The Resident's Handbook

A Guide to Navigating Medicine in Arizona

2015 Edition

ARMA
ARIZONA MEDICAL ASSOCIATION

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INTRODUCTION: This handbook is designed to provide physicians graduating from a residency program or physicians planning to begin a medical practice in Arizona with pertinent information. It is also intended to be retained as an easy-to-use reference guide.

Chapter One: Things to Do While Still a Resident

UNITED STATES MEDICAL LICENSING EXAMINATION

The United States Medical Licensing Examination (USMLE) is sponsored by the Federation of State Medical Boards (FSMB) of the United States, Inc. and the National Board of Medical Examiners (NBME). Results of the USMLE are reported to medical licensing authorities for use in granting the initial license to practice medicine. The three steps of the USMLE assess a physician's ability to apply knowledge, concepts, and principles that are important in health and disease and constitute the basis of safe and effective patient care.

Step 1 assesses whether you understand and can apply important concepts of the sciences basic to the practice of medicine, with special emphasis on principles and mechanisms underlying health, disease, and modes of therapy. Step 1 ensures mastery of not only the sciences that provide a foundation for the safe and competent practice of medicine in the present, but also the scientific principles required for maintenance of competence through lifelong learning.

Step 2 assesses whether you can apply medical knowledge, skills, and understanding of clinical science essential for the provision of patient care under supervision and includes emphasis on health promotion and disease prevention. Step 2 ensures that due attention is devoted to principles of clinical sciences and basic patient-centered skills that provide the foundation for the safe and competent practice of medicine. Step 2 CK (Clinical Knowledge) is constructed according to an integrated content outline that organizes clinical science material along two dimensions: physician task and disease category. Step 2 CS (Clinical Skills) uses standardized patients to test medical students and graduates on their ability to gather information from patients, perform physical examinations, and communicate their findings to patients and colleagues.

Step 3 assesses whether you can apply medical knowledge as well as your understanding of biomedical and clinical science essential for the unsupervised practice of medicine, with emphasis on patient management in ambulatory settings. Step 3 provides a final assessment of a physician in assuming independent responsibility for delivering general medical care.

For more information and application materials, visit http://www.usmle.org/.

After you obtain your initial licensure, under Arizona law, you must renew the license every other year on or before your birthday.

OBTAINING A MEDICAL LICENSE

Whether you are an MD or a DO, obtaining a license can be a lengthy process. We recommend you allow three to six months to assure all documentation is completed in a timely fashion.

The Arizona Medical Board (AMB) is the state regulatory agency that issues medical licenses (MDs only), and is also the oversight agency for Certified Medical Assistants and Physician Assistants. Most physicians obtain their licensure in the last year of residency to ensure no delay in employment upon graduation. The initial license application fee is $500.

An initial license in Arizona requires a criminal background check and fingerprinting. All initial applicants will receive a packet from the Board that will detail the steps the applicant must take to comply with the fingerprint process. Please note that the fingerprint card is specific and pre-printed for this Board; therefore, the applicant must use the fingerprint card provided by the Board or fingerprint card FD-258 to include the same pre-printed information within each blue box. The applicant is required to return the fingerprint card along with a check or money order for $50.00 made out to "Arizona Medical Board" together in the return envelope. It is strongly recommended that an applicant obtain the pre-printed fingerprint card prior to submitting the application for licensure. The cards are available through the AMB or your Arizona residency program. The process will proceed more expeditiously if the fingerprint card is submitted at the same time as the application. However, the AMB cannot accept the fingerprint card prior to submission of the application. Also, it should be noted that the application checklist is found at the back of the application and you should read it thoroughly prior to filling out the application. Once your medical license is approved, there is a $500 biennial license renewal fee. The biennial license will be issued on the licensee's birthday based on an odd or even year of birth.

All graduating residents are required to have 12 months of accredited post-graduate training in the US or Canada, and to have taken and passed a complete examination (i.e., Flex, National Board of Medical Examiners, USMLE I, II, III, State Written or Oral Exam) to receive an Arizona medical license. You can get more information on the examinations at www.fsmb.org, the web site of the Federation of State Medical Boards. Foreign medical school graduates are required to complete an additional 24 months of residency, for a total of 36 months. There are additional requirements for foreign medical school graduates and/or those who speak English as a second language, so please check with an AMB representative or on its website, https://www.azmd.gov/, for additional information.

AMB also issues Dispensing Registration Numbers for physicians who purchase and repackage pharmaceutical drugs on their premises. The initial registration, with unlimited locations, is $200 and $150 thereafter for license renewal. The AMB Licensing and Renewals Department can be reached at 480-551-2700 or www.azmd.gov for more information or to request an application for a medical license.

If you intend to supervise a Physician Assistant, you need to send a written notification to the AMB, and the response from AMB serves as the authorization to initiate the physician assistant supervision.

The public will have access to the "primary" practice address and phone number you provide to AMB, so make certain they are the ones you wish to have published if you are working from a home office.

If you are an osteopathic physician, an osteopathic medical license can be obtained through the Arizona Board of Osteopathic Examiners (AZBOEX). The first year you are licensed by Arizona Board of Osteopathic Examiners, expect your licensure to cost between $1200 and $1500 . The initial application fee is currently $400 with an additional prorated licensure fee upon approval. During the first year (or partial year) you have your AZ license, you are required to attend 20 hours of CME. Your new AZ license is valid until December 31 of the year it was issued. At that time, to maintain your license you will have to renew it and report your 20 CME hours. The renewal fee is $636.

Physicians must also show proof of passing the national board exams (i.e. COMLEX, USMLE) and have a minimum of one-year post-graduate training. To request an application or to receive additional information, contact a representative of AZBOEX at 480-657-7703 or visit its website at http://www.azdo.gov/.

OBTAINING A DRUG ENFORCEMENT ADMINISTRATION (DEA) NUMBER

Every physician must have a DEA (Drug Enforcement Administration) number to prescribe controlled substance medications. Online applications and renewals for DEA numbers can be completed at http://www.deadiversion.usdoj.gov/.

If you prefer to receive an application by mail, call 800-882-9539, or call the regional offices and request to be transferred to "diversion." The Phoenix DEA (covering Northern and Central Arizona) office number is 602-664-5600, and the Tucson office (covering Southern Arizona) number is 520-573-5500. It takes approximately one to two weeks to receive the one page, double-sided self-mailer. You must have a medical license (or one pending) to receive a DEA number.

The state of Arizona does not have a state controlled substance number so you should mark N/A where appropriate on the application. The cost for new registrants is currently $731 for three years.

After submitting the application to Washington, DC, it

will take approximately four to six weeks to receive your DEA number in the mail.

