born in 1916 and grew up in Irvington. He earned an AB Degree in Chemistry from Indiana University and graduated from Indiana University School of Medicine in 1942. He served his internship and surgical residency at Indianapolis City Hospital, now Eskenazi Hospital.

A veteran, Dr. Vollrath was a Captain in the U.S. Army, Medical Corp from 1944 to May 1946.

Dr. Vollrath was on the active staff of St. Vincent, Methodist, Winona, and Community Hospitals. For fifteen years, Dr. Vollrath was the Medical Director of the Indiana Division of Illinois Central Railroad. For approximately twenty years, Dr. Vollrath was the company physician for American Trans Air and a Medical Examiner for the Federal Aviation Administration. During his tenure with the Federal Aviation Administration, he received several citations for leadership and continued Medical Education. Dr. Vollrath was a former instructor in physical diagnosis at the Indiana University Medical Center.

The Indiana State Medical Society awarded Dr. Vollrath a Certificate of Distinction in January of 1992 for having practiced the medical profession 50 years. He was also made a member of the Grand Society of Hoosier Physicians. He was a member of the Theta Kappa Psi medical fraternity, and of the Indiana University Emeritus Club. His professional memberships included the American Academy of Family Practice, the American Association of Physicians and Surgeons and the American Medical Association.

Robert Steele Grief, MD
1931 - 2013

Robert Steele Grief, MD, 82, Indianapolis, passed away at home on November 21, 2013. He was born August 27, 1931 in New York, New York.

Dr. Grief earned his pre-medical degree at Indiana University and his medical degree from the Indiana University School of Medicine. He completed his internship at the Marion County General Hospital.

Dr. Grief was a Korean War Veteran serving as a corporal from 1953-1955.

Dr. Grief had a family practice on the south side of Indianapolis for 30 years before retiring in 1987. His life after retirement was dedicated to his grandchildren, vacationing in Florida and "field trips" to enlighten them to all that life has to offer.

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Project Health

Carrie Jackson Logsdon, Director

Thank you, Patrick E. Matoole, MD

Patrick E. Matoole, MD of Josephson, Wallack, and Munshower Neurology (JWM) is January's doctor of the month. He was born and lived most of his life in Omaha, Nebraska, where his father was an internist and administrator at the Veterans Hospital in Omaha. His mother and one cousin were nurses.

"I always liked the sciences and received a Bachelor's degree in chemistry from the University of Denver. However, there was not much human interaction in chemistry." Therefore, he went back to Omaha to medical school at the University of Nebraska. He completed an internship in Internal Medicine at the Medical College of Wisconsin in Milwaukee. He returned to Omaha for his residency in neurology through Creighton University and the University of Nebraska. Dr. Matoole accepted a Fellowship in clinical neurophysiology (electroencephalography and electromyography) at Indiana University's School of Medicine.

He specializes in neuromuscular diseases such as Multiple Sclerosis, Muscular Dystrophy, Epilepsy, and Parkinson's Disease as well as the brain, nerve entrapments, peripheral nerves, spinal cord problems and headaches. He is board certified by the American Board of Psychiatry and Neurology. He holds memberships in the American Association of Neuromuscular and Electro-Diagnostic Medicine; The National Multiple Sclerosis Society; The American Academy of Neurology; The Indiana State Medical Association; The Indianapolis Medical Society; the American Medical Association; and Indiana Neurological Society. He was also recognized by Elite American Physicians for Dedication, Achievements, and Leadership in Neurology.

Dr. Matoole is currently the lead investigator in a new drug that treats epilepsy which he says is very promising. Dr. Matoole has treated several of Project Health's patients with MS, Muscular Dystrophy, and Epilepsy among other things. They rave about him; saying that he conducts the most thorough exams they've ever had, and speaks in lay language. He says he loves getting to know them, and he is very appreciative of Project Health's interpreters.

In Dr. Matoole's spare time he likes to walk and swim. He was on his high school swim team for three years. He also likes to travel twice a year back to Omaha to see the University of Nebraska football games. He vacations in Las Vegas and Reno "except in August when it is unbelievably hot."

