MGMA
Medical Group Management Association
Indiana

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The Pulse

June 2017

Final Message from Our Outgoing IMGMA President

Jim Butterfield

This year has flown by in so many ways. When I was asked to serve on the board of IMGMA, and then asked to serve as President-elect and President, I was concerned about the time commitment away from my day-to-day responsibilities. However, like every other service opportunity I have experienced in my life, you normally get more out of it than you are ever able to give. This has been my experience with IMGMA and this board and our Administrator Angie Stevenson.

For the last 4 years, I have witnessed a true energy arise from within the state of Indiana! The board and committee chairs have been so committed to IMGMA that your chapter is in great shape for the foreseeable future … and that is a testament to the group I have been privileged to work with.

The camaraderie you gain from meeting with these professionals on a monthly basis, and sometimes more often, was exactly what I was looking for when I joined the board. Getting to know the Business Partners and working with them at the board level has allowed me to gain a deeper insight into this world we call "healthcare" that I would never have received if not for my involvement in IMGMA and serving on the board.

As my term as your President comes to an end, and Phil Ellis takes the reins, I look forward to supporting him and the board at whatever level they request. Please consider your involvement in IMGMA as a unique and enriching opportunity to learn from some of the best in our industry. I hope for IMGMA's sake that as practice managers in Indiana we all give our full support to this highly beneficial association so that you have the opportunity to experience what I have.

I look forward to seeing many of you at our Annual Conference in Chicago!

by Jim Butterfield
CEO, Evansville Surgical Associates

EVANSVILLE SURGICAL ASSOCIATES

On the Calendar:

- **July 26-27, 2017**: Indiana/ Illinois MGMA Annual Conference
- **October 8-11, 2017**: MGMA 2017 Annual Conference

In This Issue:

Message from Our New IMGMA President

Phil Ellis

In 1883 the first physician practice was formed. In that same year, the first issue of *Life Magazine* was published, the Brooklyn Bridge opened to auto traffic, and the Mayo Clinic opened. Since then, The Bridge still carries 120,000 vehicles each day, the Mayo Clinic is still a world leader in healthcare, and *Life Magazine*, well forget that one, but group practices are still a vital part of healthcare across the US. MGMA, along with its 33,000 administrators and executives in 18,000 healthcare organizations who serve 385,000 physicians, keep those medical practices under strong leadership.

Now as I follow the footsteps of those who have served as your Indiana MGMA President, we find ourselves in the midst of the most dynamic paradigm shift in physician healthcare in decades. Practice consolidation and acquisition, Population Health, Quality Based Reimbursement, MACRA, etc. alter practice management like nothing before … and we thought capitation was a game changer!

My focus as President will center in three areas:

1) identifying and investing resources into restoring the level of engagement, culture, and relationships we enjoyed as an association in the past,
2) expanding membership among hospital owned/ managed practices; and
3) elevating our association benefits to members through "Partnering."

Yes we have challenges, but I don't see these challenges as a problem for us … just the opposite, I see them as sources for opportunity. The fundamental model upon which I will rely to accomplish these three areas of focus originates with "The New 4 P's of Marketing" as identified by Jackie Scott, Executive Education Team at Rutgers University: (adapted for associations):

- Purpose – Members are searching for meaning and utility that goes beyond traditional features and benefits.
- Presence – Rather than just buying presence, modern member habits expect brands to be supportive and accessible.
- Proximity – Big Data, the rise of mobile communication requires brands to be wherever and whenever, and to communicate in more meaningful and relevant ways.
- Partnerships – Extend network to create solutions that accelerate innovation, provide access to new markets, increases credibility, extends reach, and reduces acquisition costs.

I am fortunate to serve this chapter along with a strong Board of Directors and an excellent Association Administrator, Angie Stevenson. These tenured colleagues bring a wide array of perspectives to physician practice management. We have members with the courage and leadership to recognize not only what makes our chapter successful, but what modifications must be considered to ensure our relevance in the future.