CONTROLLED SUBSTANCES PRESCRIPTION MONITORING PROGRAM (CSPMP)

The Arizona State Board of Pharmacy (ASBP) manages a Controlled Substances Prescription Monitoring Program (CSPMP). Arizona law requires anyone who dispenses Schedule II, III, and IV controlled substances to report the dispensing of these drugs to the CSPMP database. Dispensing is not the same a writing a prescription that is filled at a pharmacy. Every licensed medical practitioner who possesses a DEA license is required to register with the CSPMP. There is no fee for registration. Further information is available at http://www.azpharmacy.gov/.

FINDING A JOB

Check with ArMA's classifieds webpage or local medical recruiting agencies. Contacting the local health systems is another option.

The Center for Rural Health (CRH) of the University of Arizona in Tucson has contracted with a placement service for underserved areas in rural counties. For additional information, go to https://www.3rnet.org/ or call 520-626-5823. You can also visit the CRH web site at http://crh.arizona.edu/.

The Indian Health Service's web site has physician job listings available at http://www.ihs.gov/physicians/.

"Contracts: What You Need to Know"

- **Hire an attorney**
- **Read the fine print and know that verbal will not stand**
- **Why do they want me? Is this practice for me?**
- **What are the future goals of the practice?**
- **How long will the partnership negotiations take?**
- **How are new patients scheduled?**
- **What are the expectations?**
- **What is shared by partners? (Ask regarding profit and loss details.)**
- **Is the hospital agreement an employment agreement and/or an income guarantee?**
- **Are there non-compete clauses?**
- **Speak with two previous employees of the practice.**
- **Do the research: What is the job description? Benefits? Extras? How has the practice planned for this new physician? Hours required? Time off?**
- **Who are the key employees and what are they like to work with?**
- **Professional dues and CME allowance: Are they bundled under one total clause or are separate allowances made for them both?**

STARTING YOUR OWN PRACTICE

In addition to all the fees and licenses noted in this handbook, your own practice will require business/property insurance and will be subject to various health and labor laws and local/state taxation.

The Arizona Commerce Authority can provide you with information. This public-private entity has made all of their information available online at http://www.azcommerce.com/. Under Small Business Services, you will find listings of state and city requirements, office locations, applications and frequently asked questions.

You may also want to join your local chamber of commerce, which will often have helpful programs for new businesses and provide excellent resources for community contacts.

As a member of ArMA, you have valuable benefits, discounts, guidance, and services available. Contact the ArMA membership department for information at 602-347-6914.

CONTRACT NEGOTIATIONS

Contract negotiations are important. Take the time to know your rights under the law and avoid contracting away your practice protections.

Do not hesitate to seek the advice of legal counsel; it will be money well spent.

A contract will outline your obligations and responsibilities to a specific set of patients. Contracts also will determine the nature and amount of your compensation, your practice discretion, your paperwork load and the contractors' obligations to you. Many of your patients will come to you as a result of your choice to participate with insurance plans. How satisfied you are in your practice will depend largely on your success in negotiating these contracts.

Managed Care Contracts

The American Medical Association's (AMA) National Managed Care Contract (NMCC) is designed to comply with the managed care laws of all 50 states and the District of Columbia, as well as with federal requirements. The comprehensive information it provides covers the business relationship between physicians and managed care organizations. Using the NMCC, physicians can better understand, evaluate and negotiate managed care contracts. It can be accessed at http://www.ama-assn.org/go/nationalcontract.

CREDENTIALING

Credentialing of physicians is required by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and the National Committee on Quality Assurance (NCQA) to obtain hospital privileges; to ac-

"15 Questions to Ask Before Signing a Managed Care Contract."

1. How important is this contract to your practice?
2. How does the contract define "medically necessary" care?
3. How does the MCO verify that a patient is enrolled in a plan?
4. How do you determine whether medically necessary services are covered by a patient's benefit plan?
5. Does the contract (or administrative manual) clearly designate any and all services and procedures subject to prior authorization requirements?
6. What is your reimbursement under this contract?
7. Is reimbursement sufficient?
8. What are your rights to appeal a reimbursement decision?
9. Can the MCO change reimbursement terms unilaterally?
10. Does the MCO have an obligation to pay you promptly?
11. Does the contract give the MCO the right to unilaterally "offset" alleged "overpayments" from amounts otherwise due?
12. What products are you required to participate in?
13. Does the contract require compliance with a prescription drug formulary?
14. Does the contract allow the MCO to "rent" you to other entities?
15. How can you terminate the contract?

cept patients under health insurance plans with whom you choose to contract; and then will be verified by an accredited credentialing verification organization (CVO). This in-depth review involves verifying information that generally doesn't change, such as where you attended medical school, location of residency, etc. After the initial credentialing is complete, you will be required to submit reappointment credentials every one to two years to maintain hospital privileges and continue to accept patients under health insurance plans, including Medicare and Medicaid/AHCCCS.

Credentialing can be a paperwork challenge for physicians and medical staff who are faced with the task of completing 40+ applications for initial and reappointment credentialing. The credentialing process may take greater than nine (9) months to complete, and may affect your employment agreement, or salary.

The Web Credentialing Application completion software is a web-based credentialing software that automates the process of completing and tracking credentialing and allows the data to be entered once for all insurance platforms. Contact ArMA Membership at 602-347-6914 for more information on this time-saving and efficient option.

Accepting Medicare and Medicaid (AHCCCS) patients

The ArMA membership department has prepared a white paper on Participating, Non-Participating and Opt-Out decision-making for Medicare providers. To obtain this information, contact the ArMA membership department at 602-347-6914.

The ArMA credentialing software is also a great tool for completing the process of becoming a Medicare/Medicaid provider (in Arizona, the Medicaid program is the Arizona Health Care Cost Containment System, AHCCCS). Otherwise, use the following steps to register or credential with the Federal Plans:

1.) Look up your Taxonomy code number, (this is simply a specialty indicator) number from http://www.wpc-edi.com/reference and click "Health Care Provider Taxonomy Code Set." If your specialty board certification changes, you will need to re-credential and again look up the taxonomy code. These codes are updated frequently.

2.) A National Provider Identifier Standard (NPI) is a unique number required for use by all health insurance plans, Medicare and Medicaid/AHCCCS, pharmacies, DME, and to order, supervise or refer patients. Contact https://nppes.cms.hhs.gov or (800) 465-3203 to obtain your NPI number. You can save time prior to completing the online application by printing all of the helpful hints and a blank application form. IMPORTANT: The NPI information must exactly match all of the Federal systems information on file for you and your practice; for example, the exact practice corporation title or name (spaces, hyphenated, abbreviations), the exact address as on the USPS website, or any other Federal database system. While you will be able to obtain a NPI number without a 'perfect' match to the Federal systems, the payments will be affected and will require reapplying for the NPI with the matching information. Also, any address changes must be reported within 14 days or you may face non-payment in the system.

3.) In order to be paid for care rendered to Medicare patients, physicians must enroll with the local carrier, Noridian. Call 877-908-8431 ("Provider Enrollment") or access http://www.noridianmedicare.com for the multiple forms. Upon proper completion of the forms, the process usually takes at least 180 days. If the forms are not properly completed, Noridian will cancel the enrollment process and you will have to start the process over again.

