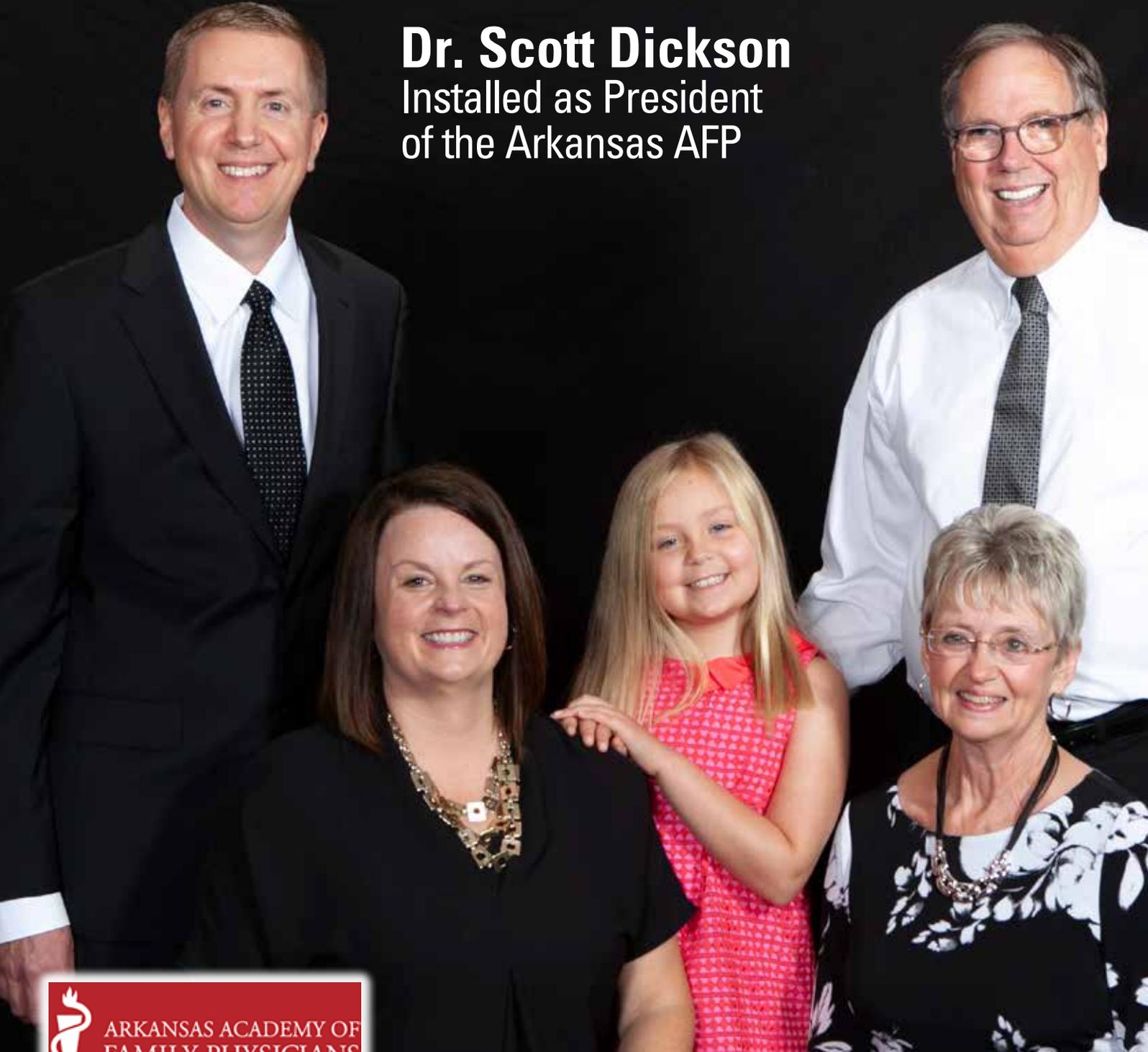


Officers and Directors Installed

The ARKANSAS FAMILY PHYSICIAN

Volume 22 • Number 2

Dr. Scott Dickson
Installed as President
of the Arkansas AFP



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The Arkansas Family Physician is the official magazine of the Arkansas Academy of Family Physicians

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EDITION 85

Dear Academy Member,

We are so excited to have pictures of our recent Annual Meeting in this issue for those of you unable to attend. Included are our newly installed President, our newly elected officers and directors as well as highlights in pictures of some of our members who attended!

Our meeting was filled with highly respected and well known speakers on topics of particular relevance to Family Medicine. It was preceded by an excellent afternoon program on Pediatrics. We had a smaller attendance this year of practicing physicians and will be doing a survey through Survey Monkey in the coming days to determine the reasons our attendance may have declined.

We are tentatively contracted for the Embassy Suites July 31-August 4 which has worked well for us the past six years for this particular time of year. The Embassy will be undergoing total renovation of the lobby area and all sleeping rooms with a projected finalization of June, 2019.

Of the 24 speakers on the program, our own Family Physicians scored the highest with Dr. Angela Driskill receiving a 98% overall on her presentation on "the Diabetic Foot". Others specialists on the program receiving high marks were: Jennifer Smith, J.D., R.N., Associate General Counsel at UAMS; Dr. Scott Dinehart, a Little Rock Dermatologist; Dr. Ryan Dare, an Infectious Disease Physician at UAMS; Dr. Joseph Thompson of ACHI and Dr. Larry Simmons, a Pediatrician at Arkansas Children's Hospital.

We received an excellent listing of topics for next year from attendees and we look forward to having many of those topics on next year's program. Comments made by attendees included: they liked most the variety of subjects, the location, networking opportunities, interactions and question and answer sessions and the shorter lectures especially the TED talks. We are Listening!!!! Several members came forward and volunteered to serve on committees in the coming year and we are thrilled to have their participation.

We will be traveling to New Orleans in October to represent the Arkansas membership at the AAFP Congress of Delegates which precedes the scientific program of the Academy. We hope to see many of you there.

As we begin a new year with new officers and directors, we invite you to participate in the ARAFP in any way you can – let us know what you would like to see on the program: let us know what is important to you.

Sincerely,



Carla Coleman
Executive Vice President



On the cover:

Dr. Scott Dickson, his wife Heather and daughter Mary Beth and his parents, Mr. and Mrs. Norman Dickson
Photographs by Darrick Wilson Photography



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Doctor Scott Dickson

Installed as President of the Arkansas AFP

Scott Dickson, M.D. of Jonesboro was installed as the 71st President of the Arkansas Chapter, American Academy of Family Physicians at the Installation of Officers held on Friday, August 3 in the Ballroom of the Embassy Suites Hotel in Little Rock, Arkansas.

Doctor Reid Blackwelder, Past President of the American Academy of Family Physicians and Professor and Chair of Family Medicine, Quillen College of Medicine, East Tennessee State University, Johnson City, Tennessee presided over the installation.

