

VIRGINIA FAMILY PHYSICIAN

THE OFFICIAL PUBLICATION OF THE VIRGINIA ACADEMY OF FAMILY PHYSICIANS

Charles H. Crowder, Jr., MD, Is Finalist For AAFP Family Physician Of The Year



The VAFP Headquarters office has been notified that VAFP Past President Charles H. Crowder, Jr., MD has been selected as one of ten finalists for the AAFP Family Physician of the Year Award.

Dr. Crowder of South Hill was selected as Virginia Family Physician of the Year in 1999. He was officially nominated by the VAFP for the AAFP Award in March of this year. The AAFP will announce the selection of the recipient of the National Award next month.

As has become tradition at the

VAFP, Virginia's Governor also presents the Virginia Family Physician of the Year Award annually. Pictured above is Governor James S. Gilmore, III presenting the award to Dr. Crowder earlier this year.

Dr. Crowder served as the 1992-1993 VAFP President. He also served as President of the Virginia Board of Medicine, Vice President of the Medical Society of Virginia and is currently President of the University of Virginia Medical Alumni Association.

Dr. Crowder and his wife Maxine have three children, Lina Sue, Roberta and Charles III.

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Richmond's Top
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David A. Ellington, MD


At this time of year our thoughts usually turn to what we will be doing for a well-deserved vacation. Time spent with family away from the hustle and bustle of a busy medical practice is invaluable in re-energizing our minds and bodies and helps us cope with the stresses we endure.

With the VAFP's **Annual Scientific Assembly in July**, your Academy gives you the opportunity to obtain top-notch CME at a great location plus lots of fun activities for you and your family. When I returned to Virginia after nine years in the Army, I thought that the only quality CME was provided at academic institutions. After becoming more involved in the Academy, I found that the CME the Academy provides at our summer and winter meetings matches or exceeds anything available in other settings. Plus, it's more fun.

This year, our Annual Scientific Assembly, which will be **held in Virginia Beach from July 19 through July 23**, will be no exception. In addition to the always lively *All Member Party* and the traditional Saturday night meal and show, your Academy will offer an **Early Bird Golf Tournament** at the TPC Course in Virginia

Beach and a reunion opportunity for graduates of all the Family Practice Residency Programs in Virginia. If you have come to this meeting in the past, you will find that this will be one of our best ever. If you have never attended before, mark your calendar and join us. You will certainly want to return again and again to VAFP sponsored events.

AAFP President Bruce Bagley recently wrote to all of us with an update on activities on a national level. These included Academy positions on a broad range of legislative issues that affect the way medicine is practiced both today and in the future. He also explained a new program called *Speak Out* that helps Academy members easily contact their national legislators on legislation of importance to medicine. If you have not read his letter, this information can be accessed on the AAFP website. Dr. Bagley also has written an editorial in Family Practice Management regarding the future of the office practice of Family Medicine. Titled ***Building For Tomorrow: The Idealized Design Of Clinical Office Practices***, he writes an editorial that accompanies an article on **ID-COP**, a nation-wide program that is attempting to design the Family Practice office of the future. Both the arti-



cle and the accompanying editorial offer quite a bit of food for thought for anyone planning to be in practice five years from now. **Dr. Susan Miller**, who presently is a member of the VAFP Board of Directors, has taken a great interest in the ID-COP Program and is very willing to provide information to interested Academy members. You can contact her by E-mail at **Samiller@hsc.vcu.edu**.

Included on page 15 is information hot off the press that gives you the latest on the **change in the Medicare carrier in Virginia**. Please read this and be thankful that we have Terry Schulte, our Executive Vice President, sitting on the committee that disseminates this information. Thanks Terry, for keeping the VAFP on the cutting edge.

Have a nice summer—thanks for all your help and support this past year. See you in Virginia Beach!

