How to fight your prior authorization battles smarter this year.

by CHRIS BOJRAB, MD
Physicians on the U.S. Army health care team support our Soldiers and their families. They take pride in the fact that their skills and experience will continue to grow, along with their nation’s gratitude.

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Attention Society Members

The Bulletin is your magazine. If you have an idea or opinion you’d like to share, or an article you have written, please email the editor at mperrill@indymedicalsociety.org.
As we are all painfully aware, the start of the new year brings with it the need to restart the process of renewing approvals for medications for our patients. Each year, this process seems to become more and more cumbersome and frustrating. Changes in insurance have resulted in many of our patients being responsible for the full cost of their medications until their deductible has been met.

Typically, the process involves writing or sending in the prescription, which then usually triggers the prior authorization request that requires information be provided through a wide variety of non-standardized processes. Because of the lack of standardization in this process, we are almost always left in the position of having to deal with the prior authorization process in a reactive rather than in a proactive way. I go out of my way to explain to patients, that despite having their insurance information, the way in which we are asked to process the prior authorization changes from year to year and varies by insurance plan, employer group, etc. so that most of the time we have to wait to be told if they require a phone call, a fax, an online form, etc.

Patients are often sent confusing letters from their insurers informing them that many medications have “generic equivalents” that are available at significantly less cost than brand name medications. Later in the letter, the company points out that after reviewing their medication list, they have identified a number of “generic alternatives” that may provide them substantial cost savings and the letter encourages them to contact their physician to consider changing their medication. I believe that this is an incredibly deceptive practice as often times the “generic alternatives” that they are recommending are not “generic equivalents” as they have described in the first part of the letter, but rather are medications that are in different classes with different mechanisms of action than the treatment which has been prescribed for them.

I am similarly baffled when patients calls their insurance plans complaining of the cost of their medication, and they are told that they can have their physician can complete a “tier exemption” or “copay reduction” form to reduce the cost of their medication. In our practice, I refer to these collectively as “obfuscation forms” or “buck-passing forms”.

The vast majority of patients who have pursued this process with their insurer seem to be led to believe that somehow, we as physicians set the price that they pay for their medications and that we determine to which medications they have access. While we will complete these forms when requested, I always ask my patients “Under what circumstances would I not want you to have access to the prescription that I have written for you and would I not want you to be able to purchase it for the lowest possible price?”

Recently, I had a patient who developed a severe drug-induced movement disorder. After failing to respond to dose reduction or changing the medication, I started her on one of the medications that is FDA approved for the treatment of this disorder. Her response was dramatic, with near resolution of her symptoms within 2 weeks. At the start of the new year, her insurer sent us a prior authorization request which we completed and returned. The request was denied, and we responded to the denial with additional medication. They stated that the patient should be changed to a medication that was not FDA approved for the condition for which she was being treated and which has in its package insert a boxed warning about the risks of worsening depression and suicidality associated with its use.

DISCLOSURE:

I want to disclose to you that I serve as a consultant and member of the speakers bureau for a number of pharmaceutical and biotech companies. This activity represents a minority of my professional time and income.
We again responded that this was inappropriate as they were asking us to treat her with a medication that was not FDA-approved, and that this patient was already struggling with significant depression and suicidal ideation. After they continued to refuse coverage, I requested an expedited external appeal. The company declined my request, stating that they would have one of their medical directors speak with me. When I asked if this would be a psychiatrist, I was told no. I pointed out that they were required to do so, and they still declined. Finally, I suggested that they may, in fact, be in violation of Indiana law. Indiana Code (section 27-8-28-17) states the following:

IC 12-8-28-17

(b) “In the case of an appeal of a grievance decision described in section 6(1) or 6(2) of this chapter, an insurer shall appoint a panel of one (1) or more qualified individuals to resolve an appeal. The panel must include one (1) or more individuals who:

(1) have knowledge of the medical condition, procedure, or treatment at issue;

(2) are licensed in the same profession and have a similar specialty as the provider who proposed or delivered the health care procedure, treatment, or service;

(3) are not involved in the matter giving rise to the appeal or in the initial investigation of the grievance; and

(4) do not have a direct business relationship with the covered individual or the health care provider who previously recommended the health care procedure, treatment, or service giving rise to the grievance.

(c) An appeal of a grievance decision must be resolved:

(1) as expeditiously as possible, reflecting the clinical urgency of the situation; and

(2) not later than forty-five (45) days after the appeal is filed.”