President Dickson urged members of the ARAFP to become involved – to attend board meetings, to submit their names for committees of the state organization and to urge colleagues and especially young Family Physicians to ask where they may serve in their professional medical organization. He thanked those who had influenced him into a career in Family Medicine – his grandmother, his own Family Doctor, his Residency Director, Doctor Joe Stallings of Jonesboro and his parents, Mr and Mrs. Norman Dickson. He mentioned several issues of particular concern to the ARAFP and legislative issues in the 2019 session that would require the attention and assistance of as many Family Doctors in the state as possible. He urged involvement and stressed the importance of membership and participation in Academy functions. His plans involve visiting the students at the osteopathic schools in Jonesboro and Fort Smith for a Family Medicine Interest Group and contacting his colleagues, past residents and medical students who are no longer members of the ARAFP to consider membership and urged others to do the same.

Doctor Dickson is a graduate of Arkansas State University, Jonesboro and received his M.D. from UAMS followed by a residency in Family Medicine at AHEC Northeast. He served for 8 years as Assistant Residency Director of AHEC Northeast Family Practice Residency in Jonesboro before being named Residency Director in 2009.

Dr. Dickson has served on the ARAFP Board for over four years and holds memberships in the Association of Teachers in Family Medicine, the American Medical Association, The Physician's Health Committee, St. Bernard's Medical Center and the Medical Executive Committee, St. Bernard's Medical Center.

Actively involved in community service, Dr. Dickson is the recipient of many honors and awards and he and his wife Heather live in Jonesboro with their daughter Mary Beth.



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Dr. Matthew Nix, Dr. Appathurai Balamurugan, Dr. Leslye McGrath, Dr. Lonnie Robinson: Dr. Reid Blackwelder at podium: Dr. Tasha Starks, Dr. Amy Daniel, Dr. Charles Smith, Dr. Gregory Sketas, Dr. Garry Stewart

2018-19 Officers and Directors Installed at Annual Assembly

The following Officers and Directors were installed Friday, August 4, 2018 by AAFP President Dr. Reid Blackwelder of Johnson City, Tennessee.

2018-19 Officers

President - Scott Dickson, M.D.,
Jonesboro
President Elect - Matthew Nix, M.D.,
Texarkana
Vice President - Appathurai Balamurugan,
M.D., Little Rock
Treasurer - Leslye McGrath, M.D.,
Jonesboro
Alternate Delegate - Lonnie Robinson,
M.D., Mountain Home
Delegate - Julea Garner, M.D., Hardy

Directors:

Amy Daniel, M.D., Searcy
Charles Smith, M.D., Little Rock
Tasha Starks, M.D., Jonesboro
Garry Stewart, M.D., Conway
Gregory Sketas, M.D., Little Rock
Chesley Murphy, Little Rock

Family Physicians Elected to AMS Offices

Congratulations to Doctor Dennis Yelvington of Stuttgart on being elected to the Arkansas Medical Society as President Elect: to Doctor George Conner of Forrest City, Secretary and to Doctor Bradley Bibb of Jonesboro as Treasurer for the coming year.



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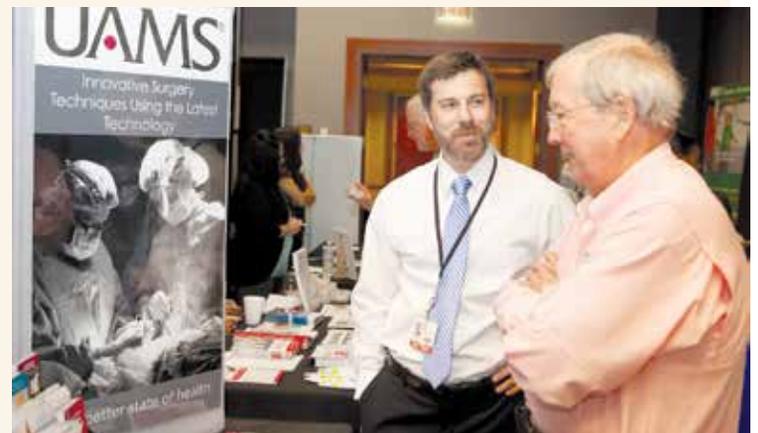
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THE 71ST ANNUAL SCIENTIFIC ASSEMBLY HIGHLIGHTS





Provider-Led Arkansas Shared Savings Entity (PASSE) Model of Care

The Provider-led Arkansas Shared Savings Entity (PASSE) is a new model of organized care that will address the needs of certain Medicaid beneficiaries who have complex behavioral health and intellectual and developmental disabilities service needs. Under this unique organized care model, providers of specialty and medical services will enter into new partnerships with experienced organizations that perform the administrative functions of managed care. Together, these groups of providers and their managed care partners will form a new business organization called a PASSE.

This organized care model is designed to achieve savings over a five-year period in the overall effort to “bend the cost curve” of Medicaid and help the program become sustainable. DHS will construct a financial baseline to reflect the five-year cost of covering the targeted population. Individuals served by this new coordinated care service delivery system must meet the Medicaid income, resources, and functional needs assessment qualifications. In addition, they must meet the Tier II or Tier III level of care defined by DBHS and DDS. Individuals will be required to have an Independent Assessment (IA) for a Tier II or Tier III determination, while individuals who need Tier I or crisis services will be able to access them directly from certified providers.

The PASSE model is built around the premise that better case management and care coordination will minimize more costly acute services, such as emergency department visits, inpatient psychiatric stays, and hospitalizations. The PASSE will proactively manage beneficiaries’ health by coordinating the efforts of all providers used by the beneficiary.

Act 775 of 2017, sponsored by Rep. Aaron Pilkington and signed by Governor Asa Hutchinson, created the structure of provider-led partnerships to coordinate care for Medicaid beneficiaries who typically require more expensive and specialized treatment.

Researchers have concluded that as health care advances and the understanding of the health needs and experiences of people with intellectual and/or developmental disabilities (IDD) improves, there is value in integrating the many potential elements of acute healthcare and linking acute with behavioral health, long-term services and support systems, and the community-based social and developmental support structures of the person with IDD.

The purpose of the PASSE is:

- To improve the health of Arkansans who have need of intensive levels of specialized care due to mental

health, intellectual or developmental disabilities.

- To link providers of physical health care with providers of behavioral health care and services for individuals with developmental disabilities.
- To coordinate care for all community-based services for individuals with intensive levels of specialized care needs.
- To reduce excess cost of care due to under-utilization and over-utilization of services.
- To allow flexibility in the array of services offered to the population served.
- Will reduce costs by organizing care, not just by managing finances.
- To increase the number of service providers available in the community to the population covered.

The PASSE model will include two phases. The first phase began **October 1, 2017**, with conditional PASSE licensure awarded by the Arkansas Insurance Department and independent assessments being completed for the those clients identified by the Department of Human Services. Client assessments will continue and those determined to need services in Tier II and III will be attributed to a PASSE in January of 2018 and each PASSE will begin providing care coordination for their attributed members **February 1, 2018**. Each PASSE will receive payment for case management and care coordination for each enrolled member. DHS will continue to pay for services on a fee-for-service basis.