Nominating Committee Announces 2000-2001 Slate Of VAFP Officers And Directors

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MSV Alternate Delegate

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RURAL HEALTH

Larry G. Mitchell, M.D., Richlands, VA

Virginia Family Physician

Summer 2000

EDITORS NOTE

For the past five years, Mary Lindsay McCorkle has been an integral part of the Academy staff. From 1995-1998 she was a full-time employee of the VAFP and for the past two years, she has worked part-time as the Associate Editor of the Virginia Family Physician, while she pursued a Masters Degree in Health Administration from MCV/VCU. Last month she completed her course requirements and has accepted a position with a healthcare management consulting firm in Washington, DC where she will complete a one-year internship program. We thank Mary Lindsay for the outstanding job she has done and for the outstanding person she is. Very Best Wishes ML!!

TJS

LETTERS TO THE EDITOR

The Virginia Family Physician welcomes reader commentary on each issue, as well as local, state and national topics of interest to Academy members. Letters to the Editor should be addressed to the Virginia Academy of Family Physicians, 2301 N. Parham Road, Ste. 4, Richmond, VA 23229 or faxed to (804) 968-4418. Letters should include the writer's full name, address and day-time phone number, and may be edited for the purposes of clarity or space.

VIRGINIA ACADEMY OF FAMILY PHYSICIANS

2000 Annual Scientific Assembly



REGISTER
ONLINE,
BY FAX OR
BY MAIL!

Come early and join us for the Early Bird
Golf Tournament at the TPC Virginia Beach
on Wednesday, July 19!

July 20-23
Virginia Beach, Virginia

Managed Care Committee Report

Submitted by Shane Kraus, MD, Chair, VAFF Managed Care Committee

1999-2000 has been an exciting time for your Managed Care Committee. As you review the participation matrix below, please notice how many of your colleagues actively engage in managed care organizations (MCO's) for your benefit. We still have room for you!

The state legislature and the Governor have resolved specific issues that affect your practice. Senate Bill 718 and House Bill 1366 forbid managed care organizations from requiring you to participate in all of their products (HMO, PPO, Indemnity) in order to participate in any of the individual plan products. Senate Bill 26 mandates state employee HMO's to cover appropriate screening for colorectal cancer as of July 1, 2000.

A controversial issue that had

been raised by the National Committee on Quality Assurance (NCQA) is a new standard requiring that all physicians complete the credentialing process before they are allowed to be included on an HMO's panel of participating providers. While the idea of protecting patients (plan members) from unqualified physicians is laudable, the proposed solution reduces the availability of physicians to your patients (on-call) and inhibits the access of your patients to appropriate medical care (office appointment/emergency room coverage).

Newly trained Family Physicians who sit for the Board Certification exam on July 14, 2000 will be notified on October 1, 2000 of successful completion of the Board exam. If the physicians completed application is submitted the next day, the

MCO's verification process would not be completed before October 17, 2000, and the new physicians name would not be printed in any plan's published provider listing before January of the following year.

While our present system is not perfect, we urge each of you to contact the Commissioner of Health with your concerns about the state adopting strict NCQA compliance as a condition for MCO licensure. The Commissioner can be contacted by writing to Anne Peterson, MD / Commissioner of Health / Commonwealth of Virginia / 1500 E. Main Street / Suite 214 / Richmond, Virginia 23219

Please remember when discussing any issues related to patient care that our public servants like to hear how adopting your position will help all patients in Virginia.

MC Company	Leadership Position						
	Board of Directors	Credentialing	Medical Advisory & Medical Review	Medical Director	Pharmacy & Therapeutics	Quality Management	Utilization Management
Aetna USHC		Donn Cobaugh MD					
Carilion					Mark Greenwald MD	Aubrey Knight MD Michael Jeremiah, MD	Aubrey Knight MD Michael Jeremiah, MD
Cigna		Jai Cho MD	Shane Kraus, MD Ed Zakaib, MD	Nick Gettas, MD Carol Churchill, MD		Anna Bittner MD	Susan Miller, MD Frank Bain, MD Ron Goings, MD
Coventry Southern Health			Ron Goings MD	Steve Mohlie MD			
Inova							
Qualchoice						Doug Smith MD	Kurtis Elward MD
Sentara			John Bryant, MD Dena Hall, MD	Dan Crabtree MD			
Trigon		Shane Kraus MD	Shane Kraus, MD Stuart Solan, MD Tom Sperry, MD			Kurt Elward MD	Anup Gokli MD
United Healthcare	David Ellington MD		Shane Kraus MD				
George Washington						Hai Jin Kim MD	
Medicare			Doug Smith, MD Susan Miller, MD				Vanessa Blowe, MD Shane Kraus, MD
Medicaid			Moses Adiele, MD	Moses Adiele, MD		Moses Adiele, MD	Moses Adiele, MD