In closing, I not only welcome your feedback, I expect it! So let's have some fun and do some cool things together!

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by Phil Ellis
Director of Member Engagement & Development,
Indiana Rural Health Association

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Data Analytics: The Transition from Data to Strategic Decision Making

Mandi M. Clossey, CPA

The role of the finance department is shifting from managing the practices day-to-day finance activities (i.e., accounting, payroll, budgeting, etc.) to becoming a strategic thought partner in providing the right insights at the right time to support organizational decision making. Although generating accurate financial statements and physician compensation calculations are key financial tasks, the benefits of deeper data analytics and benchmarking are pretty amazing.

Benchmarking is the process used to compare practice financial, operational and physician productivity to internal key performance indicators (KPI's) and external standards (i.e, practices in the same medical specialty in your area or across the country). Benchmarking is an important tool used to identify both best practices and areas where improvement may be needed. There are three main types of benchmarking:

- Performance Benchmarking: makes quantitative comparisons of other practices' performance metrics.
- Process Benchmarking: evaluates the business procedures that other practices use.
- Strategic Benchmarking: analyzes the driving strategies behind successful practices to identify possible alternative strategies and ways of improving performance.

Benchmarking and key performance indicators should not imply that a successful practice conforms to a narrow set of standards that are universal; therefore, a practice must supplement the traditional metrics-focused approach (performance benchmarking) with an analysis of why and

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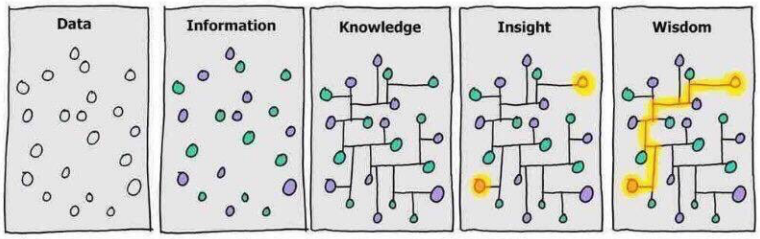
how practices produce exceptional results. Benchmarking is not just copying what other successful practices are doing. It involves not just understanding what best in class practices goals are and how they have achieved those goals through process and operations improvement; it is also taking that information back to your practice to determine how to achieve comparable results given your unique internal and external conditions.

However, despite the need for strong analytics, many organizations often struggle in this area, in part due to the sheer volume of available data. Since practices have adopted more practice management technologies, there has been a data explosion. Unfortunately, as volume has gone up, access to meaningful information on which to make sound decisions has dropped because practices are unable to fully appreciate the data they have. Also, having multiple practice management and financial solutions, yielding disparate data takes time and resources to normalize and translate into useable information.



Somerset's Healthcare Team has developed a proprietary benchmarking survey and data analytics tool providing a high degree of transparency allowing the practice to trust the information and receive it in a timely fashion without having to spend critical resources sorting through disparate data and semantics and arguing over whose answer is right or whose truth is more accurate. For instance, practice managers can look at patient visit and surgical volume pattern variations to quantify staffing level differences potentially needed across practice locations and even between providers. Also, the practice can review ancillary service line profitability and understand where best practices exist and where it can make improvements. We've spent a lot of time in practice data analytics. The intent of data analytics is not to scare you straight with underperforming areas but to acknowledge current successes and opportunities for improvement. To stay relevant we're going to have to rethink how we do business. Are you ready to change? Because here is the thing: If we don't start filling the gaps, our competition will.

By Mandi M. Clossey, CPA
Somerset CPAs and Advisors

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CPAs AND ADVISORS

New Coding Guidelines for Moderate Sedation

The removal of moderate (or conscious) sedation from hundreds of CPT codes and the creation of six new codes to be used for billing the service means providers who perform moderate sedation, even those who also are performing primary services, have more options for being reimbursed for their work. The changes were effective beginning January 1, 2017.