Phase 2 will begin **January 1, 2019**, at which time DHS will begin making an actuarially sound “global payment” to the PASSE for each enrollee to cover the administration costs and benefits for each patient, while ensuring a level of savings for the state. The global payment will include a percentage reduction to be determined off the projected baseline trend to achieve a guaranteed level of savings for the state and the federal government. The global payment will be made to each PASSE on a per-member per-month (PMPM) basis.

As an insurance product, the PASSE will be certified and regulated by the Arkansas Insurance Department (AID) as a risk-based provider organization and subject to the existing 2.5 percent premium tax.

The Nation's Leading Vaccine Buying Group Supporting Immunization Efforts for All Family Physicians

By working with leading vaccine manufacturers Merck, Sanofi Pasteur, Pfizer, Dynavax and Seqirus, Atlantic Health Partners offers the most favorable pricing, payment, and purchasing terms for a large array of pediatric, adolescent, adult and influenza vaccines. In addition to lowering vaccine costs, practices can better manage their inventory and cash flow as they are not required to make large, multiple product orders. Atlantic Health Partners program now offers one-stop shopping for Sanofi, Merck and Dynavax vaccines.

Atlantic has helped many AR AFP members strengthen their immunization performance by taking an active role in providing reimbursement guidance, advocacy, and timely updates.

We strongly encourage you to contact Atlantic to determine how they can best support your immunization efforts.



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- St. Bernards Clopton Clinic (Jonesboro)
- Arkansas Primary Care Clinic (Little Rock)
- CHI St. Vincent Primary Care – Midtowne (Little Rock)
- Little Rock Family Practice Clinic – Central (Little Rock)
- Little Rock Family Practice Clinic – West (Little Rock)
- Dr. John Alexander, Jr. (Magnolia)
- Dr. Andy's Family Practice Clinic (Mountain View)
- Baptist Health Family Clinic – Lakewood (NLR)
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Reframing Medicaid



Access to health insurance coverage is a critical component in the American Cancer Society Cancer Action Network's (ACS CAN) efforts to reduce death and suffering from cancer. ACS CAN supports efforts to protect, improve and expand access to health care coverage for low-income Americans through state Medicaid programs. Through a new partnership with the Robert Wood Johnson Foundation, ACS CAN is increasing investment in activities that raise awareness and increase public education about the value of the Medicaid program and role of the program in the lives of millions of low-income Americans.

The "Reframing Medicaid" project supports ACS and ACS CAN's goal of making sure that cancer patients, survivors, and those at risk for cancer have access to health care coverage for preventive screenings, treatment, and disease management. This two-year effort will focus on reframing public understanding and perceptions about Medicaid, to ensure that key decision makers understand the value and importance of the program for cancer patients, survivors, those who will face a cancer diagnosis, as well as the communities that support and provide care to them and their families.

Understanding and Communicating the Value of Medicaid

Federal and state policymakers continue to pursue proposals that could fundamentally change low-income state residents' ability to access benefits and services through the program. These proposals will also impact providers, hospitals and the health care systems that deliver care to millions of eligible individuals across the country.

Through this project, ACS CAN will launch a strategic, targeted, multi-media public education campaign illuminating the role of Medicaid in the lives of the individuals and families enrolled in the program, as well as the importance of the program to sustaining providers and health systems, as well as local economies.

To inform this work, ACS CAN is conducting public opinion research to identify resonant messages about the Medicaid program. Using the findings from the public opinion research and the personal stories from enrollees, providers and other key stakeholders, ACS CAN will develop the multi-media public education campaign focused on the value of the Medicaid program to state residents, their health outcomes, regional and local economies and the health care system.

2.3 Million Americans
(under age 65)



**With History of Cancer
Rely on Medicaid for Health
Care**

Role of Key Partners

ACS CAN will facilitate key informant interviews, focus groups and survey research, focusing on low-income individuals and Medicaid enrollees, providers and other key stakeholders, including policymakers. We will also identify, document and produce stories of the diverse individuals, families and providers participating in the program. By assisting ACS CAN in identifying and recruiting stakeholders to participate in key informant interviews, focus groups and story collection, partner organizations can ensure that the experience and needs of your constituency are represented in this public education campaign. We intend to illuminate and amplify the stories of the families, individuals and communities being served by the program, in an effort to shape and reframe public perceptions about the importance of Medicaid.

For more information about this effort and ACS CAN's Medicaid advocacy efforts, contact:

- Citseko Staples Miller, Director, State & Local Campaigns / citseko.staples@cancer.org
- Hilary Gee, Campaigns Manager, State & Local Campaigns / hilary.gee@cancer.org

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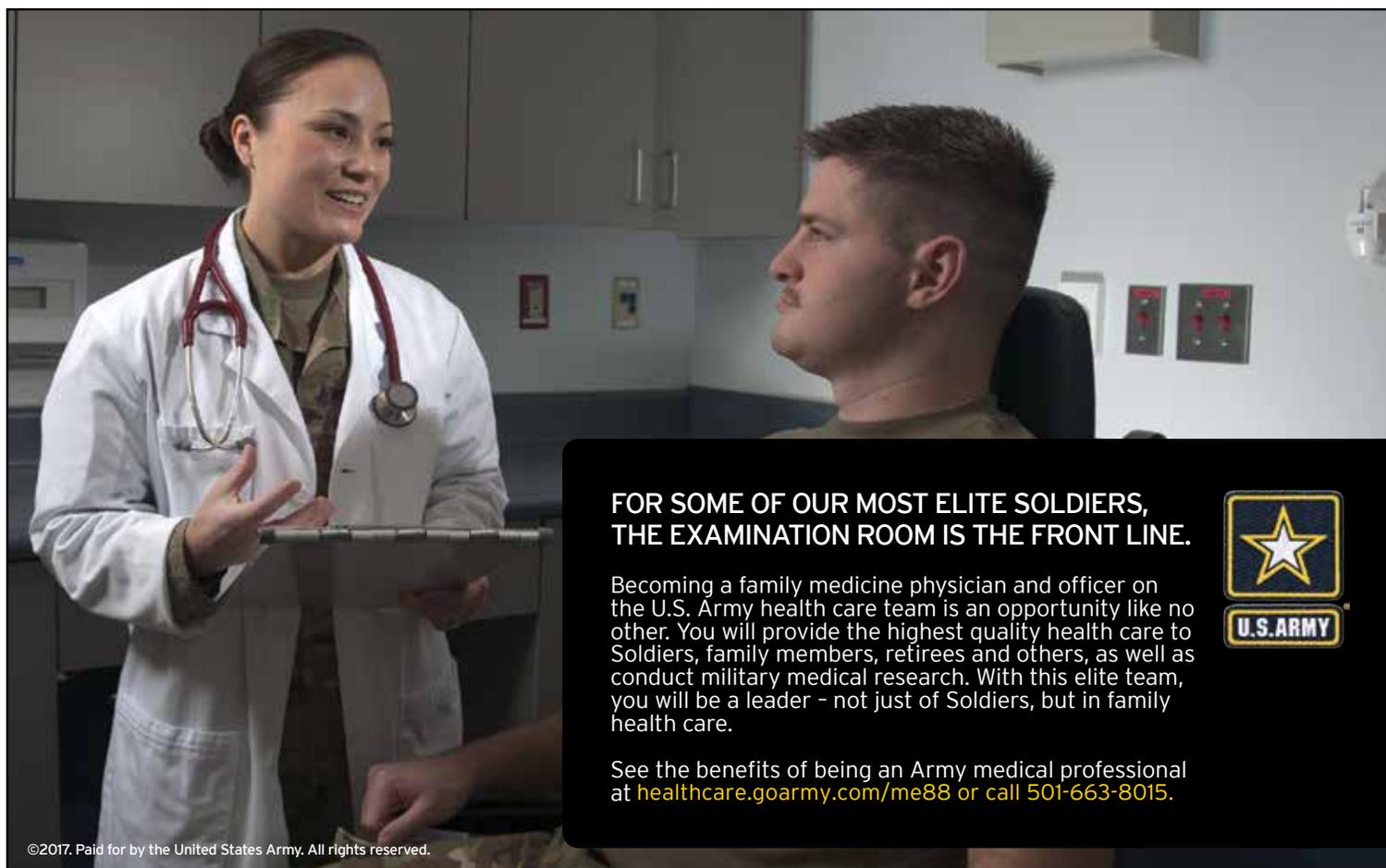
“Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2018–19 Influenza Season(https://www.cdc.gov/mmwr/volumes/67/rr/rr6703a1.htm?s_cid=rr6703a1_w)” has been published. CDC recommends annual influenza vaccination for everyone 6 months and older with any licensed, age-appropriate flu vaccine (IIV, RIV4, or LAIV4) with no preference expressed for any one vaccine over another. Content on this website is being updated to reflect this most recent guidance. More information about the upcoming 2018-2019 flu season(<https://www.cdc.gov/flu/about/season/flu-season-2018-2019.htm>) is available by going to www.cdc.gov/flu/professionals/index.htm