Harrison's Online Textbook

Submitted by Roger Hofford, MD

The eight Glaxo-Wellcome Districts in Virginia provided a \$2000 grant to Virginia Academy of Family Physicians. This grant provides unlimited access to "Harrison's Online" - an electronic medicine textbook on the Internet for all VAFP members including students and residents. Members are encouraged to use this online textbook. Up to twenty VAFP members may use this online textbook at any given time. The textbook can be accessed from the VAFP Home Page, www.vafp.org, by clicking on the orange bar located near the top of the home page. The USER ID is "vafp" without the quotation marks and in lower case letters. The password is "member" without the quotation marks in lower case letters. Next time you see your Glaxo-Wellcome representative be sure to thank them for their educational support.

VAFP Members Selected Among Richmond's Top Doctors

Stuart M. Solan, MD, Michelle Whitehurst-Cook, MD, Richard L. Gergoudis, MD, and Michael J. Petrizzi, MD were voted by their peers in a *Richmond* magazine survey as the top Family Physicians in the Richmond metro area.

Richmond magazine mailed surveys to 1,931 doctors in the Richmond area asking, "From whom would you seek treatment for yourself or a loved one?"

According to the responses received, the medical community voted most frequently for the previously mentioned Virginia Academy of Family Physicians members. Congratulations goes out to each of them!

Special Thanks To VAFP Members Who Served As Family Physician Of The Day During The 2000 Virginia General Assembly

Clay Hall, MD
Blackstone

Barbara Bernard, MD
Blackstone

Sam Jones, MD
Fairfax

Alfred L. Brassell, Jr., MD
Yorktown

Ron Labuguen, MD
Mechanicsville

Dana Burton, MD
Mechanicsville

Sylvia Luther, MD
Fairfax

Keith Chumley, MD
Fairfax

Dan McCarter, MD
Nellysford

David A. Clark, MD
Richmond

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Castlewood

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Amelia

Lina Sue Crowder, MD
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David Ellington, MD
Lexington

Chris Ogburn, MD
Mechanicsville

Kurt Elward, MD
Charlottesville

Cynthia Romero, MD
Norfolk

Eric M. English, MD
Midlothian

Yates Sealander, MD
Madison

Jamie Fitzgerald, MD
Fairfax

J. Douglas Smith, MD
Harrisonburg

Wayne T. Fuller, MD
Virginia Beach

George R. Smith, MD
Shawsville

John Gazewood, MD
Charlottesville

Gordon Theisz, MD
Newport News

John Goddard, MD
Newport News

Andrew White, MD
Front Royal

L.T. Gravatte, MD
Warrenton

Marion Hahey, MD
Blackstone

University Of Virginia

Submitted by Ms. Nina Ross, VAFP Student Representative

The year is coming to a close for the Family Practice Interest Group at UVA. Our year began with celebration of National Primary Care Week. The week included a series of lunch-time talks co-sponsored by the family practice club and the pediatrics club.

Students learned about evidence-based medicine, practice in underserved areas, and outpatient pediatrics, among other topics. Another highlight from the fall was a well-received talk by Dr. Lewis Barnett of the family practice department whose stories about his patients reminded us about the human side of medicine.

Throughout the year, several ongoing programs have provided students with

exposure to aspects of clinical family practice. The Follow-A-Resident program allows students to observe family practice training firsthand. The Adopt-A-Mom program pairs students with obstetrics patients from the family practice clinic and then enables them to follow their patient from prenatal visits to delivery to pediatric check-ups. Continuity of care at its best!

Planning is underway for next year's activities. Anthony Gust has handed over leadership to two new co-presidents, Nina Ross and Christi Sell. Officers are also being selected from all four medical school classes so that the club can meet the interests of students in both the preclinical and clinical years. Dr. John Gazewood continues as our faculty advisor.