4.) Upon receipt of the numbers, send (must be written) the NPI numbers to each insurance plan credentialing department and also the Electronic Data Information

(EDI) department where you have a participation contract agreement. If you choose not to care for Medicare patients, submit the Opt Out forms notifying of this two-year decision.

CHAPTER TWO: YOU'VE COMPLETED YOUR RESIDENCY...NOW WHAT?

5.) Establish data interchange for electronic billing with Noridian Common Electronic Data Interchange, at https://med.noridianmedicare.com/web/jddme/claims-appeals/cedi.

6.) Enroll in Noridian Endeavor, which allows online access to view each specific patient eligibility, coverage, preventive service last date of use, primary/secondary responsibility, and claim tracker through the payment process. The website is accessible at https://endeavor-am.noridianmedicare.com/opensso/UI/Login.

For AHCCCS, the first step is to determine which AHCCCS-sponsored plans offer contracts for your specialty and in your region of practice. These plans can currently be reviewed at https://azweb.statemedicaid.us/HealthPlanLinksNet/HPLinks.aspx.

The next step is to register. The forms are available with the ArMA credentialing software benefit, or may be obtained by calling (602) 417-7670 (choose option 5), or online at http://www.azahcccs.gov/commercial/ProviderRegistration/registration.aspx. There is a provider registration fee of $553.00. Processing usually takes at least 90 days and requires the NPI number be properly indicated. After completion of the AHCCCS registration form, the credentialing and contracting with various insurance plan sponsors can begin, usually an additional 90 days at a minimum.

LIABILITY AND RISK MANAGEMENT

Risk management is at the heart of efforts to reduce preventable malpractice claims and improve the defensibility of non-preventable claims and suits. Experience has shown that many lawsuits can be prevented and the dollar amounts of claims reduced through the incorporation of certain practices into a physician's daily routine. Such practices not only prevent suits, but also contribute to quality patient care and can help assure appropriate reimbursement.

Communication failures have been linked to as many as 75 percent of claims and suits. A patient who feels the physician was too rushed to listen or pay attention to complaints is more likely to sue if an unexpected outcome occurs.

Systems failures, where important data was lost or the patient's failure to follow through on needed care was not detected, are often linked to allegations of failure to diagnose. Particularly prominent are allegations concerning the failure to diagnose breast cancer or acute myocardial infarction.

Inadequate documentation is a frequent defense difficulty when an allegation of malpractice occurs. A complete, legible medical record does much to show that due

10 "tips" To Reduce the Threat of a Malpractice Claim in Your Office

1. Careful listening to patients can lead to a more timely and accurate diagnosis, as well as a more satisfied patient.

2. A calendar log or suspense sheet can be created to ensure timely follow-up on receipt of test results.

3. After reading incoming reports from labs and consultants, initial and date prior to filing.

4. Create "stamps" to target action on "no-show" patients.

5. When too rushed to write complete notes, remember dictated notes are quick, legible and tend to be more descriptive than handwritten documentation.

6. Avoid any appearance of an altered record: never scratch out, erase or obliterate with "write-overs" or "white out."

7. Use a routine format, such as the familiar "S.O.A.P" note, to ensure complete and defensible medical records.

8. Preprinted forms can be used to easily document after hours phone messages and can later be secured in the patient's record.

9. Use a consent form, in addition to progress notes, to best document informed consent discussions, always remembering not to imply or guarantee treatment will be complication free.

10. Remember to advocate for your patients and avoid the appearance that economic considerations override sound medical judgment.

Mutual Insurance Company of Arizona (MICA) Risk Management Consultants are available to assist MICA-insured physicians with tailoring risk management strategies to the individual practice setting. They can be reached at 602-808-2137.

care was exercised in diagnosis and treatment, while an incomplete or illegible record may force settlement of an otherwise defensible case. Particularly troubling is a record that appears "altered" with improper corrections or addenda. Failure to document informed consent discussions and failure to record after hours phone discussions, likewise, may cause defense difficulties.

Managed care has complicated the practice of medicine in several ways, which may give rise to claims and suits. The point at which the physician-patient relationship begins has been muddied; long-term relationships have become infrequent and physicians may feel pressured to forego treatment or diagnostic options because of economic constraints. Patients who feel you are an advocate, rather than simply a tool of an impersonal system, are less likely to fault you for their frustrations with the system.

PROFESSIONAL LIABILITY

Every physician should have professional liability (medical malpractice) insurance coverage. If you will not be working for an employer who provides appropriate coverage, it is imperative that you secure your own professional liability insurance. Most hospitals and treatment facilities require proof of coverage. While there are many carriers to choose from, there is a difference! Be sure your coverage is secured through a quality company. ArMA endorses MICA, which is physician-founded and directed and based in Arizona. Its coverage is of the highest quality and worth investigating. You can reach MICA at **800-352-0402** or https://www.mica-insurance.com.

YOUR ROLE IN ORGANIZED MEDICINE

JOIN ARMA TODAY!

The Arizona Medical Association (ArMA) is the only organization in the state advocating continuously for all physicians. Payment of your dues is the first step to protecting your profession, and joining ArMA ensures your participation in the decisions regarding the practice of medicine and care of patients. ArMA is led by physicians and has been for over 100 years, providing excellent legislative advocacy and offering value-added member benefits and endorsed services.

As an ArMA member, your benefits include the HIPAA-secure messaging app, extensive savings with membership benefits such as group health insurance, and practice management discounts. Today, every Arizona physician benefits from belonging to ArMA. You may submit your application online at www.azmed.org or call us at 602-347-6914. Students and first year residents are free as an introductory offer allowing you to get to know us.

All medical associations such as Arizona Medical Association serve as physician advocates, whether at the national, state, or local level. Their impact upon your practice in the future is tremendous. In Arizona, you may choose which organizations to join, as all are strictly voluntary. This may not be the case in every state, however.

The **American Medical Association** (AMA) functions as your advocate at the national level. It has full-time lobbyists in Washington, DC and publishes the popular *Journal of the American Medical Association* (*JAMA*), as well as the Current Procedural Terminology Code Book. Visit http://www.ama-assn.org/ for membership and other information.

The **Arizona Osteopathic Medical Association** (AOMA) promotes the osteopathic medical profession and is an additional option for osteopathic physicians. For more information regarding their dues or benefits, visit http://www.az-osteo.org/.

Within Arizona, there are a few county medical societies, including the Maricopa County Medical Society at 602-252-2015, or online at https://www.mcmsonline.com, and the Pima County Medical Society at 520-795-7985, or online at http://www.pimamedicalsociety.org/. County medical societies are available throughout the U.S. and offer valuable services for your consideration.