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Quality Reporting Support for Facilities

Are you responsible for quality reporting in a health care facility? Do you need help finding resources and guidance?

The TMF Quality Innovation Network, under contract with the Centers for Medicare & Medicaid Services (CMS), provides free assistance to educate and guide you through quality reporting for critical access hospitals, ambulatory surgical centers, hospitals and inpatient psychiatric facilities. Access individual support from a quality improvement consultant, join the TMF QIN Learning and Action Network to find educational resources, or view or attend a webinar.

Consultant Support

Contact the TMF QIN at QualityReporting@tmf.org to connect with a quality improvement consultant.

Learning and Action Network

Visit <https://tmfqin.org> and find the [Value-based Improvement and Outcomes](#) network from the “Networks” drop-down menu at the top of the page. Register for a **free** account to access educational materials, recorded and upcoming webinars, and email updates.

Educational Webinars

Attend a live webinar or access a recorded webinar to learn from subject matter experts about topics pertinent to your reporting.

Upcoming Event:

Is Your Hospital’s Quality Improvement Program Going Nowhere?

Join the TMF Quality Innovation Network on [Thursday, Aug. 30, noon – 1 p.m. CT](#), for a webinar focusing on how to develop and implement a productive quality improvement program for your hospital. We will walk step-by-step through the planning process and will discuss how to connect your quality measures to your hospital’s overall strategic goals. Our panel for this webinar will include speakers from different hospitals to discuss their barriers and successes related to streamlining and improving their quality programs.

Recorded Events:

Critical Access Hospitals: Your Essential Resources

Access this [recorded webinar](#) from May 17, 2018, hosted by the TMF QIN and the Rural Quality Improvement Technical Assistance Program (Stratis Health RQITA). This region-wide webinar included each of the local state support contacts to cover essential resources for critical access hospitals.

Ambulatory Surgical Centers Quality Reporting: Tips and Success Stories

View this [recorded webinar](#) from July 26, 2018, hosted by the TMF Quality Innovation Network and the Health Services Advisory Group (HSAG). This multi-state open forum webinar focused on ambulatory surgical center (ASC) quality reporting. Quality measure reports at the state level were shared, along with resources and tips that can assist you in improving your own reporting program. Several ASCs shared their personal success stories on how they have improved their ASC quality reporting.



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The Long-Term Risks of Common Sports Injuries

When we play sports, our knees, shoulders, spine, ankles, and hips each take extra wear and tear. Severe injuries to these areas might require orthopedic surgery to repair or replace damaged ligaments or cartilage. If these injuries go untreated, they can cause problems throughout life.

For many sports-related injuries, individuals can try rest and icing the spot—but unfortunately, that is not always enough for long-term relief. An orthopedic specialist at Arkansas Surgical Hospital can better assess each condition and explain the options for treating sports-related injuries.

Here are some of the most common sports-related injuries and the long-term risks associated with them:

ACL Tears

Torn cartilage and ligaments are common injuries for people who participate in sports, from the high school athlete to the active senior. The National Center for Sports Safety found that these injuries often contribute to the development of arthritis. However, with proper treatment from a sports medicine specialist and adequate rest, the risk of arthritis can be reduced.

Rather than going directly to surgical interventions, those with partial ACL tears are often encouraged to undergo extensive physical therapy to restore their knee function and learn ways to prevent future injuries.

Unfortunately, half of all ACL injuries are combined injuries, meaning they also result in damage to the meniscus, cartilage, or other ligaments. Combined ACL injuries will need reparative surgery to avoid secondary damage to the knee.

Fractures

Stress fractures are a common problem for athletes who engage in repetitive, weight-bearing activities. Examples of these activities include weightlifting, pitching, and rowing. Quickly switching directions

in active sports—like basketball, football, and soccer—can also cause stress fractures.

Fractures require immediate medical attention to prevent the injury from becoming worse. Severe fractures or complete breaks may require surgery in order to make the bone whole again.

A person who suffers a stress fracture has a greater risk of experiencing another one later in life, so it's important to prevent them from happening at all. A sports medicine specialist can advise athletes on the best practices to avoid stress fractures.

Dislocations

Dislocations require immediate medical care in order to realign the joint. Lingering pain and other symptoms can occur if the soft tissue around the affected joint is damaged. Having the joint immediately reset can help prevent long-term damage.

Surgery might also be needed for recurrent dislocations, which can limit a patient's ability to participate in sports for an extended period.

When problems arise from a sports-related injury, call Arkansas Surgical Hospital at 877-918-7020 for help making an appointment with a sports medicine specialist.

Dear Friends,

I hope this brief essay finds you well. Over the last two centuries there have been a number of delightful country physicians scattered around this state of ours. In the last several years I have had the wonderful opportunity to research many of their lives and communities. Over the next few issues I will be sharing the lives of these men and women. I hope you enjoy.



by: Sam Taggart, M.D.,
Family Physician and Author

Dr. Leonidas Kirby of Harrison



LEONIDAS KIRBY,
Harrison, Ark.

“Dr. Leonidas Kirby was as near the ideal of what a country doctor should be as this section of the state has ever known.” This was quote from an article by Ralph Hull for the Arkansas Gazette in 1931, six years after the good doctor passed away.