Congratulations To Eastern Virginia Medical School

Eastern Virginia Medical School (EVMS) earned a **Bronze Achievement Award** from the American Academy of Family Physicians (AAFP).

This award recognizes outstanding efforts to promote student interest in family practice and produce graduates who enter the specialty.

Based on a three-year average for the period ending October 1999, 20.8% of EVMS's graduates have entered an ACGME-accredited family practice residency program upon graduation.

EVMS was recognized for their accomplishment on May 5, 2000 during the Society of Teachers of Family Medicine Annual Spring Conference in Lake Buena Vista, Florida.

NATIONAL conference

of family practice residents and medical students



2000

Reserve August 2-6, 2000
on your calendar now!

Your career!
Your future!
Your conference!



American Academy
of Family Physicians

register online at www.aafp.org/conference



Mental Health 2000

Over 13 Million Americans suffer from a depressive illness.

What can you do to help?

The American Academy of Family Physicians has created the Annual Clinical Focus (ACF) on Mental Health for the year 2000. The ACF is an educational initiative designed to bring members the most current information in the area of mental health.

ACF activities include:

- Mental Health Video CME Programs
- American Family Physician Monographs on Mental Health
- Patient Education Handouts
- Mental Health Clinical and Promotional Articles Appearing in AAFP Publications
- Mental Health Topics as part of the Chapter Lecture Series and National CME Courses

You can find additional information, including patient education materials by calling or visiting the web sites of the ACF cooperating partners:

National Institute of Mental Health nimh.nih.gov (801) 413 3013	American Psychiatric Association psych.org (202) 682 6000
National Alliance for the Mentally Ill nami.org (800) 950 5264	National Mental Health Association nmha.org (800) 969 6612

For more details about ACF Mental Health 2000, please visit aafp.org/acf or call 1 800 274 2237, ext. 6538.



American Academy
of Family Physicians



How The Emergency Regulations For Durable Do Not Resuscitate Orders Differ From The EMS DNR Orders

Submitted by the Virginia Office of Emergency Medical Services

Emergency regulations governing the Durable Do Not Resuscitate (DDNR) program, adopted by the Virginia State Board of Health, became effective on January 3, 2000.

The emergency regulations amend the EMS Do Not Resuscitate (DNR) regulations and establish a DDNR Order that follows the patient throughout the entire health care setting. Once issued by a physician for his patient, the DDNR Order applies wherever that patient may be — home, EMS vehicle, hospital, nursing home, adult care residence or other health care facility.

Permanent regulations will be developed and adopted by the Virginia Board of Health to replace and supercede these emergency regulations.

Significant differences in the new DDNR Order and the former EMS DNR Order are listed here with reference to where they can be found in the Virginia Administrative Code.

Differences In Definitions

(Section 12VAC5-65-10)

Physician

The definition of “attending physician” in the former EMS DNR regulations is not included in the emergency DDNR regulations. This is because the former EMS DNR regulations allowed only attending physicians to issue EMS DNR Orders. The emergency DDNR regulations allow DDNR orders to be issued by “a physician for his patient with whom he has a bona fide physician/patient relationship, as defined in the guidelines of the Board of Medicine.”

Qualified Health Care Personnel

Qualified EMS personnel are now included in the definition of “qualified health care personnel” in the emergency DDNR regulations. Qualified personnel who are authorized to honor DDNR Orders are defined as licensed health care personnel, which includes qualified emergency medical services personnel.

Forms, Alternate Forms And Other DNR Orders

(Sections 12VAC-65-70 through 12VAC-65-90)

DDNR Order Form

A new DDNR form is included as part of the emergency regulations.

Other DNR Order Forms

New regulations do not limit the issuance of or authorization of health care practitioners to follow DNR Orders other than DDNR Orders for patients who are currently admitted to a hospital or other health care facility.

Physician/Patient Relationship

The emergency DDNR regulations contain a provision stating that the DDNR Order shall be completed by a physician on a patient with whom he has a bona fide established physician/patient relationship. The EMS DNR regulations stated that DNR Orders had to be completed by the attending physician.