I believe that is our responsibility to try to practice cost-effective medication whenever we can, and to be good stewards not only of our individual patients, but also of the resources of the health care system. I prescribe generics whenever I can (and most of the medications I take personally are generics), but I also recognize that they are not identical to brand name medications. Federal guidelines permit generic versions of medications to receive the top “AB-rating” if their bioequivalence is within 80%-125% of the brand name medication for measures of the rates and extent of absorption (Cmax and AUC). I believe that many of the policies of insurers are reasonable. I see no problem with “step-edits” requiring trials of FDA-approved medications which are less expensive prior to using more expensive medications if there is no data demonstrating superior efficacy or safety of the more expensive drug. However, when insurers require patients to fail trials of an excessive number of medications in the same class, or when they inexplicably require patients to have failed trials of medications within the last 90 or 180 days (as if a patient who had intolerable side effects or a failure to respond to a medication more than three to six months ago will now have a completely different response), then their policies seem unscientific, illogical, and irrational.

Chris Bojrab, MD
President, Indianapolis Medical Society
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317-261-9000
**Life in the Legislature: with State Representative Brad Barrett, M.D., FACS**

*by LYDIA KIRSCHNER*

*Press Secretary, Indiana House Republicans*

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**Question:** Why did you choose to become a surgeon?

**Barrett:** There are many reasons why I became a surgeon, but I think the primary reason was because it allows you to identify a problem and then definitively address it. That was very satisfying to me, as well as the complexity of patients, the acuity, the challenge and the ability to do things with my hands. All of those things I found to be very fulfilling.

**Question:** Why did you choose to run for state representative?

**Barrett:** I wanted to pursue becoming a state representative because I retired relatively early in my life, which was part of an effort to fulfill a lifetime goal. The goal was to retire at age 55, but then to replace work with something of relevance. I had considered policy due to some advocacy that I had participated in as a surgeon, which I found to be very rewarding.

**Question:** What was it like to transition from the medical field to the General Assembly?

**Barrett:** Well there are certainly some things that are similar, like dealing with complex problems, learning about issues and reaching decisions, and using previous education to affect an outcome.

The differences I’m learning are that, at the Statehouse, there are already policy and plans at play, and things that happen for a reason, which I was not privileged to know or see. I tell people it’s kind of like walking into a movie an hour in and trying to figure out not only where things are going, but where things had been. That is how it can feel at the Statehouse as a new member.

The other thing that is different is that surgery was very definitive in terms of identifying a problem and treating it. In the Statehouse, it seems like there is a slower process in defining a problem and a less defined feeling of resolution at the end. We make these laws and we change the idea of a statute, but at the end of the day, I hope to see the eventual impact that change creates. Where as in surgery it’s instant, or relatively instant, feedback.

“Another similarity I noticed is the whole process of developing credibility and relationships, and then using momentum to solve problems.”
**Question: How have you used your past career experience to benefit your career as a state representative?**

**Barrett:** I think the main benefit is the people skills that you develop. As a doctor or surgeon, you need to gain people’s trust, relay confidence and then carry out a plan in a short period of time. For instance, meeting someone for the first time and having a discussion that they have cancer, need surgery or they’re not doing so well. That’s a skillset I feel I used in the practice of medicine that I’m transferring to policy.

There are several health care providers in the Statehouse – all at different levels. I’m the only surgeon in the Indiana General Assembly, and I think with that I bring a skillset in knowledge of science and health care, and in other life experiences. I am able to take this past career experience and use it when evaluating legislation considered in the House Public Health Committee.

In your practice you meet all members of society and interact with them. When I transfer those relationships to the Statehouse, I feel that I’m able to speak on certain situations because I’ve met the people they impact and seen the problems.

**Question: Are there any skillsets that cross over from surgery to policy?**

**Barrett:** I believe that practicing medicine has helped me deal with stress. Things move through the Indiana General Assembly at a pretty hectic pace, but my previous job prepared me for that kind of environment. I jokingly tell people that as stressful as session can be at times, it’s a lot easier than my last job. By putting it into perspective, I feel that medicine served as boot camp in preparing me for other avenues in life. There was always the mindset that if you were successful as a doctor, with the intense training and hours, and you put half that time into any other career, you would be greatly successful.

Another similarity I noticed is the whole process of developing credibility and relationships, and then using that momentum to solve problems.

**Question: What is it like to be a surgeon in the Statehouse?**

**Barrett:** I think being a doctor or surgeon in the Statehouse brings a certain level of respect because people realize that it’s a trusted profession. To translate those skills into a new environment seems to bring with it some instant level of credibility, as well. The challenge with that is to then either maintain the credibility or build upon it. That is what I find to be the biggest challenge, knowing when to speak out and knowing when to sit quiet. Trying to balance that in order to gain a reputation with someone can be beneficial in the system.