Thank you, Dr. Matoole, and to all of our very generous physician volunteers for your time, talents and incredible kindness to Project Health patients. HAPPY NEW YEAR!

IMS

For information on how you can support Project Health, http://imsonline.org/projecthealth






These are just some of the Project Health patients whose lives HAVE BEEN SAVED by the PH volunteer physicians, labs and hospitals! On behalf of the Project Health staff, IMSF Board and thousands of patients! Thank you and Happy 2014!

CME & Conferences

Community Hospital East

First Wednesday — Critical Care Conference
Bradley Board Room, 12:00 - 1:00 p.m.

Second Tuesday — Medical Grand Rounds
Bradley Board Room, 12:00 - 1:00 p.m.

Community Hospital North

First Wednesday — Pediatric Grand Rounds
Multi Services Rooms 1 & 2
7250 Clearvista Dr. 7:30 – 8:30 a.m.

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

Every Other Month 4th Thursday — Psychiatry Grand Rounds
7250 Clearvista Dr.
Multi-Service Rms. 1 & 2 7:30 - 8:30 a.m. begin 1/23/14

Community Heart & Vascular Hospital

First Wednesday — Imaging Conference:
rotates Cath & Echo Case Presentations
CHVH MCV Boardroom Videoconference to
HVC Anderson Office, HVC East Office BR (Ste. 420)
HVC South Office CR (Suite 2400)
7:00.- 8:00 a.m.

Third Wednesday — Ken Stanley CV Conference
CHVH MCV Boardroom Videoconference to
HVC Anderson Office, HVC East Office BR (Ste. 420)
HVC South Office CR (Suite 2400)
7:00 - 8:00 a.m.

Fourth Wednesday — Disease Management Conference:
rotates CHF & EP Case Presentations
CHVH MCV Boardroom Videoconference to
HVC Anderson Office, HVC East Office BR (Ste. 420)
HVC South Office CR (Suite 2400)
7:00 - 8:00 a.m.

2014 Cancer Conferences
Community Hospital East

Third Thursday — East General Cancer Conference - CHE
Medical Staff Conference Room
12:00 noon to 1:00, lunch provided

Fourth Tuesday — East Multidisciplinary Breast Cancer Conference - CHE
Medical Staff Conference Room
7:00 to 8:00 am

Community Hospital North

First & Third Tuesdays — North Multidisciplinary Breast Cancer Conference - CHN
8040 Clearvista Parkway, Suite 550
7:00 to 8:00 am

Second & Fourth Wednesdays — North Multidisciplinary GI Oncology Conference - CHN
8040 Clearvista parkway, Suite 550
7:00 to 8:00 am

Second & Fourth Fridays — North Multidisciplinary Gynecologic Surgical Oncology Conference - CHN
8040 Clearvista Parkway, Suite 550
7:30 to 8:30 am

First Wednesday — North Chest Cancer Conference - CHN
8040 Clearvista Parkway, Suite 550
7:00 to 8:00 am

Third Wednesday — Melanoma Cancer Conference - CHN
8040 Clearvista Parkway, Suite 550
7:30 to 8:30 am

Community Hospital South

Second Wednesdays — South Multidisciplinary Breast Cancer Conference - CHS
Community Breast Care Center South
533 E. County Line Rd., Suite 101
8:00 to 9:00 am

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

Indiana University School of Medicine/ Indiana University Health

IU – Methodist – Riley

Jan. 17-19 — Musculoskeletal Ultrasound Beginner Level Course
IUSM, South Bend, Indiana

Jan. 23 — Pain symposium: Acute Pain Management with Existing Chronic Pain
Latitude 39, Indianapolis

Jan. 25 — Practical Pearls General and Community Pediatrics 2014
Riley Outpatient Center, Indianapolis

Jan. 25 — Breast Cancer: Year in Review
Indiana History Center

March 7 — Let's Talk Palliative Care: Improving Care for Seriously Ill Patients and their Families
Ritz Charles Banquet Facility, Carmel

March 10-12 — Second Annual Children's Health Services Research symposium
HITS Building, Indianapolis

May 1 — Advancing the Medical Role in Child Protection
Evansville, Indiana

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

The Indiana University School of Medicine is accredited by the ACCME to provide continuing medical education for physicians.