Medicare offered its stamp of approval for unbundling the sedation and primary services in the 2017 Medicare Physician Fee Schedule, saying, "This coding change [provides] for payment for moderate sedation services only in cases where it is furnished."

According to the *Physicians Practice* article, "Coding for Moderate Sedation is Different in 2017," the six new codes for billing moderate sedation allow providers to indicate who performs the sedation, how long the sedation service lasted, and the age of the patient.

Code	Provider Performing Sedation and Primary Service	Code	Provider Performing Sedation but not Primary Service
99151	"initial 15 minutes of intraservice time, patient younger than 5 years of age"	**99155**	"initial 15 minutes of intraservice time, patient younger than 5 years of age"
99152	"initial 15 minutes of intraservice time, patient age 5 years or older"	**99156**	"initial 15 minutes of intraservice time, patient age 5 years or older"
99153	"each additional 15 minutes intraservice time (list separately in addition to code for primary service)"	**99157**	"each additional 15 minutes intraservice time (list separately in addition to code for primary service)"

Another change in the moderate sedation coding guidelines is the length of the intraservice time required to bill for the service. According to CIPROMS Coding Liaison Cara Geary, previously the threshold for coding moderate sedation was 16 minutes. With the new codes, physicians can bill sedation if they spend 10 or more minutes in intraservice time. Additionally, at least seven minutes must pass to report an additional unit.

"This is closer to what [ER physicians] are doing with simple joint dislocation reductions," Geary said. "Prior to these new codes, there were a lot of instances where we could not bill sedation, but had to take all the risks for it. Now those are billable services."

For example, a phsician who spends 21 minutes sedating a 4-year-old patient could bill only 99151 for minutes 1-15. Minutes 16-21 would not be billable because they didn't add up to at least seven minutes. However, if that same physician spent 27 minutes sedating a 4-year-old patient, she could bill 99151 for minutes 1-15 and 99153 for minutes 16-27 since she spent at least seven minutes after the initial intraservice range.

For more information, review the CPT coding guidelines for codes 99151-99157.

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by CIPROMS, Inc.

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The Cost of Abandonment – Patient Records

Stephanie Eckerle

Meghan Linvill McNab

The 120th Indiana General Assembly recently enacted legislation to revise Indiana Code ("IC") 4-6-14 regarding abandoned health records. Under the current statute, the attorney general ("AG") may take possession of, store, maintain, transfer, protect, or destroy health records that the AG determines are abandoned (IC 4-6-14-5). The AG will also notify patients and those individuals identified in the health records that the AG has taken possession of the abandoned records. The current definition of "abandoned" means when a health care provider or regulated professional voluntarily surrendered, relinquished, or disclaimed records, with no intention of reclaiming or regaining possession.

The new legislation expands the definition of abandoned to also include when records are recklessly or negligently treated, such that an unauthorized person could obtain access or possession. The legislation also adds a definition for the previously undefined term "health records," which includes written, electronic, or printed information possessed or maintained by a health care provider concerning any diagnosis, treatment, or prognosis of the patient, including information that is possessed or maintained on microfiche, microfilm, or in a digital format. Health records also include mental health records, alcohol and drug abuse records, and records protected by HIPAA.

Under the new legislation, effective July 1, 2017, if the attorney general determines that health records are abandoned and takes action under IC 4-6-14 to take possession of, store, maintain, transfer, protect, or destroy health records, the AG may also file action against the health care provider or former health care provider who is or was responsible for maintaining or possessing the health records that have been abandoned, to recover costs incurred by the AG to implement IC 4-6-14 with respect to such records. Pursuant to such action, a court may order the health care provider or former health care provider to reimburse the AG's costs, if the court finds that the health care provider or former health care provider intentionally or negligently abandoned the health records.