**Question: How have the first few months as a state representative gone?**

**Barrett:** Since we started working, I find it similar to medicine in the fact that every day is a learning experience and every day is a challenge. I know we are only halfway through the process, but there has not been a day that has gone by that I have not seen or learned something new, obtained a different perspective, or met someone who saw a different angle on an issue. I’m finding it to be very rewarding.

**Note from the Editor:**

If you would like to learn more about State Representative Brad Barrett and what legislation he is working on this session you can visit his website at www.in.gov/h56.
“We (Indiana) are seventh highest (in infant mortality) among the states and have almost twice the rate compared to some states...One could consider our high infant mortality as rivaling some third world countries.”

by Richard D. Feldman, MD
Indiana has a horrible problem: Infant mortality. We are seventh highest among the states and have almost twice the rate compared to some states. The rate is also more than twice as high for African-Americans as compared to Caucasians and higher in those living in poverty regardless of race. One could consider our high infant mortality as rivaling some third world countries. This is reflective of our poor state of health, lack of early pregnancy care, deficiency of public health funding, and poor lifestyle choices.

Governor Eric Holcomb made infant mortality one of his top priorities during this legislative session. He proposes funding for a pilot program for “obstetric navigators” for at-risk pregnant women in areas with the highest infant mortality rates. A good idea and a good start.

The next logical additional step should be to intervene in the unacceptably high rate of Hoosier smoking during pregnancy. The chief causes of infant deaths are conditions related to premature birth, low birth weight, congenital anomalies, and Sudden Infant Death Syndrome. All are associated with smoking during pregnancy. The smoking rate among pregnant women in Indiana is almost 14 percent, nearly twice the national average. Really want to lower the infant mortality rate? Get serious about lowering this statistic.

Expansion of another public health program could make a profound impact on infant mortality in Indiana. Implemented by Goodwill, I.U. Health, and Healthier Moms and Babies, the Nurse-Family Partnership is an evidenced-based national program with 40 years of experience demonstrating significant improvements in the health and lives of high-risk first-time mothers and their children living in poverty.

The no-cost program is intensive, holistic, and individualized with regular home nurse visits; this provides moms with good parenting and child-development information, health-related education, and role modeling. The nurse and mother make a two and a half-year commitment to one another that involves potentially 60 planned home visits depending on maternal needs. Women voluntarily enroll between 16 and 28 weeks of pregnancy and continue until the child is 2 years old.
These low-income women face many burdens including domestic violence and other emotional, social and physical challenges to a healthy pregnancy and motherhood. The Hoosier women in the program have a median age of 25, 88 percent are unmarried, 21 percent Hispanic, 52 percent African American, and 61 percent have completed high school. Knowledge means empowerment, and this program enables more confident, capable mothers who can better assure a more successful and healthy future for their children.

The nurses facilitate obtaining early prenatal care, improving diet, and preparing for a new baby. They endorse breast feeding, reduced tobacco and alcohol use, and intervene in illegal substance use and opioid addiction. There is encouragement to look at the long-term for further education and employment.

Proven returns on investment include enhanced pregnancy outcomes, reduced risk for infant mortality, improved child health and development, less child abuse and neglect, high infant vaccination rates, reduced substance abuse, and improved economic self-sufficiency. Every $1 invested in the program saves society and government (including Medicaid) $7.10.

Although there is some funding from the state and federal government, other community partner sources, and in-kind support from various community organizations, the program serves only 36 counties helping 1,028 mothers. The Nurse-Family Partnership is requesting $10 million a year in the next biennium to enhance its outreach. What a splendid public health approach that deserves the attention of Indiana legislators for increased funding and expansion to address infant mortality and beyond.
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<td>AMWA Learn to Identify &amp; Fight Trafficking (LIFT) Training</td>
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**Online CME Activities**

- HPV Documentary: Someone You Love: The HPV Epidemic
  [http://cme.medicine.iu.edu/hpvdocumentary](http://cme.medicine.iu.edu/hpvdocumentary)
- Opioid TeleECHO Clinic Providers and Prescribers Webinar
St Vincent Hospital Indianapolis CME Series Conferences
Schedule & Location