Expiration Date Eliminated

The emergency DDNR regulations state that the DDNR Order is valid until revoked. The former EMS DNR regulations limited the effectiveness of the EMS DNR Order to one year.

Where DDNR Orders Can Be Honored

A DDNR Order is valid in any facility, program or organization operated or licensed by the State Board of Health or by the Department of Mental Retardation and Substance Abuse Services, or operated, licensed or owned by another state agency. The former EMS DNR regulations limited the validity of the EMS DNR Orders to qualified EMS personnel when in an out-of-hospital setting.

Alternate Forms Approved By The State Board Of Health

At the present time, the Board has not approved any alternate forms of DDNR. The emergency DDNR regulations contain

a DDNR Order Form and allow the use of alternative forms of Durable DNR Order identification that is approved by the State Board of Health. The former EMS DNR regulations allowed the use of a bracelet, in addition to the EMS DNR Order Form.

Who Is Eligible For The DDNR Order

(Section 12VAC5-65-100)

DDNR Orders can now be written for anyone, regardless of health condition or age. Inclusion of minors is a significant change in the emergency DDNR Order.

Significant differences in the new DDNR Order and the former EMS DNR Order are listed here with reference to where they can be found in the Virginia Administrative Code.

How To Request Durable Do Not Resuscitate Forms

Submitted by the Virginia Office of Emergency Medical Services

Who Can Request Durable Do Not Resuscitate (DNR) Forms

"Distribution of Durable DNR Forms - Authorized Durable DNR Forms, with instructions, shall be available only to physicians and to any facility, program or organization operated or licensed by the Board of Health or by the Department of Mental Health, Mental Retardation and Substance Abuse Services, or operated, licensed or owned by another state agency."

- *Emergency Regulations Governing the Durable Do Not Resuscitate Program, State Department of Health, January 3, 2000.*

The Virginia Department of Health cannot issue a Durable DNR Order Form directly to a patient. It can only be issued by a physician to a patient with whom there is a bona fide physician/patient relationship. It is this physician's responsibility to discuss information on the Durable DNR Form with the patient or the person authorized to consent on the patient's behalf.

How To Order Durable DNR Forms

All requests for Durable DNR forms must be submitted to the Office of Emergency Medical Services on a Durable DNR request form. A request can be faxed to 804-371-3543. Forms are mailed once

For more information, visit the Office of Emergency Medical Services Web site at the following address:
www.vdh.state.va.us/oems/licensur.htm.

a week. Average time for receiving forms is two to three weeks. Please do not call to check on the status of your order unless you haven't received the requested forms after three weeks. Once you receive your

Durable DNR forms, please discard any unused EMS DNR Forms.

Sample Durable DNR Forms are available for facilities to use for patient education. If you have further questions about ordering the forms, contact the Durable DNR Forms Distribution Assistant at 804-371-3500.

Requests cannot be accepted if they are written on an EMS DNR Order request form (no longer being used), fax cover sheet or prescription pad. Phone orders cannot be accepted.

EMS DNR Bracelets Are No Longer Available

DNR bracelets, which aren't required by law, are no longer being issued. There are no alternative forms of Durable DNR identification approved by the Virginia Department of Health at this time.

For More Information On The Durable DNR Order Program

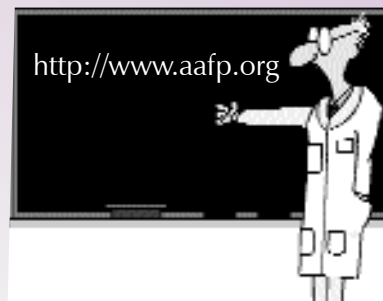
The Emergency Regulations Governing the Durable DNR Program, Virginia Durable DNR Protocols for EMS Personnel, How to Request Durable DNR Forms and the Durable DNR request form are posted on the Office of Emergency Medical Services Web site at this address:

www.vdh.state.va.us/oems/licensur.htm.

REPORTING CME HOURS IT'S A MUST!

Don't let yourself get caught out on a limb! Remember that all Active members of the Academy are required to report at least 150 hours of CME every three years, of which at least 75 must be Prescribed (AAFP approved) credit and at least 25 of the 150 must be obtained from group activities.