Therefore, a health care provider or former health care provider that abandons health records, whether in paper or electronic form, by either: (i) voluntarily surrendering, relinquishing, or disclaiming the records with no intention of reclaiming or regaining possession; or (ii) recklessly or negligently treating such records such that an unauthorized person could obtain access or possession, may be required to repay to the AG for any costs incurred by the AG to take over the records and provide notice to affected patients. Practicing health care providers, and health care providers that are retiring or leaving the practice should take great care to ensure health records continue to be properly stored and protected to avoid any determination that the provider's records have been abandoned and the imposition of any cost by the AG. Retiring providers or providers leaving their practice should also ensure that they comply with Indiana law regarding discontinuing a practice, including retirement or leaving the community, as well as patient notification laws for when the providers withdraws from a case.

The legislation also revises IC 24-4.9-3-3.5 to ensure health records continue to be protected when a health care provider ceases to be a covered entity under HIPAA (such protection shall be in accordance with IC 24-4.9-3-3.5(c) and (d)).

A copy of SB549 is available here: https://iga.in.gov/legislative/2017/bills/senate/549#.

For any questions regarding this final rule and article, please contact Meghan Linvill McNab at mmcnab@kdlegal.com or Stephanie Eckerle at seckerle@kdlegal.com.

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by Stephanie Eckerle
Partner, Krieg DeVault LLP

***and* Meghan Linvill McNab**
Senior Associate, Krieg DeVault LLP

KRIEG DEVAULT

ACMPE Corner

MGMA will offer the following exam dates for 2017.

Exam Window	Registration
September 9 – 23	July 24 – August 4, 2017
December 2 – 16	October 23 – Nov. 3, 2017

Registration information is located online.

Track and Follow up on Your Tests

Jeremy Wale

Missed or delayed diagnosis is one of the most often litigated allegations in medical malpractice. These claims often result from tracking and follow-up procedure failures.

Lab testing is one of three key areas (the others are referrals to specialists and missed/canceled appointments) where tracking and follow-up are vitally important. A retrospective study researched the frequency of patients not being informed of test results, concluding there was a 7.1 percent failure rate. Tracking and follow-up procedural safeguards can be implemented and have a large impact on potential liability claims.

A reliable test tracking and follow-up system ensures the following steps occur:

- The test is performed.
- The results are reported to the practice.
- The results are made available to the ordering physician for review and sign-off.
- The results are communicated to the patient.
- The results are properly filed in the patient's chart.
- The results are acted upon when necessary.

Here are some suggestions for improving your process:

- Route all test results to the ordering physician for review. Procedures to ensure the ordering physician receives each and every test result can help lessen the risk of a result "falling through the cracks." Something as simple as a log book or email notification can help facilitate physician review.
- Ask the ordering physician to review and sign off on each ordered test result. Physicians order lab tests for specific reasons; physicians are encouraged to sign or initial each test result following review.
- Notify your patients. Several practices notify patients only when there is an abnormal result. Some practices choose to send a letter for normal results and call the patient for abnormal results. Others call patients with all results. In today's technology-driven world, an email may be appropriate for normal results, or an email directing patients to a portal where results can be reviewed. Patient notification of all test results is advised—however your practice chooses to do so.

Ensuring all tests ordered by your physicians are handled a consistent manner will help avoid tracking and follow-up errors. Develop a system which works within the context of your practice, and follow these protocols with every patient—helping to effectively and efficiently stay on top of test results.

By Jeremy Wale
Risk Resource Advisor , ProAssurance

ProAssurance
Treated Fairly

Join a Committee!

IMGMA encourages your participation on a committee! Please contact the office at 317.371.4354 or indianamgma@gmail.com, or on-line at www.imgma.net for more information on how you can get involved!

Get to know your Indiana MGMA Business Partners!

This Month's Spotlight Partner: Marcia Proffitt, Robard Corp.

Contact:
Marcia Proffitt
Robard Corporation
800-310-6259
marcia@robard.com
www.robard.com

Indiana MGMA: For members who are newer to the association and may not have met you yet, please tell us what Robard Corporation offers?