Both his father and his maternal grandfather had been physicians in southern Missouri. He completed his public-school education in Mound City, Missouri. While in school he worked in a drug store. He first arrived in Harrison, Arkansas in 1871 and opened a drugstore. In his first winter in Boone county there was a sever epidemic of diphtheria and

because of his modicum of education in medicine he was actively recruited by the community to intervene. In 1875, he returned to school at St. Louis, by 1879 had completed his medical education and had a degree in medicine.

One of the events that cemented his relationship with rest of the community was an event that occurred soon after he arrived in town. The young child of G.J. Howells had inhaled a quantity of corn, some of which was stuck in the child’s airway. The young doctor met the frantic father and his cyanotic child on the street of Harrison. Assessing the situation, he pulled out a pocket knife, laid the dying child down on the street and did a tracheotomy. The child survived, and Dr. Kirby’s reputation was made.

In the early days there were few

roads and the ones that did exist were almost impassible most of the year. He had a reputation of making his sickest call early in the morning often sleeping on horseback. He was always cheerful. He would often enter the home before dawn with a hearty “Good Morning,” making the patient feel that he should get well just to please the doctor. He seldom wrote prescriptions, compounding his own medicines from his stock of drugs at the store or if on a call from rows of vials he carried in his pill bags and satchel.

Kirby was active in his community including playing Santa Claus at Christmas. He was described as “so nearly like his roly-poly self with full white beard that he didn’t fool many of the children.”

Of his four sons three became doctors and one a druggist. One of his sons returned and practiced with him.

His daughter married a physician and the druggist-son married a physician's daughter.

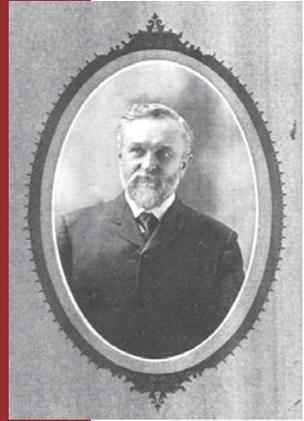
In addition to community involvement, he was active in the Arkansas Medical Society. In 1905, when the medical society was working to strengthening the state medical laws, he presented a paper entitled "Some Needed Medical Legislation" that called for the creation of an effective state board of health and a new attempt to pass a state pure food and drug law.

One of his favorite sayings was, "I would rather wear out than rust out." A few days before his death he suffered an attack of heart trouble. He told his relatives and friends that it was just a matter of time until he would pass away, "*My heart is worn out.*"

When he did die, he left behind a grateful community and a legacy of descendants who continue to this day practicing the healing arts.

The following is an excerpt from a poem, written by Walt Mason and published in the Emporia Kansas Gazette in 1916. The poem is entitled: **Prescription for a Doc:**

It mattered not how storms were roaring,
Nor how the darkness grew more thick,
Nor how the chilling rain was pouring—
The doctor went to heal the sick,
His years are sixty-five, and truly the
Doc's entitled to a rest;
But at that thought he grows unruly—
He still is full of vim and zest.
Still active, and with zeal unflaggin', and
Eager yet to help and please,
He travels in his mountain wagon,
To put a spoke in some disease.



Goodspeed Biographical and Historical Memoirs of the Ozark Region, p.317-318

Centennial History of Arkansas, p484-485) (Hull, Ralph, Country Doctor Was Beloved Character, Arkansas Gazette, Sunday Magazine, March 22, 1931, p 9

Arkansas Country Doctor Museum, Hall of Honor, last accessed 4-3-2018)

Walt Mason prescribes for a Doc, Boone County Historian, Vol 23(3) 61. July-Sept 2000



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FAQ

on the Medicare Annual Wellness Visit (AWV) and Initial Preventive Physical Examination/Welcome to Medicare Preventive Visit

- Why should I consider implementing Medicare's Annual Wellness Visits?
- Is there a difference between the Initial Preventive Physical Examination (IPPE)/Welcome to Medicare Preventive Visit and the AWV?
- Can the IPPE be done if 12 months have elapsed since enrollment in Medicare Part B?
- Is the AWV the same as an annual physical exam?
- What is the cost to the beneficiary?
- What information is necessary to educate the beneficiary?
- Can the patient complete any portion of the AWV?
- What steps does my practice and patient take to complete the components of the AWV?
- What steps does my practice take to complete the components of the IPPE?
- Who can perform the AWV?
- What codes are used to file claims?
- How do I bill for the yearly physical exam and AWV?
- Can evaluation and management (E/M) services be provided the same day as the AWV?
- Does the patient need to sign a consent form for the AWV or IPPE?
- What happens if another provider files a Medicare AWV?
- How can I check a Medicare patients' billing history to see whether or not they have received an AWV within the past 12 months, so I know whether Medicare will cover the AWV I am about to provide?

Why should I consider implementing Medicare's Annual Wellness Visits? Medicare's Annual Wellness Visit (AWV) is a way for your practice to keep patients as healthy as possible. As health care moves from volume- to value-based models, the AWV addresses gaps in care and enhances the quality of care you deliver. A personalized prevention plan created for the Medicare beneficiary is a way to improve patient engagement and promote preventive health care.

Medicare Part B. The AWV is covered only after the first 12 months of Medicare Part B coverage have passed. The AWV can be provided annually once per 12-month period thereafter.

Can the IPPE be done if 12 months have elapsed since enrollment in Medicare Part B? No. Patients are only eligible within the first 12 months of Medicare Part B enrollment for an IPPE/Welcome to Medicare Preventive Visit.

Is the AWW the same as an annual physical exam? No. The AWW does not replace a complete head-to-toe physical exam. A yearly physical CPT codes: 99381-99397) is never a covered service.

What is the cost to the beneficiary? The AWW is covered 100% by Medicare. There is no deductible or coinsurance owed by the patient.

What information is necessary to educate the beneficiary? Medicare pays 100% for the AWW and focuses on health promotion and prevention. A problem-oriented visit is not part of this benefit and is subject to deductibles or coinsurance.

Can the patient complete any portion of the AWW? Yes. The patient may be asked to complete portions(www.cms.gov) of the IPPE or AWW prior to the appointment, such as demographic information and self-assessment of health status. The AAFP's *FPM Journal* has several patient surveys and questionnaires for patients and/or your staff to complete.

What steps does my practice and patient take to complete the components of the AWW?

1. Administer a health risk assessment (HRA). Access a health risk assessment and other patient surveys and questionnaires at the AAFP's *FPM Journal*. Keep in mind the following items when administering an HRA:

- The practice or beneficiary may complete an HRA before or during the AWW.
- Communication needs (such as

individuals with limited health literacy or English proficiency) may need to be accounted for to fit the patient's needs.

- An HRA should not take more than 20 minutes to complete.
- At a minimum, collect and document information about:
 - Demographics;
 - Self-assessment of health;
 - Psychosocial risks;
 - Behavioral risks;
 - Activities of daily living (ADLs), including, but not limited to dressing, bathing, and walking; and
 - Instrumental ADLs, including, but not limited to shopping, housekeeping, medication management, and the handling of finances.