We have more than 100 recurring meetings available. For a listing or more information, please visit http://cme.medicine.iu.edu or call 317-274-0104.

JWM Neurology

Saturday, March 8, 2014

"Neurology Connection 2014: Useful Advances and Important Updates" Seminar for Physicians

This half-day course covers 9 topics relative to neurologic conditions and sleep disorders. For more information contact JWM Neurology at 317-806-6905.

Searching for Assistance with a particular business practice issue?

Want to attend a collegial, best practices event?

Please let us know. We are planning webinars and "Meet & Greet" events to help IMS Members with the issues that matter, mail mhadley@imsonline.org

CME & Conferences

Indianapolis Medical Society

January
- 21 — IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg.

February
- 16-19 — AMA Presidents' Forum, Sun., 4-6:30 PM; continues Mon., from 7:30 AM-1 PM, Grand Hyatt, Wash., D.C.
- 17-19 — National Advocacy Conference (NAC), Monday afternoon and Tuesday
- 18 — Executive Committee, Society, 6:00 PM, Sandwiches. Nominating Committee appointed

March
- 2 — IMS Advisory Breakfast (Le Peep's), 7:30 AM … prior to ISMA BOT 9:00 AM, ISMA
- TBD — 7th District Organizational Dinner, Dr. G. Mitchell Cornnett chairs. 6:30 PM
- 12 — Senior/Inactive Luncheon, Society, 11:30 AM. Speaker TBA
- 18 — IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg.
- 30 — HAPPY DOCTOR'S DAY!
- TBD — IMS Nominating Cmte., Hale Room, Society Headquarters, 6:30 PM, Light Dinner

April
- 15 — Executive Committee, Society, 6:00 PM, Sandwiches
- 24 — Administrative Professional's Day (aka Secretaries' Day)
- TBD — IMS Women in Medicine, 7:00 – 10:00 pm.

May
- 20 — IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg
- TBD — MSE Board Meeting, Society, 6:15 PM, Sandwiches

June
- 7-11 — AMA House of Delegates Annual Meeting, Chicago, IL
- 11 — Senior/Inactive Luncheon Meeting, 11:30 AM, Society
- 17 — Executive Committee, Society, 6:00 PM, Sandwiches
- 22 — IMS Advisory Breakfast (Le Peep's), 7:30 AM … prior to ISMA BOT, 9:00 AM, ISMA
- TBD — Project Health Board Meeting, Society, 6:00 PM, Light Meal

July
- 15 — IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg.

August
- 19 — Executive Committee, Society, 6:00 PM, Sandwiches

September
- 5 — ISMA BOT, Indianapolis Westin., Indpls., 46204. 1:00 PM
- 10 — Senior/Inactive Luncheon Meeting, 11:30 AM, Society, Speaker TBA
- 16 — IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg. Light dinner. Dr. David R. Diaz will be installed as 141st IMS President.
- 20-22 — ISMA CONVENTION, JW Marriott Hotel, 10 S. West St., Indpls., 46204

October
- 30 — ISMA's Fall Legislative Dinner, Downtown Marriott
- 15 — Executive Committee, Society, 6:00 PM, Sandwiches

November
- 8-11 — AMA House of Delegates, Dallas, TX
- 18 — IMS Board, Society, 6:00 PM, Social; 6:30 PM, Dnr/Mtg
- 23 — IMS Advisory Breakfast, 7:30 AM …prior to ISMA BOT @ 9:00 AM, ISMA Headquarters

December
- 10 — Senior/Inactive Luncheon Meeting, 11:30 AM, Society TBD
- 16 — Executive Committee Holiday Dinner, with Spouses/Guests, Dr. Diaz selects location.