Marcia: Healthcare professionals count on Robard Corporation for our evidence-based medical obesity treatment programs and scientifically designed nutrition products. Our multi-disciplinary programs and wide variety of products help you improve patient health by decreasing chronic conditions related to obesity, while enhancing your overall revenue and patient census..

Indiana MGMA: What would be a few of the most compelling reasons an organization would use Robard Corporation?

Marcia: Comprehensive medical protocols; Continuous business growth and marketing resources; and Treating the whole person (Obesity and their associated medical conditions).

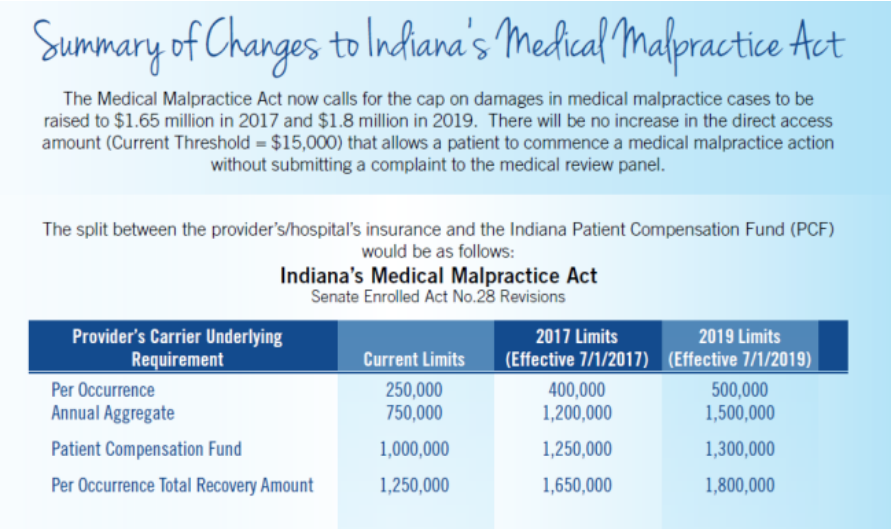
Indiana MGMA: Please share a recent success story you have from working with a medical practice client?

Marcia: I worked with Dr. Michelle Haendiges of Haendiges & Associates, P.C. to help her get her weight management program started at her practice. Like many physicians, she was new to obesity treatment and of course wanted to be sure that she could add this service without any interruption of her normal business flow. With the combination of our onsite training, online staff training resources, complete medical protocols, printable marketing materials, and other resources, she said she was thrilled with the ease of implementation and the variety of services and products we offer.

How Does Indiana's New Medical Malpractice Law Affect Your Practice?

As July 1 Medical Professional Liability Renewals draw near, the thoughts of "will our practice's premium and state surcharge increase" and "we need to send the hospital our updated Certificate of Insurance" become more prevalent. The sort of general malaise that your broker lives for and the practice administrator laments. The 2017 renewal, however, is the catalyst for a different discussion. One that has not happened since 1999.

Prior to becoming Vice President of the United States, then Governor Mike Pence signed into law Senate Enrolled Act No. 28 on March 24th, 2016. This legislation, carried by Indiana State Senator Brent Steele, significantly changes Indiana's Medical Malpractice Act beginning July 1, 2017.



Summary of Changes to Indiana's Medical Malpractice Act

The Medical Malpractice Act now calls for the cap on damages in medical malpractice cases to be raised to $1.65 million in 2017 and $1.8 million in 2019. There will be no increase in the direct access amount (Current Threshold = $15,000) that allows a patient to commence a medical malpractice action without submitting a complaint to the medical review panel.