PEDIATRIC CARDIOTHORACIC SURGERY & CARDIOLOGY CONFERENCE
Thursdays
12:00pm-1:00pm
PMCH

PEDIATRIC GRAND ROUNDS
Wednesday (2nd) of the month
12-1 pm at William K Nasser MD, Education and Simulation Center

CCEP (CLINICAL CARDIAC ELECTROPHYSIOLOGY PROGRAM)
Wednesdays, weekly,
7-8 am at St Vincent

ECHOCARDIOGRAPHY CONFERENCE
Thursday (2nd), monthly,
7-8 am at St Vincent

GENERAL CARDIOLOGY
Mondays, weekly,
7-8 am at St Vincent

INTERVENTIONAL CARDIOLOGY
Wednesdays, weekly,
7-8 am, Heart Center

ADVANCED HEART FAILURE
Wednesdays, weekly,
7-8 am at St Vincent

CARDIOLOGY/MED/SURG
Thursday, (3rd) evens,
7-8 am, Heart Center

FRACTURE
Thursdays, weekly,
8-9 am at OrthoIndy

SURGERY DIDACTICS
Wednesdays, weekly,
7:30-8:30 am at St Vincent

SURGERY M&M
Wednesdays, weekly,
6:30-7:30 am at St Vincent

MULTI-DISCIPLINARY TRAUMA
Tuesdays, weekly,
Trauma Case 12-1 pm at St Vincent

NEONATOLOGY GRAND ROUNDS
Wednesdays (2nd) monthly,
12-1 pm at Womens

NEONATOLOGY JOURNAL CLUB
Tuesdays, every other month,
12-1 pm at Womens

PERINATAL CASE REVIEW
Wednesdays, monthly (4th),
7-8 am at Womens

MFM ULTRA SOUND SERIES
Quarterly
1-4 pm at Womens

SIM DEBRIEFING ESSENTIALS
12 times a year at
William K Nasser MD,
Education and Simulation Center

PMCH CRISIS MANAGEMENT ESSENTIALS
12 times a year at
William K Nasser MD,
Education and Simulation Center

INTERNAL MEDICINE M&M
12 times a year, various dates

Course dates and locations are subject to change.
For more information please call (317) 338-3460.

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THANK YOU
TO SOME OF OUR EARLY SPONSORS
Charles Kulwin, MD

Charles Kulwin, MD, has been named one of the 2019 Forty Under 40 by the Indianapolis Business Journal. Dr. Kulwin is an assistant professor of clinical neurosurgery with Indiana University’s Department of Neurological Surgery and Goodman Campbell Brain and Spine (GCBS) and was recognized for helping to pioneer a surgical treatment for patients suffering from severely disabling strokes. He now travels to teach the procedure. “Nothing beats the smile on patients’ and families’ faces when you can help them through one of the scariest times in their lives,” Kulwin told IBJ. Each year, IBJ selects 40 of the city’s rising stars and honors their accomplishments at work and in the community.

Carl Sartorius, MD

Carl Sartorius, MD, is a recipient of a 2018 Distinguished Physician Award at St. Vincent Indianapolis. The award signifies the exceptional work and leadership demonstrated by Dr. Sartorius throughout his career in neurosurgery. He is the first GCBS physician to receive this honor.

Jeffrey Raskin, MD

Jeffrey Raskin, MD, played a significant role at the 2nd Middle-eastern Society for Stereotactic and Functional Neurosurgery Conference in Cairo, Egypt. He was chairperson of the plenary session “Pain” and also served as faculty instructor for two courses: “Baclofen pump implantation—surgical tips and tricks” and “Robotic laser ablation in pediatric neurosurgical population: Epilepsy and Oncology.” The conference was held February 6–8.

Dr. Raskin was also an invited lecturer at the 1st Annual Surgical Epilepsy Symposium in Indianapolis. His three talks were: “Stereoelectroencephalography and Laser Ablation in Pediatric Epilepsy,” “Disconnection Surgeries,” and “Neuromodulation in Pediatric Epilepsy.” The symposium was held on February 9.

Jesse Savage, MD

Jesse Savage, MD, recently joined his co-authors in publishing new research in Cureus. “Endoscopic en-donosal surgery for the resection of a cavernous hemangioma with a sellar extension,” appeared in the November 18 issue.

Theresa Rohr-Kirchgraber, MD

Theresa Rohr-Kirchgraber, MD recently had her research paper on women and URM physicians and patient satisfaction scores published in Health Equity.


Please submit Bulletin Board Information to ims@imsoline.org.
Your photo in the IMS files will be used unless an updated picture is submitted with your material.
WHEN IT COMES TO BACK PAIN,

EXPERTISE COUNTS.