Indianapolis Medical Society

631 East New York Street • Indianapolis, IN 46202-3706
Phone: (317) 639-3406 • Fax: (317) 262-5609 • E-Mail: ims@imsonline.org • Web: www.imsonline.org

Officers 2013-2014

Mark M. Hamilton .....President
Bruce M. Goens ..... Immediate Past President
David R. Diaz..... President-Elect
David H. Moore..... Secretary/Treasurer

Board of Directors 2012-2013

Terms End with Year in Parentheses
Stephen W. Perkins, Chair (2015); Mary D. Bush, Vice Chair (2015)

Christopher D. Bojrab (2014)
Marc E. Duerden (2014)
John C. Ellis (2014)
Bernard J. Emkes (2014)
Paula A. Hall (2014)
Gerald T. Keener, Jr. (2014)
John C. Kincaid (2014)
John E. Krol (2014)
Gregory N. Larkin (2014)
Susan K. Maisel (2014)
John F. Schaefer, Jr. (2014)

Mary D. Bush (2015)
Robert J. Goulet, Jr. (2015)
David C. Hall (2015)
Marc R. Kappelman (2015)
Jeffrey J. Kellams (2015)
Anthony W. Mimms (2015)
Caryn M. Vogel (2015)

*Appointed from the President's Advisory Council
Carolyn A. Cunningham
Heidi M. Dunniway
Jon D. Marhenke

Linda Feiwell Abels (2016)
James A. Dugan (2016)
Richard D. Feldman (2016)
Gary R. Fisch (2016)
Ronda A. Hamaker (2016)
Stephen R. Klapper (2016)
Mary Ian McAteer (2016)
John P. McGoff (2016)
Maria C. Poor (2016)
Richard H. Rhodes (2016)
Barbara K. Siwy (2016)
Michael T. Stack (2016)
John J. Wernert (2016)

Delegates to the State Convention, September 2014

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

Mary D. Bush (2014)
David R. Diaz (2014)
Gary R. Fisch (2014)
Jonathan A. Fisch (2014)
Bruce M. Goens (2014)
Ann Marie Hake (2014)
Robert M. Hurwitz (2014)
Paul D. Isenberg (2014)
David A. Josephson (2014)
Marc R. Kappelman (2014)
Randall A. Lee (2014)
Mary Ian McAteer (2014)
Clement J. McDonald III (2014)
Richard H. Rhodes (2014)
Jodi L. Smith (2014)

Linda Feiwell Abels (2015)
Christopher D. Bojrab (2015)
Charles W. Coats (2015)
John C. Ellis (2015)
Robert J. Goulet, Jr. (2015)
C. William Hanke (2015)
Gerald T. Keener, Jr. (2015)
David H. Moore (2015)
Robert B. Pauszek, Jr. (2015)
J. Scott Pittman (2015)
John F. Schaefer, Jr. (2015)
Caryn M. Vogel (2015)

David S. Batt (2016)
Daniel J. Beckman (2016)
Carolyn A. Cunningham (2016)
Margaret M. Gaffney (2016)
David C. Hall (2016)
Ronda A. Hamaker (2016)
Mark M. Hamilton (2016)
Jeffrey J. Kellams (2016)
Stephen R. Klapper (2016)
Frank P. Lloyd, Jr. (2016)
Susan K. Maisel (2016)
David M. Mandelbaum (2016)
John P. McGoff (2016)
Dale A. Rouch (2016)
Jason K. Sprunger (2016)

Alternate Delegates to the State Convention, September 2014

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

William C. Buffie (2014)
Brian D. Clarke (2014)
Robert E. Dicks (2014)
Doris M. Hardacker (2014)
Douglas J. Horton (2014)
Daniel E. Lehman (2014)
Ramana S. Moorthy (2014)
Maria C. Poor (2014)
Philip W. Pryor (2014)
Jason E. Rieser (2014)
Steven M. Samuels (2014)
Kenneth N. Wiesert (2014)

James P. Bastnagel (2015)
John H. Ditslear, III (2015)
Robert S. Flint (2015)
Tod C. Huntley (2015)
Norman Mindrebo (2015)
Robert Michael Pearce (2015)
David M. Ratzman (2015)
Michael A. Rothbaum (2015)
Jeffrey M. Rothenberg (2015)
Richard M. Storm (2015)
Jeremy T. Sullivan (2015)
H. Jeffery Whitaker (2015)
Allison E. Williams (2015)
Steven L. Wise (2015)