The split between the provider's/hospital's insurance and the Indiana Patient Compensation Fund (PCF) would be as follows:

Indiana's Medical Malpractice Act

Senate Enrolled Act No.28 Revisions

Provider's Carrier Underlying Requirement	Current Limits	2017 Limits (Effective 7/1/2017)	2019 Limits (Effective 7/1/2019)
Per Occurrence	250,000	400,000	500,000
Annual Aggregate	750,000	1,200,000	1,500,000
Patient Compensation Fund	1,000,000	1,250,000	1,300,000
Per Occurrence Total Recovery Amount	1,250,000	1,650,000	1,800,000

The law that is currently in effect until June 30, 2017 caps total damages available to a patient for an act of malpractice at $1.25 million. The new law will call for the cap on damages to be raised to $1.65 million on July 1, 2017 and then to $1.8 million on July 1, 2019.

Indiana was the first state to pass comprehensive medical malpractice reform legislation in 1975. The initial cap that year of $500,000 was increased to $750,000 in 1990 and then increased again to $1.25 million in 1999. Since no escalators where established in 1999, the Indiana Compensation Act for Patients has been called into question as unconstitutional.

Although the law has withstood a number of constitutionality challenges since 1980, the Johnson decision in 1980 set a precedent that held the act was constitutional as it had built-in cap escalators through the 1999 increase to $1.25 million.

With no cap increase since 1999, the plaintiff's bar continued to challenge the law specifically with cases involving catastrophic injuries. The 2005 Bobbitt and 2013 Plank cases challenged the cap based on current social and economic conditions that would call for life long care that would total $8.5 to $15 million, far exceeding the current cap. Even though the new cap has not shifted to match the catastrophic indemnification, it is viewed as an appropriate compromise.

Currently, qualified health care providers are only responsible for the first $250,000 in damages to any patient for one act of malpractice and no more than $750,000 in the annual aggregate. The state Patient's Compensation Fund (PCF) pays any excess, not to exceed $1 million -- for a total of $1.25 million.

For claims that occur after June 30, 2017 but before July 1, 2019, qualified healthcare providers will be responsible for the first $400,000 in damages to any patient for one act of malpractice and no more than $1,200,000 in the annual aggregate. The state Patient's Compensation Fund (PCF) pays any excess, not to exceed $1.25 million — for a total of $1.65 million.

For claims that occur after June 30, 2019, qualified healthcare providers will be responsible for the first $500,000 in damages to any patient for one act of malpractice and no more than $1,500,000 in the annual aggregate. The state Patient's Compensation Fund (PCF) pays any excess, not to exceed $1.3 million -- for a total of $1.8 million.

It is important to note that the definition of a qualified provider has been expanded to include an anesthesiologist assistant. A few other changes to the law include that payment from the patient's compensation fund must be made within 60 days after the issuance of a court approved settlement or final nonappealable judgment (final nonappealable judgment has been defined as a final judgement with respect to which the time for filing an appeal has expired, the appeals have been exhausted, or both have occurred); the fees to be paid to panel members will increase from $350 to $500, while the fees payable to the panel chair will increase from $2,000 to $2,500; and attorney fees are capped at 32% of any recovery (up from 15%).

There will be no increase in the direct access amount that allows a patient to commence a medical malpractice action without submitting a complaint to the medical review panel. The current threshold is $15,000. There was discussion that this threshold was going to be increased to $75,000, but in the end will be kept status quo.

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Although it is nice to know and understand the changes to Indiana's Medical Malpractice Law, the question still remains… what is the financial impact of the law to my practice when my renewal date approaches in 2017?

If your practice renews prior to July 1st, consider yourself lucky. The admitted medical professional liability carriers in the state of Indiana as well as the Patient Compensation Fund (IN PCF) are not charging additional premium or surcharge to any policy that renews prior to July 1, 2017. For example, if a policy renewed on May 31, 2017, the carrier will add an endorsement to the policy on July 1, 2017 increasing the provider's underlying limit requirement to $400,000/$1,200,000 and the PCF excess to $1,250,000 without issuing a rate increase until the provider's next renewal on May 31, 2018.