The neurosurgeons of Goodman Campbell receive 60 months of residency training on the neck and back. Compare that with just 18 months spent by orthopedic surgeons. When you're suffering from neck and back pain, choose expertise you can count on.
JOSEPH DAVID MCPIKE, SR.

Joseph David McPike was born on March 4, 1934 in Bedford, Indiana. He attended Bedford High School and then served in the United States Army from 1954-1956. Joseph passed away on his birthday, March 4, 2019. Joseph received his medical degree from Indiana University School of Medicine. He completed a Rotating Internship at Marion County General Hospital in General Practice in 1965 and went on to complete a General Practice Fellowship in Radiology and Anesthesiology in 1969. Joseph engaged in general practice and part-time emergency medicine practice from 1969-1971. From there he started practicing emergency medicine full-time, contracting with hospitals inside and outside of Indiana as a Director of Emergency Services. In 1971, Joseph was a founding member and first president of the Indiana Chapter of the American College of Emergency Medicine Physicians. In 1986, he returned to family practice and had an office on the south side of Indianapolis where he practiced until he retired. Doctor McPike practiced Family Medicine and Emergency Medicine for 50 years. He has been an IMS member since 1988.
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**Delegates**

Delegates to the Annual State Convention

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

- Carolyn A. Cunningham (2019)
- Susan K. Maisel (2019)
- J. Scott Pittman (2019)
- Ann C. Collins (2020)
- Marc E. Duerden (2020)
- Bruce M. Goens (2020)
- Paula A. Hall (2020)
- Daniel E. Lehmans (2020)
- Mary Ian McAteer (2020)
- Mercy O. Obeme (2020)
- Robert M. Pascuzzi (2020)
- Stephen W. Perkins (2020)
- Richard H. Rhodes (2020)
- John J. Wernert (2020)
- H. Jeffrey Whitaker (2020)
- Linda Feiwell Abels (2021)
- Mary Pell Abernathy (2021)
- Jeffery J. Kellams (2021)
- Richard H. Rhodes (2021)
- Susan K. Maisel (2019)
- J. Scott Pittman (2019)
- Ann C. Collins (2020)
- Marc E. Duerden (2020)
- Bruce M. Goens (2020)
- Paula A. Hall (2020)
- Daniel E. Lehmans (2020)
- Mary Ian McAteer (2020)
- Mercy O. Obeme (2020)
- Robert M. Pascuzzi (2020)
- Stephen W. Perkins (2020)
- Richard H. Rhodes (2020)
- John J. Wernert (2020)
- H. Jeffrey Whitaker (2020)
- Linda Feiwell Abels (2021)
- Mary Pell Abernathy (2021)
- Jeffery J. Kellams (2021)
- Richard H. Rhodes (2021)

**Alternate Delegates**

Delegates to the Annual State Convention

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

- Daniel J. Beckman (2018)
- Amy D. Shapiro (2018)
- Jason K. Spranger (2019)
- Brian D. Clarke (2020)
- Julie A. Daftari (2020)
- Christopher M. Doran (2020)
- David A. Josephson (2020)
- Chad R. Kauffman (2020)
- Ramana S. Moorthy (2020)
- Ingrida I. Ozols (2020)
- John C. Ellis (2017-2018)
- George T. Lukenswayer (1983-1984)
- Jodi L. Smith (2020)
- Eric E. Tibesar (2020)
- Rania Abbasi (2020)
- Heather N. Berke (2020)
- Robert S. Flint (2021)
- Michael Payne (2021)
- Richard M. Storm (2021)
- Jeremy T. Sullivan (2021)

**Past Presidents’ Council 2018-2019**

- Carolyn A. Cunningham
- David R. Diaz
- Marc E. Duerden
- John C. Ellis
- Bernard J. Emkes
- Bruce M. Goens
- Paula A. Hall
- Susan K. Maisel
- Jon D. Marhenke
- John P. McGoff
- Stephen W. Perkins
- Richard H. Rhodes

**Indiana State Medical Association**

<table>
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<tr>
<th>Year</th>
<th>President</th>
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<tr>
<td>2017-2018</td>
<td>John P. McGoff</td>
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<tr>
<td>2014-2015</td>
<td>Heidi M. Dunniway</td>
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<tr>
<td>2007-2008</td>
<td>Jon D. Marhenke</td>
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**Seventh District Medical Society Trustees**

- John C. Ellis (2021)
- David R. Diaz (2020)
- Susan K. Maisel (2019)
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- Family Fun

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