You can now review and report your CME hours online via the AAFP web site. To access your CME record online, first go to the AAFP's website which you'll find at: <http://www.aafp.org> and select AAFP Online. Your user name or user ID is your AAFP identification number. Your password is your last name all in caps with no punctuation. then click on "What's New" or "CME" and follow the directions.



Plan To Give Less To The IRS And More To Your Heirs

You may think that estate planning doesn't affect you, but you're probably wrong. The good news is that this year each person can exempt up to \$675,000 of his or her estate from taxes. The bad news is that with the recent bull market for stocks, the booming economy and the rapid increase in house prices, more and more people have estates valued above this level. In fact, the federal government estimates that the revenue it collects from estate taxes will increase 63% from 1998 to 2004.

And don't wait for Congress to abolish estate taxes. Although there's much talk about it, estate taxes bring in too much tax revenue that would have to be replaced from other sources. The best you can hope for is a faster increase in the estate tax exemption, which is already scheduled to increase to \$1 million by 2006.

Planning Techniques

The cornerstone of your estate plan is your will, which directs the overall distribution of your assets. But to minimize estate taxes, you may need a variety of other techniques, such as trusts, a lifetime giving program, or even a family limited partnership.

Credit Shelter Trust

One commonly used trust is the credit shelter trust or bypass trust, designed to make sure that a married couple uses both of their \$675,000 exemptions.

The cornerstone of your estate plan is your will, which directs the overall distribution of your assets.

If, for example, a husband leaves his half of the estate to his wife, the transfer is free of estate tax. But she will then own all

the estate with only her \$675,000 exemption left to protect it. If, instead, the husband leaves \$675,000 of his assets to a trust, his exemption shelters the transfer from tax. The wife can use the earnings from the trust while she is alive and since the trust is not part of her estate, she will have a smaller estate to shelter with her exemption.

Life Insurance Trust

Another type of trust can be set up to hold life insurance policies, preventing the proceeds from being included in your estate.

Charitable Trust

A charitable remainder trust allows a spouse or children to access the earnings from assets in the trust for a time, with the assets eventually going to charity.

Living Trust

A revocable living trust is intended to avoid the need for assets to go through a court proceeding known as probate after you die.

Lifetime Gifts

A lifetime giving program takes advantage of the fact that any person can give tax-free gifts of up to \$10,000 per recipient each year. This can be a great way to transfer assets to children, grandchildren and other intended heirs while you're still alive, reducing the taxable value of your estate in the process. And if you're worried that they'll squander the money too soon, there are ways to give assets to a trust and limit their access to it.

You can even avoid the \$10,000 annual limit if you make gifts directly to an educational institution for college expenses or to a hospital for medical expenses.

Family Business

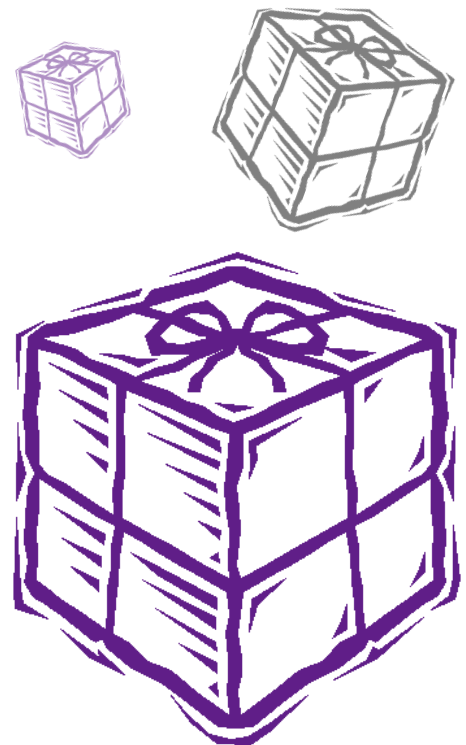
If you own a family business or farm, you have special estate planning challenges. Congress provided some relief a few years ago, but a lack of cash to pay estate taxes forces the sale of many family businesses.