Robert J. Alonso (2016)
Ann M. Collins (2016)
Andrew J. Corsaro (2016)
Stephen B. Freeman (2016)
John Douglas Graham, III (2016)
Andrew A. Johnstone (2016)
Andrew L. Morrison (2016)
Mercy O. Obeime (2016)
Ingrida I. Ozols (2016)
David L. Patterson (2016)
Michael A. Rothbaum (2016)
Kenny E. Stall (2016)
Samuel T. Thompson (2016)
Ronald L. Young, II (2016)

Indiana State Medical Association Past Presidents

Jon D. Marhenke 2007-2008
Bernard J. Emkes, 2000-2001
Peter L. Winters, 1997-1998
William H. Beeson, 1992-1993
George H. Rawls, 1989-1990
John D. MacDougall, 1987-1988
George T. Lukemeyer, 1983-1984
Alvin J. Haley, 1980-1981

Indiana State Medical Association President-Elect

John J. Wernert (2013-2014)

House of Delegate Speaker, ISMA

Heidi M. Dunniway (2013-2014)

Vice-Speaker, ISMA

Heidi M. Dunniway (2012-2013)

Seventh District Medical Society Trustees

Vicki M. Roe (2014)
John P. McGoff (2015)
Marc E. Duerden (2016)

Alternate Trustees

Robert A. Malinzak (2014)
John C. Ellis (2015)
G. Mitch Cornett (2016)

Special Feature(Continued from page 8)

writing for opioids. INSPECT should be checked for all new chronic pain patients, at least annually for all established chronic pain patients, and whenever clinical data suggest a patient may be using multiple controlled substances from other prescribers.

9. Urine drug monitoring (UDM) protects you and your patients. UDM is one of the three objective measures of treatment compliance: UDM, INSPECT and random pill counts. Each measure complements the other to help identify patients at risk for harming themselves (addiction/OD) or others (diversion/MVAs). Ordering and interpreting UDM tests can be complicated at first. Section 7 of the Toolkit provides detailed information on the appropriate use of UDM for chronic pain patients on opioid therapy.

10. Action is required as a patient's Morphine Equivalent Dose (MED) escalates above 30 mg per day. For chronic non-terminal pain, we have no evidence that escalating doses of opioids improves patient outcomes. In fact, most data demonstrate negative effects. Dose-response curves clearly indicate an increased risk for respiratory depression and death in patients taking MED greater than 30 mg per day, with a 3.7 fold increase in risk beginning at 50 mg/day. Before prescribing opioid doses beyond 60 MED, the Medical Licensing Board requires a clinical reassessment of the patient for improvement in pain and function, and thoughtful consideration of treatment and evaluation options, such as opioid rotation, including an additional modality of pain management in the therapeutic regimen, and referral and or co-management options (see our Pain referral documents).

President's Page(Continued from page 7)

state's primary care practices aren't accepting new patients. At practices that are accepting new patients, the average wait to see a family physician is 39 days, and the average wait to see an internal medicine physician is 50 days.[6]

Many have also said that the jump to expanded coverage for the US is much larger than it was for Massachusetts. In Massachusetts before Romneycare the number of uninsured was less than 10%.[7] Compare that to around 16% for the United States – a significantly greater challenge. In addition, Romneycare placed minimal stipulations on the type of insurance policies individuals were required to hold. Even low benefit catastrophic plans were acceptable. Compare that to the extensive requirements of Obamacare requiring so many people to change policies.[8] Obviously "You can keep your policy and your doctor" is proving not to be true.

If there's one lesson we can take away from the Massachusetts model over the past 6 years, it's that health care reform must continue to focus on controlling cost (and address medical liability) and grow the number of physicians while expanding coverage. Hopefully theses issues will get more attention as Obamacare progresses than they did in Massachusetts.