All of the build-up, questions and what ifs surrounding the inevitable rate increase, since Senate Bill 28 was signed in the spring of 2016, will be answered on July 1st. With the increased limits comes and increased cost of doing business. The medical professional liability carriers are all faced with a 15 percent loss cost charge increase for the higher insurance limit. No carrier is directly passing the full 15% cost on to the provider. Depending on a number of factors, including: favorable loss trends, policy type (claims made vs occurrence), and spreading out the lost cost increase over a few years… you can expect an increase from your carrier to be somewhere between approximately 2% to 10% at the first full year renewal under the new limit structure.

The Indiana Department of Insurance will release a new surcharge index on July 1, 2017. All providers will be subject to the new surcharge index. The surcharge for physicians will increase by 0.8% from the currently effective physician specialty rates. As a reference point, the surcharge for hospitals represents an overall 14.8% increase from the currently effective hospital rates.

This dialogue will inevitably reconvene in July of 2019 as we await what the state and carriers will decide in respect to a rate increase, but at least for now we understand the changes to the law and what it means to the practices bottom line.

By Nicholas J. Lizanich II
Director of Healthcare & Technology Risk Management, USI Indiana

Get to know your Indiana MGMA Business Partners!

This Month's Spotlight Partner: Andy Banning, Cyberian Technologies

Contact:
Andy Banning
Cyberian Technologies
317-926-9000 x 1207
abanning@cyberianit.com
www.Cyberianit.com

Indiana MGMA: For members who are newer to the association and may not have met you yet, please tell us what Cyberian Technologies offers?

Andy: We are a complete technology provider offering services of Data Backup & Recovery, Virtualization, VoIP, and Private Cloud Hosting and Managed Services. We are 100% committed to making sure business owners have the most reliable and professional IT service in the greater Indianapolis area. With our growing MSP practice, we are starting an enhanced security initiative that can provide HIPAA readiness services for our healthcare clients.

Indiana MGMA: What would be a few of the most compelling reasons an organization would use Cyberian Technologies?

Andy: We are one of few MSP's in Indianapolis to hold a CompTIA Trustmark. We assess and customize solutions based upon our customer's budgetary and technological initiatives. We offer month-to-month contracts on our Managed Services and keep our clients based solely on the performance of our services.

Indiana MGMA: Please share a recent success story you have from working with a medical practice client?

Andy: We began working with GroupOne Healthsource at a very critical time for their organization. In March of 2012, their network administrator resigned and left the company on virtually the same day. We came into a difficult situation, reviewed their network and server systems, updated their IT environment documentation, discussed their workflow with all departments, and most importantly, provided an immediate sense of stability to their global teams.

Get to know your Indiana MGMA Business Partners!

This Month's Spotlight Partner: Meghan Linvill McNab, Krieg DeVault

Contact:
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Krieg DeVault LLP
317-808-5863
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Indiana MGMA: For members who are newer to the association and may not have met you yet, please tell us what Krieg DeVault LLP offers?

Meghan: I serve as an Senior Associate Attorney in the firm's Health Care Practice Group. The firm's Health Care Practice Group serves a full range of health care providers and provider organizations including hospitals and health systems, senior living facilities, physician groups, pharmacies, and other similar related entities. Our firm is equipped to resolve regulatory and transactional issues involved with business combinations and market expansion, risk assessment and compliance, staff relations, and governmental approvals. We use our industry knowledge to help clients avoid problems, pursue opportunities, and better serve their patients.

Indiana MGMA: What would be a few of the most compelling reasons an organization would use Krieg DeVault?

Meghan: **Responsiveness** – clients know they can reach us anytime to address their needs. **Industry Knowledge** – We take pride in keeping up with the latest law changes and industry trends so that our clients are prepared to address their daily business challenges. **Client Asset** – We strive to be a true asset to our clients by knowing all facets of their organization and industry.

Indiana MGMA: Please share a recent success story you have from working with a medical practice client?