2. List current providers and suppliers of health care.

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Joe Elser, MD Pediatrician



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3. Establish medical and family health history.

- At a minimum, collect and document information about:
- Medical events of parents, siblings, and children, including disease(s) that are hereditary or place the beneficiary at increased risk.
- Past medical and surgical history, including illnesses, hospitalization(s), operations, allergies, injuries, and treatments.
- Current medications and supplements.

4. Document risk factors for potential depression, including current or past experiences with depression or other mood disorders.

- For beneficiaries without a current diagnosis of depression, use the appropriate

screening instruments, including this patient health questionnaire (www.uspreventiveservicestaskforce.org) from the U.S. Preventive Services Task Force (USPSTF). You may select from various standardized screening tests designed for this purpose that are recognized by national professional medical organizations.

5. Review functional ability and level of safety.

- Use direct observation, select appropriate screening questions, or utilize a screening questionnaire from recognized national professional medical organization. At a minimum, these should assess:
- Ability to perform ADLs;
- Fall risk (www.cdc.gov);
- Hearing impairment; and
- Home safety.

6. Conduct a general health assessment.

- Obtain and document information about:
- Height;
- Weight;
- Body mass index (BMI);
- Blood pressure; and
- Other routine measurements appropriate to gather a thorough medical or family history.
- Detect cognitive impairment(s) the beneficiary may have by the:
- Direct observation of the beneficiary's cognitive function, taking into account information obtained from the beneficiary directly or from concerns by family members, friends, or caretakers.

7. Counsel the beneficiary.

- Establish a written screening schedule, such as a checklist for the next 5-10 years. Base the written screening schedule on:
- Age-appropriate preventive services covered by Medicare;

- Recommendations from the USPSTF and the Advisory Committee on Immunization Practices (ACIP); and
- The beneficiary's HRA, health status, and screening history.
- Establish a list of risk factors and conditions for which primary, secondary, or tertiary interventions are recommended or underway for the beneficiary. These may include:
- Any mental health conditions or any risk factors or conditions identified through the IPPE; and
- A list of treatment options and their associated risks and benefits.
- Furnish personalized health advice to the beneficiary and provide a referral to health education, preventive counseling services, or programs, as appropriate. Referrals to programs are aimed at:
- Fall prevention;
- Nutrition;
- Physical activity;
- Tobacco use and cessation; and
- Weight loss.

What steps does my practice take to complete the components of the IPPE? The AAFP has developed a Medicare Wellness Visit Toolkit that goes over the elements of the IPPE.

Who can perform the AWW? The following health care providers can perform the AWW: a physician who is a doctor of medicine or osteopathy, physician assistant (PA), nurse practitioner, certified clinical nurse specialist, or medical professional, including a health educator, registered dietitian, nutrition professional or other licensed practitioner, or a team of medical professional working under the direct supervision of a physician (doctor of medicine or osteopathy).

What codes are used to file claims?

IPPE – G0402

- EKG/ECG with IPPE – G0403

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- Other codes that are applicable – G0404 and G0405
- Initial AWV – G0438 (includes personalized prevention plan of service)
- Subsequent AWV – G0439 (includes personalized prevention plan of service)

How do I bill for the yearly physical exam and AWV? The yearly physical exam is not a covered benefit for the beneficiary and would need to be billed to the patient. However, Medicare pays 100% for the AWV. After the first 12 months of Medicare Part B enrollment, the beneficiary is eligible for the initial AWV and subsequent AWVs. This allows AWVs to become an ongoing source of revenue.

Can evaluation and management (E/M) services be provided the same day as the AWV? Yes.

The appropriate E/M service may be billed in addition to the AWV. Report the CPT code with modifier -25. The E/M service is subject to a co-payment.

Does the patient need to sign a consent form for the AWV or IPPE?

No consent form is required for this benefit.

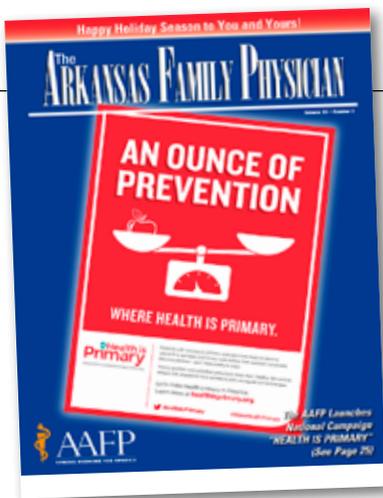
What happens if another provider files a Medicare AWV? This would depend on which provider submitted the claim first. The AWV can only be billed once in a 12-month period for a single beneficiary.

How can I check a Medicare patients' billing history to see whether or not they have received an AWV within the past 12 months, so I know whether Medicare will cover the AWV I am about to provide?

Contact your local Medicare administrative contractor (MAC) to verify whether the coverage requirements concerning time intervals between services have been met.

If the patient has moved or spent part of the year in another part of the country (e.g., is a "snowbird"), you may also need to contact the MAC for the part of the country where the patient lived previously. You can identify the relevant MAC and their contact information through this interactive map(www.cms.gov) from CMS.

Alternatively, you may want to access the CMS HIPAA Eligibility Transaction System (HETS) Help (270/271)(www.cms.gov), a secure website you can use as your primary Medicare information source for patient eligibility and liability. HETS is available at no cost to you at any time, with limited functionality outside of normal business hours.



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Security Risk Assessments Protect You and Patients

By Breck Hopkins, JD and Steven Chasteen, MNSC, RN

Don't take your annual security risk assessment (SRA) lightly. The successful completion of audits, random compliance reviews and complaint investigations depend upon your SRA. If your SRA is not current, is incomplete, or staff is not complying with it, you could risk losing a substantial amount of reimbursement and must pay fines if you're audited. Problems with your SRA also leave your patients' protected health information (PHI) vulnerable to breaches of the Health Insurance Portability and Accountability Act (HIPAA).

An SRA evaluates the risks and vulnerabilities in an organization's environment and includes appropriate security measures to protect the integrity and security of the patients' PHI.

The HIPAA Security Rule applies to ALL electronic patient health information that is created, received, maintained or transmitted by an organization. The Security Rule requires the organization and each of its business associates to conduct an SRA. A business associate includes any person or entity that creates, receives, maintains or

sends PHI on behalf of a provider, practice, hospital or other entity that provides health care services to individuals.

The Department of Health and Human Services (HHS) recommends that SRAs be ongoing but it has not adopted minimum SRA-frequency requirements. The industry standard is to conduct SRAs annually to keep pace with changing technology and information environments. SRAs must be completed/updated when

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you add new technology or make other changes that could affect electronic PHI.

Completing an SRA and correcting any deficiencies that are found is a core requirement of many incentive and quality-improvement programs. Annual SRAs are required to qualify for electronic health record (EHR) Meaningful Use incentive payments. They are also required annually to satisfy the Quality Payment Program (QPP) Merit-based Incentive Payment System (MIPS) and Advancing Care Information (ACT) standards for Medicare patients.