References:

1.http://www.forbes.com/sites/aroy/2011/10/11/how-mitt-romneys-health-care-experts-helped-design-obamacare/

2.http://www.healthcareitnews.com/infographic/infographic-comparing-obamacare-and-romneycare

3.http://www.rawstory.com/rs/2013/11/15/maddow-think-obamacare-rollout-is-messy-you-should-have-seen-romneycare/

4.http://www.csmonitor.com/USA/DC-Decoder/2013/0929/Romneycare-vs.-Obamacare-Lessons-for-today-s-shutdown-debacle-video

5.http://www.massmed.org/Advocacy/Key-Issues/Health-Care-Reform/The-Facts-About-Massachusetts-Health-Reform/#.UpInW4V0Hys

6.http://www.forbes.com/sites/jimpowell/2013/11/13/the-fourth-obamacare-shock-wave-is-about-to-reach-us/

7.http://www.creators.com/opinion/terence-jeffrey/individual-mandate-romneycare-insured-only-another-5-percent.html

8.http://www.swingstatevoter.com/p/differences-between-romneycare-and.html

IMS

Countdown to ICD-10, October 1, 2014

It seems we have heard about ICD-10 for years now and it is true, we have.

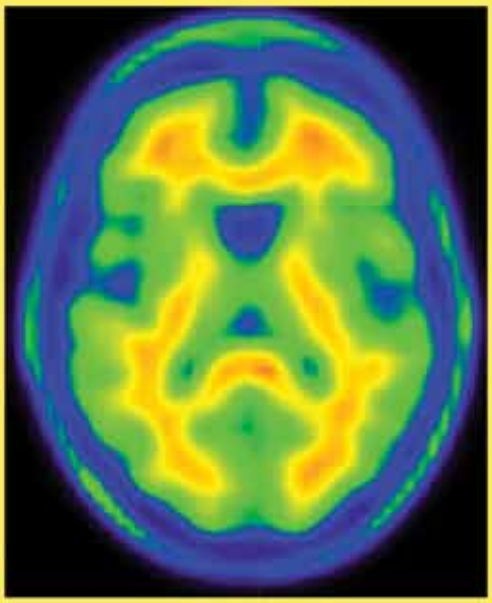
What's the big deal about this coding and billing change? 13,000 codes to 68,000 codes … that's a lot of coding, but ICD-10 is more than the additional codes.

It is a transformational process for healthcare providers, payers and vendors. Physicians have the most to lose in this new requirement. Impact is on every process in your practice. It will impact your time with patients, your planning and training, your reimbursements, your cash flow, basically, your entire practice. Even things we don't necessarily consider in the coding process. Effective October 1, 2014, if you don't code properly using ICD-10, it is more than a delay in reimbursements – **you simply won't be paid!**

The Indianapolis Medical Society will focus on small steps and information you need to know over the next several months in your *Bulletin*, events and on imsonline.org

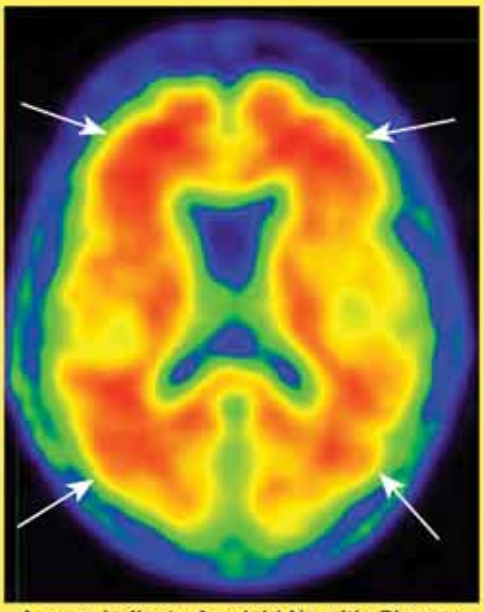
Now Available In Indianapolis!

PET-CT Tracer to Help Diagnose Alzheimer's Disease ...and Memory Disturbances



Negative Scan

A negative Amyvid scan indicates that a person has few or no amyloid plaques – consistent with no presence of Alzheimer's Disease.



Arrows Indicate Amyloid Neuritic Plaques

Positive Scan

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.

The first and only FDA-approved PET-CT tracer, Amyvid, is now available for use in testing patients being evaluated for Alzheimer's Disease and other causes of cognitive decline.

To schedule a scan or for more information, call 317-XRAY NOW (972-9669), or toll-free 800-400-9729.

NWR

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