MEMBERSHIP IN SPECIALTY SOCIETIES

Physicians have the option of joining a local and/or national specialty society that focus on the interests of physicians in a particular area of medicine. The specialty societies department of ArMA can be contacted at (602) 246-8901 or patriceh@azmed.org for information on the following:

- Arizona Chapter, American College of Surgeons
- Arizona Chapter, American College of Physicians
- Arizona Society of Plastic Surgeons
- Phoenix Urological Society
- Arizona Neurosurgical Society
- Arizona Ophthalmological Society
- Arizona Orthopaedic Society
- Arizona Psychiatric Society
- Arizona Radiological Society
- Arizona Society of Otolaryngology/Head & Neck Surgery
- Arizona Society of Anesthesiologists
- Arizona Society of Pathologists
- Phoenix Society of Gastroenterology

MEDICAL BOARDS

American Board of Allergy and Immunology
866-264-5568
http://www.abai.org

American Board of Anesthesiology
919-745-2200
http://www.theaba.org

American Board of Colon and Rectal Surgery
734-282-9400
http://www.abcrs.org

American Board of Dermatology
313-874-1088
http://www.abderm.org

AmerIcan Board of Emergency Medicine
517-332-4800
http://www.abem.org

American Board of Family Medicine
859-269-5626
http://www.theabfm.org

American Board of Internal Medicine
215-446-3500
http://www.abim.org

American Board of Medical Genetics
301-634-7315
http://www.abmg.org

American Board of Neurological Surgery
713-441-6015
http://www.abns.org

American Board of Nuclear Medicine
314-367-2225;
http://www.abnm.org

American Board of Obstetrics and Gynecology
214-871-1619
http://www.abog.org

American Board of Ophthalmology
610-664-1175
http://www.abop.org

American Board of Orthopaedic Surgery
919-929-7103
http://www.abos.org

American Board of Otolaryngology
713-850-0399
http://www.aboto.org

American Board of Pathology
813-286-2444
http://www.abpath.org

American Board of Pediatrics
919-929-0461
http://www.abp.org

American Board of Physical Medicine and Rehabilitation
507-282-1776
http://www.abpmr.org

American Board of Plastic Surgery
215-587-9322
http://www.abplsurg.org

American Board of Preventive Medicine
312-939-2276
http://www.abprevmed.org

American Board of Psychiatry and Neurology
847-229-6500
http://www.abpn.com

American Board of Radiology
520-790-2900
http://www.theabr.org

American Board of Surgery
215-568-4000
http://home.absurgery.org

American Board of Thoracic Surgery
312-202-5900
http://www.abts.org

American Board of Urology
434-979-0059
http://www.abu.org

OSTEOPATHIC BOARDS

American Osteopathic Board of Anesthesiology

800-842-2622

American Osteopathic Board of Dermatology

800-449-2623

American Osteopathic Board of Emergency Medicine

312-335-1065

http://www.aobem.org

American Osteopathic Board of Family Physicians

847-640-8477

http://www.aobfp.org

American Osteopathic Board of Internal Medicine

918-561-1267

Email: AOBIM@mail.com

American Osteopathic Board of Neurology and Psychiatry

480-650-3206

Email: aobnp@att.net

American Osteopathic Board of Neuromusculoskeletal Medicine

317-879-1881

http://aobnmm.org/

American Osteopathic Board of Nuclear Medicine

800-621-1773, ext. 8227

http://www.aobnm.org

American Osteopathic Board of Obstetrics and Gynecology

708-755-2490

http://www.aobog.org

American Osteopathic Board of Ophthalmology and Otolaryngology

800-575-2145

http://www.aoboo.org

American Osteopathic Board of Orthopedic Surgery

877-982-6267

http://www.aobos.org

American Osteopathic Board of Pathology

800-621-1773 ext. 8227

http://www.aobpath.org/

American Osteopathic Board of Pediatrics

800-621-1773 ext. 8267

http://www.aobp.org

American Osteopathic Board of Radiology

660-265-4011

American Osteopathic Board of Physical Medicine and Rehabilitation

800-621-1773 ext. 8226

http://www.aobpmr.org/

American Osteopathic Board of Preventive Medicine

800-621-1773, ext. 8229

http://www.aobpm.org

American Osteopathic Board of Proctology

317-923-1033

American Osteopathic Board of Surgery

800-782-5355

http://www.aobs.org/

Other State Societies or Chapters

The Arizona Academy of Family Physicians at 602-274-6404 or http://azafp.org

The Arizona Chapter of the American Academy of Pediatrics at 602-532-0137 or http://www.azaap.org;

The Arizona Geriatrics Society at 602-265-0211 or http://www.arizonageriatrics.org, and

The Arizona College of Emergency Physicians at 602-336-4599 or http://www.azcep.org.

BECOMING BOARD CERTIFIED

Physicians can become board certified through national specialty boards. A written exam must be completed with a satisfactory score to be eligible as a board-certified physician in your area of specialty.

Fees for board certification vary, so contact your specialty board for more information. You can also visit the American Board of Medical Specialties web site at http://www.abms.org/.

PAYING OFF YOUR STUDENT LOANS

Various organizations and government entities offer options for loan repayment programs.

The **Indian Health Service (IHS)** has more information on its loan repayment program on its web site www.ihs.gov/loanrepayment. The Indian Health Service, Loan Repayment Program can be reached at 801 Thompson Ave., TMP Suite 450A, Rockville, MD 20852 or 301-443-3396.

Service-based loan repayment programs are available through **state loan repayment programs**, the National Center on Minority Health and Health Disparities, and the National Health Service Corps. Many states including Arizona have federally designated Health Professional Shortage Areas (HPSA) and encourage physician graduates to serve in these areas by offering a loan repayment program.

The **Arizona Loan Repayment Programs** are administered by the Arizona Department of Health Services. In Arizona, physicians may receive a maximum repayment of $65,000 for a two-year initial service commitment. For each year of continued service in the underserved area after the first two years, physicians can receive up to $35,000. For more information, visit http://www.azdhs.gov/hsd/workforce/alrp/index.htm.

To learn more about these programs, contact Ana Lyn Roscetti, MPH, Workforce Section Manager, Bureau of Health Systems Development, 150 N. 18th Avenue, Suite 300, Phoenix, AZ 85007, by phone (602) 542-1066, by fax (602) 542-2011, or by email at ana.lyn.roscetti@azdhs.gov.

The **National Center on Minority Health and Health Disparities Loan Repayment Program (LRP)** offers an educational loan repayment of up to $35,000 per year to qualified health professionals with doctorate degrees (e.g., M.D., Ph.D., Dr.PH.) who are employed in non-federal academic/research settings and are able to conduct two years of health disparities or clinical research. Learn more at http://www.nimhd.nih.gov/programs/extra/lrp.html.

The **US Army Reserve Medical Corps** offers several incentive programs for physicians in exchange for military service. The Health Professionals Loan Repayment Program (HPLR) provides up to $250,000 education loan repayment for physicians in certain specialties, in yearly increments of up to $40,000.