SRAs protect you

- A comprehensive SRA identifies security gaps so you can document and create an action plan to address them. SRAs can prevent data breaches, and improve the outcome of HIPAA compliance audits or

complaint investigations. SRA documentation is required if you are audited. Strong audit trails are a critical component of any security strategy. A deficient SRA is the primary reason that an organization fails to pass an EHR audit.

If HHS audits or investigates your practice or hospital, you must submit a tremendous amount of detailed documentation, including:

- Policies, procedures and evidence of security efforts
- Proof of prevention, detection, containment and correction of security violations
- Authentication methods used to identify users with access to private information
- Lists of individuals and contractors with access to private information
- Copies of business associate agreements
- Details about encryption,

decryption and destruction of private information

If you cannot produce a current and complete SRA, HHS will impose a civil money penalty for that alone. If an audit or investigation identifies a potential HIPAA data breach or other compliance issue, any SRA-related flaw will add to the civil penalty amount, even if the breach or other noncompliance was unrelated to the SRA problem.

SRAs evaluate safeguards

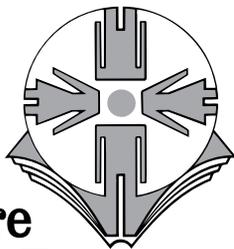
SRAs evaluate a wide range of safeguards over electronic PHI, including technical, administrative and physical safeguards.

- **Technical safeguards** include the technology, policies and procedures for its use that protect electronic PHI and control access to it. Technical safeguards include information technology (IT) standards for firewalls, data encryption and access protocols. They include unique-user

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- **Administrative safeguards** are administrative actions, policies and procedures to manage the selection, development, implementation and maintenance of security measures to protect electronic PHI. They also manage the PHI-related conduct of the covered entity's or business associate's workforce. Administrative safeguards include the designation of persons responsible for privacy and security, establishment of formal privacy and security policies, sanctions for employees who violate policies, business associate agreements, PHI access permissions and restrictions, PHI storage, incident response, disaster planning, contingency plans and job descriptions. They also include policy update processes, and policies for granting, denying or terminating employee access to EHR.
- **Physical safeguards** are physical measures, policies and procedures to protect a covered entity's or business associate's electronic information systems. They also physically protect related buildings and equipment from natural and environmental hazards and unauthorized intrusion. Physical safeguards include controlled environments to protect equipment, controlled facility access and internal facility access, workstation use policies and procedures, portable device security, workstation visibility protections, hardware/media assignment/movement records, data destruction and limitations on network access to employee-owned equipment.

SRA help is available

HHS prefers that SRAs be an ongoing process. However, if you want your

Meaningful Use incentive payments, you must have an SRA for each annual Meaningful Use reporting period.

You may conduct an SRA yourself or use external assistance. Many health care organizations and practices have their IT staff conduct internal SRAs, if they have the necessary expertise and experience. HHS offers a free SRA tool to help guide providers who want to conduct risk assessments of their organization. The tool is designed to help practices document the SRA information in a thorough and organized manner.

Audits require a tremendous amount of detailed documentation, extensive knowledge of security, and details about how your clinic handles and manages individual patient information.

A competent and thorough SRA cannot be conducted, and deficiencies corrected, without extensive knowledge of HIPAA privacy and security rules and the ever-evolving information security technologies. Seeking external

assistance can be worth the investment.

SRA specialists often can do the work more efficiently and reduce the chances of missing a potential vulnerability. In addition to saving time and money, SRA specialists minimize intrusion on day-to-day operations without diverting your administrative and IT staff from critical support functions.

Organizations such as AFMC offer comprehensive SRAs under the HIPAA Security Rule as a paid service. AFMC staff is highly experienced and has in-depth knowledge of HIPAA compliance standards and SRA requirements. For nearly 20 years, AFMC has successfully helped practices and providers complete their SRAs. For more information about SRAs, visit <https://afmc.org/services/security-risk-analysis/>.

Mr. Hopkins is AFMC's general counsel and Mr. Chasteen is director of practice transformation at AFMC.



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AAFP Adds Five New 'Choosing Wisely' Recommendations

August 15, 2018

Chris Crawford

The AAFP has added five new recommendations to its Choosing Wisely list, (www.choosingwisely.org) which highlights medical tests, treatments and procedures that may be unnecessary and should prompt discussion between patients and their physicians.

The additions cover pelvic exams, home glucose monitoring, screening for genital herpes simplex virus (HSV) infection, testicular cancer screening and blood transfusion.

New Recommendation Specifics

AAFP Commission on Health of the Public and Science member James Stevermer, M.D., of Fulton, Mo., told *AAFP News* the commission vetted multiple possible recommendations, working from current AAFP clinical policies and reviewing Choosing Wisely recommendations from other organizations.

"We focused on topics that had evidence to support our recommendation, and where we knew the benefits, if any, did not justify the cost, risks and harms to patients," Stevermer said. "After narrowing our slate, we moved these through two subcommittees of the commission, as well as the entire commission. Once finalized there, we moved the recommendations to the Board of Directors for their approval."

The AAFP's five recommendations are as follows:

Don't perform pelvic exams on asymptomatic nonpregnant women unless necessary for guideline-appropriate screening for cervical cancer.

"The only exception for screening is appropriate cervical cancer screening procedures (e.g., Pap smears)," Stevermer said. "There is little evidence that the exam itself finds problems that would benefit the patient by finding early. However, studies have shown that pelvic exams can lead to more invasive testing and procedures. Some data also suggest that the prospect of a pelvic exam keeps some women from seeking routine care."

Stevermer said it was important to note that this recommendation does *not* apply to women who have symptoms, in which case a pelvic exam can help determine appropriate treatment for their condition.

Don't routinely recommend daily home glucose monitoring for patients who have type 2 diabetes mellitus and are not using insulin.

Stevermer said a series of studies the group examined was fairly consistent in showing that daily glucose monitoring in patients not using insulin has little effect on hemoglobin A1c testing or other measures of blood glucose control. Some of these studies noted that when patients monitor their glucose daily, they were more likely to be depressed or anxious, he added.

"Here's a case where we have testing that doesn't improve glucose control, but costs money and stresses patients out -- exactly the type of practice that the Choosing Wisely program is trying to reduce," Stevermer said.

Don't screen for genital HSV infection in asymptomatic adults, including pregnant women.

This recommendation aligns with the U.S. Preventive Services Task Force's (USPSTF's) 2016 final recommendation (www.uspreventiveservicestaskforce.org) to not screen serologically for herpes simplex, which the AAFP supports.

"There is relatively little benefit to most people by screening, and at typical prevalence in the United States (15 percent), half of the screening tests will be falsely positive," said Stevermer.

Don't screen for testicular cancer in asymptomatic adolescent and adult males.

This recommendation aligns with the USPSTF's 2011 recommendation (www.uspreventiveservicestaskforce.org) to not screen for testicular cancer, which the AAFP supports.

"Relatively little is known about how well screening will work, but even if highly accurate, it's not likely to add that much benefit," Stevermer explained. "Regardless of stage of presentation, testicular cancer treatment is highly effective."

Don't transfuse more than the minimum of red blood cell units necessary to relieve symptoms of anemia or to return a patient to a safe hemoglobin range (7 to 8 g/dL in stable patients).