Meghan: We successfully assisted a surgery center client in upholding a non-compete against a physician who was attempting to depart for a nearby competing center, thereby discouraging future attempts by other physicians and preserving our client's value.

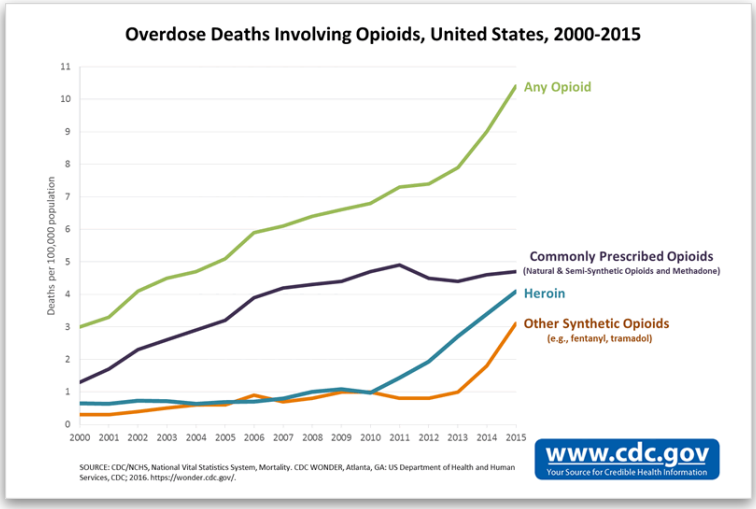
New Law Addresses Opioid Crisis

A senate bill addressing issues of prescribing and dispensing of opioids, particularly to help prevent new addictions from forming, was signed into law on April 26, 2017, by Governor Eric Holcomb. The bill was authored by Senator James Merritt, who has submitted several other bills related to the opioid addiction crisis.

"This scourge is affecting every cul de sac in the state of Indiana. We need to act quickly," Merritt said back in February at a news conference.

In essence, the bill, which passed promptly through the Senate and House, limits the amount of an opioid prescription a prescriber may issue for adults being prescribed an opioid for the first time and for children, unless the prescription is used to treat specified conditions or circumstances. Generally, first-time opioid users and children will receive no more than a seven-day prescription.

The bill also attempts to keep fewer opioids from leaving the pharmacy, even when they are prescribed. For instance, under the new law a prescriber must issue an opioid prescription in an even smaller quantity than the seven-day maximum if requested to do so by the patient, a personal or legal representative of the patient, or a guardian of the patient. Likewise, pharmacists must partially fill the opioid prescription in compliance with federal law upon the request of the patient, a personal or legal representative of the patient, or a guardian of the patient.



The new law will become effective July 1, 2017.

New Members to IMGMA - Welcome!

Karen Briggs
Reid Health Physician Assoc.
Service Line Dir., Specialty Care
Richmond

Kris Carlile
Franciscan Health
Operations Director
Lafayette

Pamela Cawood
Reid Health Physician Assoc.
Business Line Manager
Richmond

Julie Dalrymple
Pulaski Memorial Hospital
Director of Clinical Operations
Winamac

Linda Forbes
A&F Healthcare Services
Adjunct Instructor

Crystal Haney
IU Health Physicians
Practice Administrator,
Neonatal-Perinatal Medicine
Indianapolis

Anthony Hayes
American Health Network
Executive Director
Greenfield

Polly Malloy
Nephrology Specialists, PC
Practice Manager
Munster

T. Patrick Murray
Reid Health
Service Line Director,
Musculoskeletal Care
Richmond

Constance Runkel
American Health Network
Finance Manager
Indianapolis

Paul Smith
Parkview Physician Group
Vice President of Operations -
Primary Care
Fort Wayne

Judy Uzubell
North Point Orthopaedics
Practice Manager
Munster

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with grateful appreciation to our business partners . . .

PLATINUM BUSINESS PARTNERS
Somerset Health Care Team

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