The length of service in exchange for loan repayment and special pay varies. If you have never been on active duty, the length of service is eight years military standard obligation, with service time split between active and inactive reserve duty.

If you have not completed your residency program, the US Army Medical Corps Reserves also offers a Specialized Training Assistance Program (STRAP) to residents. It is a stipend program for physicians currently enrolled in an accredited residency program for certain critical shortage specialties. The stipend is currently $2,060 a month.

To obtain more information, call 1-800-550-2769 or visit http://www.goarmy.com/amedd/physician/benefits.html. Other military branches may offer loan repayment programs; check with your local recruiters' office.

NAME AND ADDRESS CHANGES

Physicians must immediately notify Arizona Medical Board (AMB) or Arizona Board of Osteopathic Examiners (AZBOEX) of name changes due to marriage or other circumstances. There is a $50 fee for the duplicate license in the new name and you must submit documentation (i.e., marriage certificate, legal name change). A physician can legally practice medicine only under the name stated on the medical license. AMB or AZBOEX must also be notified, in writing (faxes and e-mails are accepted as written notification), of all address changes. Failure to notify AMB within 30 days of an address or phone number change is a violation of the board's statutes, which may result in a fine of $100 plus the costs incurred by the board to locate you. You can reach AMB at 480-551-2700 and AZBOEX at 480-657-7703.

As your practice activity changes over the course of time, it is strongly advised that you take a moment to contact ArMA. Changes in your practice activity may affect your dues amount. Call 602-347-6914 to speak to the Membership Department.

All other organizations to which you belong should also be notified. Your contract or agreement with HMOs, PPOs, etc. may be voided if you cannot be located.

Once again, remember that the National Provider Indicator (NPI) must be notified of any name or address changes within 30 days of the change or physicians may face non-payment of claims.

CHAPTER THREE: FEDERAL REGULATIONS YOU SHOULD KNOW

EMTALA

The Emergency Medical Treatment and Active Labor Act ("EMTALA"), also known as the Patient Anti-dumping Law, was enacted in 1986. The statute is enforced by the Arizona Department of Health Services, which investigates EMTALA complaints on behalf of the federal Centers for Medicare and Medicaid Services (CMS), an agency within Department of Health and Human Services. The state agency follows interpretive guidelines promulgated as part of the CMS Medicare State Operations Manual.

The statute applies to hospitals that provide emergency services and participate in Medicare/Medicaid programs. It requires hospitals to provide emergency treatment to all persons without their regard to ability to pay.

EMTALA requires an appropriate medical screening examination ("MSE") to determine whether an emergency medical condition ("EMC') exists for all patients who come to the emergency department seeking examination and treatment of a medical condition.

An Emergency Medical Condition (EMC) is defined as the manifestation of acute symptoms of such severity that the absence of immediate medical attention could reasonably be expected to place the health of the patient or unborn child in serious jeopardy, or create a serious impairment or dysfunction to bodily functions or organs. It also includes severe pain, conditions caused by substance abuse, and psychiatric disturbances. With respect to a pregnant woman who is in labor/having contractions, an EMC arises when there is inadequate time to effect a safe transfer to another hospital before delivery or if the transfer may pose a threat to the health or safety of the woman or the unborn child.

The Medical Screening Examination (MSE) must be provided by qualified medical personnel (either a physician or other person, as approved by the hospital's board).

A Medical Screening Examination (MSE) is a process required to make a determination, within reasonable clinical confidence, as to whether or not an Emergency Medical Condition (EMC) exists. The MSE must be the same MSE that the hospital would perform on any individual presenting with the patient's signs and symptoms, regardless of ability to pay.

If the Medical Screening Examination reveals that no Emergency Medical Condition exists, then the hospital has satisfied its obligation under EMTALA.

If the Medical Screening Examination (MSE) reveals an Emergency Medical Condition (EMC), the hospital must provide further examination and stabilizing treatment within its capability to stabilize the patient, or make an "appropriate transfer" to another facility that has the capability and capacity to treat the patient's EMC. The hospital's capability includes its ancillary services and on-call specialists.

A patient is regarded as "stabilized" when the physician treating the patient has determined, with reasonable clinical confidence, that the Emergency Medical Condition (EMC) has resolved or that no material deterioration of the patient's condition is likely, within reasonable medical probability, to result from or occur during a transfer. With regard to a patient in active labor, stabilization occurs after the infant and placenta have been delivered.

The hospital may not transfer an unstable patient to another facility unless the hospital meets the regulatory requirement for an "appropriate transfer." In addition, a physician must sign a written notification stating that the medical risks of transferring the patient are outweighed by the medical benefits of the transfer. A hospital may also transfer a patient at his or her written request and in lieu of a physician's written certification.

A hospital that has specialized capabilities or facilities (such as burn units or neonatal intensive care units) may not refuse to accept a patient in transfer if the hospital has the capacity to treat the individual. The receiving hospital will be obligated to accept the transfer in most cases, so long as the hospital has the ability to treat the patient and its capabilities exceed those of the referring hospital (e.g., overcrowding or temporarily unavailable personnel).

A patient may be stable for discharge with follow-up arranged by the hospital.

EMTALA requires that signs be posted in conspicuous places likely to be noticed by all individuals entering the emergency department, and waiting for treatment or being treated in the hospital, particularly in the emergency department and labor and delivery units. The signs must specify the rights of individuals under EMTALA.

A hospital must keep a list of physicians who are an-call to provide further examination or treatment necessary to evaluate or stabilize a patient with an Emergency Medical Condition (EMC). If the hospital offers a service to the public, the service should be available through

on-call coverage. If a patient with an EMC is transferred because an an-call physician fails to respond in a prompt fashion and provide a required Medical Screening Examination (MSE) or stabilizing care, the hospital is required to include the name of the physician who did not respond in the records accompanying the patient. An available on-call physician must accept a patient in transfer from another hospital.

On-call physicians to whom patients are referred may have obligations under EMTALA and hospital by-laws to provide office follow-up care.

Regulations have defined hospital property to include the entire main hospital campus including parking lots, sidewalks, and driveways. This does not include other areas or structures of the hospital's main building that are not part of the hospital (such as nonmedical facilities and offices of physicians and others who separately participate under Medicare).

For violations of EMTALA, a hospital may be subject to monetary penalties of up to $50,000 per violation and exclusion from Medicare and state health care programs. A physician would be subject to hospital and state board of medical examiners' discipline, and would have to report to the National Practitioner Data Bank. Physicians cannot be sued by patients for EMTALA violations; hospitals can be.

THE HITECH Act and HIPAA Rules

1. HIPAA Privacy and Security

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) requires the establishment of standards for the privacy of individually identifiable health information (the "Privacy Rule"). The Privacy Rule was issued by the Department of Health and Human Services (HHS) and became effective April 14, 2001. The compliance date for physicians was April 14, 2003.