"This recommendation is consistent with multiple randomized trials that show little benefit to transfusing above the 7-8 g/dL range (for most patients)," Stevermer said. "This recommendation also parallels those from the American Association of Blood Banks." (jamanetwork.com)

Value of Choosing Wisely

Stevermer said he thinks the AAFP's Choosing Wisely list will prove to be quite a valuable reference for family physicians.

"It's a reminder that more is not always better, and that by being judicious, we can reduce unnecessary interventions, with no harm coming to our patients," he said.

Stevermer recommended a 2015 *FPM* article titled "How to Help Your Patients Choose Wisely" as a nice overview of tactics that can help family physicians implement the Choosing Wisely list.

"Once they know what's on the Choosing Wisely list, family physicians can then use their knowledge of their patients and local community to help their patients make well-informed decisions," Stevermer concluded.

The American Board of Internal Medicine Foundation and *Consumer Reports* formally launched Choosing Wisely in 2012. Nine medical specialty organizations -- the AAFP among them -- joined the initiative at that time; since then, more than 80 such groups have signed on to the initiative.

AAFP President's Message

"Fighting for a Fee Schedule That works for You, Your Patients"

By: Michael Munger, M.D., President, AAFP

Leawood, Kansas

CMS released the 2019 Medicare physician fee schedule and Quality Payment Program proposed rule(s3.amazonaws.com) on July 12. Given the potential impact this proposed rule would have on family physicians and our patients, as AAFP president, I felt it important to provide an update on both the proposal and the AAFP's related advocacy work. I understand there are concerns about this proposal. The AAFP shares these concerns and is expressing its misgivings to HHS and CMS as we simultaneously prepare our comprehensive response to the proposed rule.

I would urge each of you to access the resources made available by the AAFP to assist you in learning more about the proposed rule and its potential impact on your practice. We have produced a summary on the subject(2 page PDF) and published some initial analysis in the Fighting for Family Medicine newsletter via the In the Trenches blog. In addition, earlier this month, the AAFP hosted a webinar outlining the proposed rule and its content, featuring staff from CMS. An archived version of the webinar and the accompanying slide deck are available to all AAFP members.

The 2019 proposed rule contains several provisions that will impact each of us and our practices. Over the past few weeks, the AAFP has carefully analyzed the 1,400-plus pages of the proposed rule, taking extra care to model the payment impact of the various provisions, independently and collectively, on family physicians. Although the proposed changes to evaluation and management (E&M) codes are top of mind for most family physicians, there are other important adjustments that will have short- and long-term impacts on our specialty and our patients. I assure you we are carefully analyzing all these issues to best represent our interests and those of our patients.

Your AAFP leadership and professional staff have been actively engaged in analyzing the rule, evaluating its impact and preparing the AAFP's response. In addition, over the past month, we have directly engaged with senior leadership at HHS and CMS, including Administrator Seema Verma, M.P.H., regarding the proposed rule on several occasions. These conversations provide the AAFP an opportunity to learn more detail from CMS and provide directed feedback on behalf of each of you. We've also shared our initial views with key congressional committees and are prepared to initiate a full lobbying campaign should it become appropriate and necessary.

In short, be assured we've heard you and have your back. We are fighting every day to promote the interests of our

members and protect the foundations of family medicine. Based on our analysis, we've identified several provisions that raise concerns, some that are in need of greater clarity, and others that are positive. Allow me to outline a few items:

The goals: We view the goals CMS is attempting to accomplish -- coding simplification and a potential reduction in documentation -- as positive and consistent with AAFP policy, but we have significant concerns regarding how CMS proposes to accomplish these goals. We applaud CMS for bringing these issues to the forefront and proposing some initial solutions, and it is now our responsibility to evaluate those solutions and respond appropriately on behalf of our members and for our specialty.

Documentation guidelines: The AAFP strongly challenges CMS' assertion that the documentation, coding and payment provisions must be combined to be implemented. It is our opinion CMS can and should initiate reductions in documentation and administrative burden regardless of any changes in coding standards and payment options. We are developing a recommendation that will allow CMS to reduce the documentation requirements independent of the coding and payment decisions.

E&M codes: The proposal to simplify the E&M codes for both new and existing patient visit codes is conceptually consistent with the AAFP's position that coding for services needs to be easier and less burdensome. However, we strongly believe that any new or revised codes must reflect the complexity of family medicine and support comprehensiveness and continuity. The current proposal -- to collapse payment into a single amount for levels 2-5 for new and established patients -- will not achieve this intent and is fundamentally flawed. Our data show that, over the past few years, family physicians have more accurately coded for complexity and services. As a result, we've seen a significant decrease in the number of 99213 codes and an increase in 99214 codes billed by family physicians. Based on our modeling, in 2021, 99214 codes will account for more than 60 percent of all visits to a family physician. Overall, we cannot support the proposed changes to E&M coding and payment in its current form.

Primary care add-on payment code: Although the AAFP strongly supports increasing the overall spend

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on family medicine and primary care, the proposed primary care “bonus” payment of \$5 as outlined in the CMS rule is woefully insufficient. This will not achieve the desired outcome of reflecting the complexity and comprehensiveness of the care we deliver daily.

Multiple procedure payment reduction: The proposed rule would require a 50 percent reduction in payment of procedures provided at the time of an E&M visit via a -25 modifier. The AAFP strongly opposes this policy. We have forcefully opposed this when recommended by commercial insurers and we will continue to oppose its implementation in the Medicare program.

Patient-centered primary care: The proposed rule undercuts advances we have made to provide comprehensive primary care in every visit. This proposal incentivizes physicians to perform fewer services per visit and to conduct more physician visits per patient. This is not patient-centered, and it is not how you and I want to practice medicine. Medicare should pay family physicians for the comprehensive care we provide instead of forcing us to churn our patients to remain economically viable.

Advanced primary care: The AAFP is most disappointed that CMS continues to attempt unrealistic

reforms of the broken fee-for-service system. Our proposal to CMS for an Advanced Primary Care Alternative Payment Model (APC-APM)(38 page PDF) for family medicine and primary care would allow CMS to accomplish its three goals of reducing the burden of documentation, simplifying coding and increasing the overall spend on primary care in a seamless manner. We continue to strongly advocate to CMS that the path to achieving their goal is directly in front of them. The agency should act immediately to implement the APC-APM proposal.

Please be assured that the AAFP will respond to this proposed rule prior to the Sept. 10 deadline. Our response will be available at the Fighting for Family Medicine hub, and we will publish a summary of our response letter in *AAFP News*. If you have comments on our approach, or if you wish to share recommendations on how the AAFP should respond to the proposed rule, please email AAFP Senior Vice President of Advocacy, Practice Advancement and Policy Shawn Martin at smartin@aafp.org with the subject line “MPFS2019.”

These are the times when the AAFP serves as a bold champion on your behalf to achieve what is best for us and our patients. Thank you for your membership and support of the AAFP and all that you do every day for your patients, your communities and our specialty. If you have any other concerns or comments, as always, please let me know.

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