The Health Information Technology for Economic and Clinical Health Act (HITECH) was part of the American Recovery and Reinstatement Act of 2009. The HITECH Act expanded privacy and security requirements under HIPAA.

The HITECH Act and HIPAA create national standards to protect individuals' personal health information while the information is 'in motion' from one physical site to another, and further gives patients increased access to their medical records. The Privacy Rule generally requires a physician to:

- Provide information to patients about their privacy rights and how their health information can be used.
- Allow patients to request the encounter be 'off the record' and keep the information confidential.
- Designate an individual to be responsible for seeing that privacy procedures are adopted and followed.
- Adopt office privacy procedures.
- Require all organizations using medical information to abide by the rules.
- Implement notification processes if breach should occur (including patients, media, government).
- Train employees in the office privacy procedures.
- Secure portions of patient records so that they are not readily available to those who do not need them.

Protected Health Information (PHI) is defined as individually identifiable health information that concerns an individual's past, present or future physical or mental condition, treatment and/or billing or payment information that is created or received by a physician in oral, electronic or written form. Individually identifiable health information includes many common identifiers (e.g. name, address, birth date, social security number).

PHI may not be used or disclosed except as permitted or authorized by the Privacy Rule. The Privacy Rule requires a physician to obtain a patient's written acknowledgement of the office privacy practices, (there are exceptions), and to properly use PHI. An authorization must also be obtained for a physician to use or disclose PHI for other specified purposes. Patient rights under the Privacy Rule include, among other things, the right to receive a written notice of the physician's privacy practices; to inspect, copy, and amend their medical record; and beginning January 1, 2011, to receive an accounting of any and all disclosures of PHI.

A physician's office must meet certain administrative requirements, among them: to designate a privacy official who is responsible for implementation and compliance, to provide privacy training for employees, to develop policies and procedures to protect and secure PHI, and to provide monitoring. Hospitals typically have HIPAA compliance officers and policies and procedures for their staff.

The Rules provide that a person or entity who provides certain functions, activities or services for or to a physician involving the use and/or disclosure of PHI is a "business associate" (BA). The physician is required to obtain, typically by contract from the BA to whom PHI is disclosed, and requiring the BA to abide by the rules; they are only to use the information for the purposes for which it was engaged by the physician, and that the BA will "appropriately safeguard" the information from misuse, will timely notify of potential or actual breach, or investigation by the DHHS/OCR.

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The Rules are complex, and Arizona state privacy law was recently changed to be consistent with the Federal rules. There are both civil and criminal penalties for violating HIPAA. The maximum civil penalty is $100 per violation per person, up to $25,000 per calendar year for multiple violations of the same requirement. Criminal penalties primarily concern wrongful disclosure of PHI with bad intent and are substantial, with a $50,000-100,000 fine and imprisonment between one and five years. The criminal penalty increases to $250,000 and up to ten years imprisonment if a physician intends to sell, transfer, or use PHI for commercial advantage or personal gain.

Privacy compliance is enforced by the HHS Office of Civil Rights.

2. HIPAA Administrative and Simplification Act

As part of HIPAA, the Administrative and Simplification Act dictates the transactions and code set standards. Transactions are activities involving the transfer of healthcare information for specific purposes. Under HIPAA, if a physician engages in a transaction, they must comply with the standard for it, which includes using a standard code set to identify diagnoses and procedures. The transaction and code sets identify the accepted standard for the transmission of electronic claims. The Secretary of HHS selects the standards for the claim form for all health insurance claims (excluding workers' compensation or automobile insurance claims).

Currently there is an extensive revision to the system, inclusive of all of the transaction communications within the payment cycle. The format that will affect physicians in their practices is the transition to the 'digitized' CMS 1500 claim form, in addition to the eligibility inquiry and response, electronic remittance, explanation of benefits etc.

The Secretary of HHS has declared the AMA Current Procedural Terminology codes, descriptions, and their modifiers to be the standard code set for physician procedures. The ICD9CM is the standard code set for diagnosis codes currently, but will be updated to the ICD10CM code set effective October 1, 2015. The HCPCS Level II is the standard code set for items, supplies, medications, and other services. See the Coding Books section of this Handbook for details on purchasing the necessary books. Also, the AMA offers a web link to report HIPAA violations for those who choose not to implement the standard codes and the proper use.

The Administrative and Simplification Act also streamlines the provider numbers that physicians obtain for use in the administrative and financial transactions adopted under HIPAA, including for insurance plans, and reporting on the claim forms (whether electronic or paper claims).

For each insurance plan, a physician can choose to sign a contract to participate with that plan and the physician must also complete provider enrollment forms. For electronic claims to be processed for *any* insurance plan, it is also necessary to apply for the National Provider Identifier number. This can be done at https://nppes.cms.hhs.gov/.

3. HIPAA Security Rules

The HIPAA Security Rule establishes national standards to protect electronic PHI that is created, received, used, or maintained. The additional HIPAA security standards compliance date for physicians was April 20, 2005. It requires physicians to implement administrative, physical, and technical safeguards to protect electronic PHI. This includes protecting against any reasonably anticipated threats or hazards to the security or integrity of such information.

The HIPAA rules were revised in early 2009 to specifically address electronic use of information surrounding e-prescribing, and the responsibilities of parties to maintain privacy and security using high standards.

Additional information on the Privacy Rule and standards can be obtained from either the HHS website, http://www.hhs.gov/, or the CMS web site, http://www.cms.gov/, under the tab entitled "Regulations & Guidance." Next, click on the link for "HIPAA – General Information," then click on the link "Privacy and Security Standards," which will refer you to the Office for Civil Rights (OCR), the authority that regulates and enforces the Privacy Rule. Helpful information can be found on the OCR "Frequently Asked Questions" tab available at http://www.hhs.gov/ocr/privacy. The OCR can also be contacted at its toll-free telephone numbers: 1-866-368-1019 or TDD 1-800-537-7697.

For specific questions and legal advice, legal counsel should be consulted.

ArMA's website, http://www.azmed.org/ and membership office at 602-347-6914 may also be helpful resources for members.

CODING REQUIREMENTS

Based upon the documentation of the encounter, the physician is required to properly select the codes for the procedure rendered, the diagnosis indicating the medical necessity, and the extra medications or supply items used. With implementation of ICD-10 scheduled for

October 1, 2015, there are resources available for preparing to transition from ICD-9 to ICD-10. More information is available at Road to 10, a project of CMS, at http://www.roadto10.org/.

The Industrial Commission of Arizona's codes and fee schedule for worker's compensation claims can be ordered by contacting the Claims Division at 602-542-4661, or online at www.ica.state.az.us. If you have further questions, call 602-542-4661.

STARK

The federal physician self-referral statute (commonly referred to as the "Stark Law" after Congressman Pete Stark, who introduced the statute), generally prohibits a physician from referring Medicare and Medicaid beneficiaries for certain "designated health services" to health care providers in which the referring physician (or an *immediate family member*) has a "financial relationship." The term "financial relationship" is defined in the Stark Law to include both compensation arrangements and investment and ownership interests. In addition, the term "referral" is defined more broadly than merely recommending a vendor or designated health service to a patient. Stark Law "designated health services," include the following:

- Clinical laboratory services
- Physical therapy services
- Occupational therapy services
- Speech-language pathology services
- Radiology, including MRI, CT, and ultrasound services
- Radiation therapy services and supplies
- Durable medical equipment and supplies
- Parenteral and enteral nutrients, equipment, and supplies
- Prosthetics, orthotics, and prosthetics devices
- Home health services
- Outpatient prescription drugs
- Inpatient and outpatient hospital services

The Stark Law contains several exceptions, with some applying to both ownership and compensation arrangements, some applying to only ownership arrangements, and the remainder applying only to compensation arrangements.

Common exemptions from *both* ownership and compensation arrangements are: for designated health services provided personally by or under the personal supervision of another physician in the same group practice as the referring physician; for designated health services provided by a referring physician or another physician who is a member of the same group practice, or if other individuals, such as technicians, perform the service and they are directly supervised by the referring physician or another physician in the same group practice; and for designated health services furnished to enrollees of certain health plans.

Exceptions applicable to compensation arrangements include certain exceptions for rental of office space and equipment, professional service agreements, amounts paid by an employer to a physician who has an employment relationship with the employer, physician recruitment, as well as several others.

Penalties for violations of the Stark Law can be severe. Penalties include: civil penalties of up to $15,000 per claim; denial of payment; return of monies received; exclusion from the Medicare program and/or state health care program; and sanctions of up to $100,000 if a physician enters into a cross-referral or circumvention scheme.

An in-depth analysis of the Stark exceptions and the state statute are beyond the scope of this Handbook, and an attorney should be consulted for advice on a particular situation.

FRAUD AND ABUSE

In recent years, the federal government has taken an active role in combating health care fraud and abuse by filing criminal indictments and civil lawsuits. In fiscal year 2013, the federal government reported the recovery of $4.3 billion in taxpayer dollars from individuals and companies who attempted to defraud federal health programs. Since the enactment of the Affordable Care Act, it has also excluded over 14,000 individuals and entities from participation in federal health care programs. It brought 1,013 new criminal health care fraud investigations and 137 civil actions.

There are a host of criminal statutes commonly applied to health care providers including those related to: health care fraud, theft or embezzlement in connection with health care, false statements relating to health care matters, obstruction of criminal investigations of health care offenses, mail and wire fraud, and criminal penalties for acts involving federal health care programs. The most common civil claims that apply to health care providers are the False Claims Act, the Civil Monetary Penalties Law, the Stark Law and the Anti-Kickback Statute. Because it is a federal crime to defraud the United States Government or any of its programs, these laws impose stiff criminal and civil penalties along with possible exclusion from participation in Medicare, Medicaid, and other federal programs.

The state of Arizona has been selected for extensive audits by the Recovery Audit Contractors (RAC) hired by CMS. The program allows auditors to review claims in more detail while at the physician's office, reporting the

findings. The RAC are paid on a commission or incentive methodology for each rejected claim. The AHCCCS integrity division's plan is to use every effort to evaluate for properly submitted claims, with additional investigations planned in the very near future.

The **Federal Anti-Kickback Statute** is a criminal statute that prohibits knowingly and willfully soliciting, paying, or receiving remuneration in exchange for inducing or referring an individual for goods or services paid for in whole or in part under a federal health care program. Discounts, rebates, or other reductions in price may violate the anti-kickback statute because such arrangements induce the purchase of items or services payable by Medicare or Medicaid. However, certain arrangements are permissible if they fall within a "safe harbor." Safe harbor provisions protect certain individuals, providers or entities from criminal prosecution and/or civil sanctions (when certain requirements are met) for actions which may appear unlawful or inappropriate under the Statute. There are currently over 20 safe harbor regulations that have been promulgated by the Office of the Inspector General (OIG). Conviction for a single violation under the Anti-Kickback Statute may result in a fine of up to $25,000 and imprisonment of up to five years.

The **False Claims Act** was originally enacted in 1863, has been amended three times since 1986. The Act imposes liability on any person who knowingly submits a false claim to the government, or causes another person to submit a false claim to the government for payment. The most recent amendment's definition of "knowingly" allows not only actual knowledge, but also deliberate ignorance or reckless disregard for the truth to be sufficient for liability purposes. Under the FCA, in addition to actions being instituted by the federal government, the statute authorizes "Qui Tam Actions" to be brought on behalf of the federal government by a private party having direct knowledge of the fraud. Physicians are obligated to be certain that each and every detail is accurate prior to submitting a claim to the government for payment of services, items, medications, etc. Penalties for violations of the FCA are monetary sanctions between $5,500 and $11,000 for *each* false claim made.

In addition to the Anti-Kickback Statute and False Claims Act, there are also health care fraud offenses contained in HIPAA, the Social Security Act, and other areas of the US Criminal Code. An in-depth analysis of what is prohibited by the Anti-Kickback Statute, the FCA, and other healthcare offenses is beyond the scope of this Handbook. An attorney should be consulted for advice on a particular situation.

Examples of fraud include:

o Billing for services not rendered.

o Soliciting, offering, or receiving a kickback, bribe, or rebate.

o Using an incorrect or inappropriate provider number in order to be paid (e.g., using a deceased provider's number).

o Signing blank records or certification forms that are used by another entity to obtain Medicare payment.

o Selling or sharing patients' Medicare numbers so false claims can be filed.

o Offering incentives to Medicare patients that are not of¬fered to non-Medicare patients (e.g., routinely waiving or discounting the Medicare deductible and/or coinsurance amounts).

o Falsifying information on applications, medical records, billing statements, and/or cost reports or on any statement filed with the government.

o Misrepresenting, as medically necessary, non-covered services by using inappropriate procedure or diagnosis codes.

Examples of abuse include:

o Using procedure or revenue codes that describe more extensive services than those actually performed.

o Collecting more than the 20% coinsurance or the deduct¬ible on claims filed to Medicare. Providers may, of course, bill patients not covered (e.g., service exclusions).

o Routinely submitting duplicate claims.

o Billing for services grossly in excess of those needed by patients. For example, always billing for complete lab profiles when only a single diagnostic test is necessary to establish diagnosis.

o Incorrectly apportioning costs on cost reports for Part A providers.

o Charging more than the actual purchase price of a service, item, or drug.

COMPLIANCE PROGRAMS

In October 2000, OIG issued its compliance program guidance for individual and small group physician practices ("OIG Compliance Program for Individual and Small Group Physician Practices"), which can be found at http://oig.hhs.gov/authorities/docs/physician.pdf. The Compliance Program provides a resource for a small physician practice implementing a compliance program. The benefits of regulatory compliance include: increased accuracy in documentation, minimizing billing mistakes; optimizing proper payment of claims; avoiding conflicts with self-referral (Stark) and anti-kickback statutes; and reducing the chances that an audit will be conducted by CMS or the OIG. The basic components of a compliance program are:

- Conducting internal monitoring and auditing;
- Implementing compliance and practice standards;

- Designating a compliance officer or contact;
- Conducting appropriate training and education.

Other components may include:

- Responding appropriately to detect violations through investigation of allegations and disclosure of incidents to appropriate government entities.
- Developing open lines of communication, such as

  1. discussions at staff meetings regarding how to avoid erroneous or fraudulent conduct, and

  2. community bulletin boards, to keep practice employees updated regarding compliance initiatives; and,

Enforcing disciplinary standards through well-publicized guidelines.

In considering a compliance plan, it is worth noting that the OIG has identified four specific risk areas that should be included in any checklist:

- Coding and billing
- Reasonable and necessary services
- Documentation
- Improper inducements, kickbacks, and self-referrals

For additional information the Office of the Inspector General publishes special fraud alerts and the annual work plan that depicts investigational goals. This information can be obtained from various government web sites, including OIG at http://oig.hhs.gov/, and CMS at http://www.cms.gov/.

AFFORDABLE CARE ACT

The Affordable Care Act (ACA), passed in 2010, provides expanded healthcare coverage to the uninsured. The bulk of the coverage provisions went into effect on January 1, 2014. The ACA prohibits insurers from rescinding coverage or discriminating due to pre-existing conditions, eliminates lifetime coverage limits, and requires all new plans to cover certain preventive services without charging a deductible, co-pay or coinsurance. Additionally, the ACA encourages coordinated care via the formation of medical team organizations – accountable care organizations or ACOs – in order to provide better care at lower costs. The ACA also reduces administrative costs by standardizing billing.

More information on the ACA and its effect on physicians is available on the American Medical Association's website at http://www.ama-assn.org/ama/pub/advocacy/topics/affordable-care-act.page.

SUMMARY

As a physician licensed in Arizona, you are bound by the laws that regulate different areas of medicine. Please refer to the summary of laws and regulations published on the Arizona Medical Board website, particularly those dealing with licensure, unprofessional conduct, and communicable disease reporting. Supervision of physician assistants and office-based surgery are of particular interest in Arizona. Failure to comply could result in disciplinary action against your medical license. To read the statutes, rules and policy statement on-line, visit http://www.azmd.gov/.

DISCLAIMER

This handbook is not meant to provide legal advice on employment or other contracts entered into with managed care companies, HMOs or any third party payer. We STRONGLY urge you to carefully review any such contracts with legal counsel so that you have a full understanding of your rights and obligations in each specific case.

IMPORTANT NOTICE: If you will be a salaried employee after completing residency, many of the necessities of beginning medical practice listed in this handbook may be included in your benefits package. Check with your future human resources or medical staff services department for verification of what may be provided as a condition of employment before you proceed.

HELP IS JUST A PHONE CALL OR CLICK AWAY...

Arizona Medical Association (ArMA)
602-246-8901, 800-482-3480
Web site: www.azmedassn.org

Aging & Adult Administration
(All Health Forms) 602-542-4446
Web site: www.azdes.gov/aaa/

American Medical Association (AMA)
800-621-8335
Web site: www.ama-assn.org

AMA Members-Only Hotline
800-262-3211

American Osteopathic Association (AOA)
800-621-1773
Web site: www.do-online.org

Arizona Board of Osteopathic Examiners
(AZOBEX) 480-657-7703
Web site: www.azdo.gov

Arizona Coalition Against Domestic Violence
(ACADV) 800-782-6400
Web site: www.azcadv.org

Arizona Department of Insurance
800-544-9208
Web site: www.id.state.az.us/

Arizona Health Care Cost Containment System
(AHCCCS) A.K.A. Arizona's Medicaid
602-417-4000
Web site: www.azahcccs.gov/
To obtain a Provider Registration Number
602-417-7670 - select option 5

Arizona Health-e Connection
AZ HIT Information and Resources
602-288-5130
Website: www.azhec.org/index.jsp

Arizona Hospital & Healthcare Association
(AzHHA) 602-445-4300
Web site: www.azhha.org

Arizona Latin American Medical Association
480-720-6509
Web site: www.almahealthcare.com/

Arizona Medical Board (AMB)
480-551-2700
Web site: www.azmd.gov

Arizona Osteopathic Medical Association
(AOMA) 602-266-6699
Web site: www.az-osteo.org

Bone Marrow Donation Location Hotline
800-MARROW2, 800-627-7692

Child Abuse Hotline
888-SOS-CHILD, 888-767-2445

Arizona Department of Health Services
Phoenix 602-542-1025
Web site: www.azdhs.gov

Drug Enforcement Administration (DEA)
602-664-5600 (Northern & Central AZ)
Web site: www.justice.gov/dea/index.htm

Food & Drug Administration (FDA)
888-463-6332, 888-INFO-FDA
Web site: www.fda.gov

Greater Arizona Central Credentialing Program
(GACCP) 602-256-0705
Web site: www.azcvo.com

Health Services Advisory Group
602-264-6382
Web site: www.hsag.com/azmedicare.aspx

Hospice of the Valley - Health Care Decisions
(Living Wills) 602-222-2229
Web site: www.hov.org/health_care_decisions.aspx

Industrial Commission of Arizona (ICA)
602-542-4411
Web site: www.ica.state.az.us

Maricopa County Bar Association
(lawyer referral service) 602-257-4434
Web site: http://maricopalawyers.org/

Maricopa County Medical Society
602-252-2015
Web site: www.mcmsonline.com/

Mutual Insurance Company of Arizona (MICA)
602-956-5276, 800-352-0402
Risk Management Hotline: 602-808-2137
Web site: www.mica-insurance.com

Occupational Safety & Health Administration
(OSHA) 602-542-5795
Web site: www.osha.gov

Pima County Medical Society
520-795-7985
Web site: www.pimamedicalsociety.org
Rural County Societies outside Maricopa & Pima -
Call ArMA for contact information:
602-246-8901; 800-482-3480

State of Arizona
Web site: http://az.gov/

The Arizona Partnership for Immunization
(TAPI) 602-288-7566
Web site: www.whyimmunize.org

THE MED FORM

Name:_____Date Completed:_____
Preferred Pharmacy/Phone:_____
Address:_____
Phone Number:_____Birth Date:_____
Emergency Contact/Phone:_____

Allergies and Drugs to Avoid/Adverse Reactions:

_____
_____
_____

Current Medications:

List all medications you are taking, include over-the-counter (e.g., aspirin, antacids, vitamins and herbals).

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Medication:_____Dosage:_____
Reason for Taking:_____Directions:_____
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Reason for Taking:_____Directions:_____
Doctor:_____Date Started:_____

Always keep this form with you. *(over)*