Good estate planning can minimize taxes or provide the liquidity to pay them, and can also help ease the problems of transferring management to the next generation. For example, a family limited partnership may offer both tax savings and a way to gradually transfer ownership of the business to your heirs while still maintaining control yourself.

Other Needs

Finally, don't forget that an estate plan is about more than taxes. Your plan should include a durable power of attorney in case you become incapacitated, a medical directive or "living will" to specify your wishes for medical treatment, and directives for guardianship of your minor children.

And if you already have an estate plan, pull it out for a review. You'll be surprised how quickly it can become out of date.



How To Succeed In Business.com

If you run a business, you're probably inundated with advice about the Internet and the World Wide Web. At times like these, it helps to step back and review some of the basic rules for online success.

Fit The Internet To Your Business, Not The Other Way Around

The Internet is a powerful tool, but you don't need to take advantage of every Internet capability simply because it's there. For example, e-commerce is currently a hot area, but online product sales

The Internet is a powerful tool, but you don't need to take advantage of every Internet capability simply because it's there.

aren't appropriate for every company. Your business might be able to benefit from something as simple as a private e-mail system or bulletin board (an "Intranet"), which would allow customers and employees to communicate more effectively.

Don't Try To Accomplish Everything At Once

If you are faced with several possible Internet projects, start with activities that are most likely to lower costs or expand existing sources of revenue. For example, by posting a list of job openings and an application form on your company Web site, you might be able to hire one less employee in your human resources department. To help generate new customers, consider posting your company's brochure, newsletter or product list online.

Remember The Business Basics

A Web site is an investment, and it should generate a reasonable financial

return. If it doesn't, something is probably wrong. Also, major business projects often involve hidden costs and the Internet is no different. For example, by posting your catalog online you might be able to lower your printing and postage bill, but you also might incur additional expenses for computer support and special Web graphics. Make sure that you understand all of the costs before you take the plunge.

As Always, The Customer Comes First

An online visitor who gets confused or frustrated is likely to be gone in the click of

a mouse. And an ugly Web site with a poor design sends the same bad message as a messy store or office. Visit your own site at least once a week, and try to view it through the eyes of a customer. If you invite visitors to submit E-mail feedback or questions, respond at least as quickly as you would to a phone message. If applicable for your business, consider posting an online guarantee, product return policy, privacy statement and at least one telephone number with a live person at the other end.

Tax Talk



Little Change To Auto Depreciation Limits

Depreciation limits for business automobiles in 2000 will be similar to limits for 1999. The only change is a \$100 drop for depreciation in year two. The 2000 limits will be \$3,060 for the first year, \$4,900 for the second year, \$2,950 for the third year and \$1,775 for every year thereafter.

Per Diem Rates For 2000

Rates that can be used to reimburse or substantiate expenses for business travel have been released by the IRS. For expenses paid or incurred after January 1, 2000, the meal and incidental expenses (M&IE) reimbursement rates under the optional high-low method will remain at \$42 for high-cost areas and \$34 for other locations. Per diem rates for travel within the continental United States increase from \$185 to \$201 for high-cost locations and \$115 to \$124 for other locations.

Last Minute Law Extends Credits

After giving up hope on reaching agreement on any significant tax legislation in 1999, Congress passed a minor tax bill last November that extends several expired or expiring tax provisions. Among the tax relief provisions included in the bill:

- ❖ Extension of the research and experimentation tax credit through June 30, 2004.
- ❖ Extension of the work opportunity tax credit through December 31, 2001.
- ❖ Extension of the welfare-to-work tax credit through December 31, 2001.
- ❖ Extension through December 31, 2001, of the exclusion from income for employer-provided education assistance.
- ❖ Extension through December 31, 2001, of alternative minimum tax relief for taxpayers claiming non-refundable personal tax credits, such as the child tax credit and education credits.

Among Revenue-raising Provisions In The Bill

- ❖ Modification of the prior-year safe harbor for estimated tax payments made by

individuals with annual income in excess of \$150,000. For 2000, the prior-year safe harbor percentage increases to 108.6% from the previous 105%.

- ❖ Repeal of the installment method of reporting for sales for most accrual basis taxpayers.

Other Changes For 2000

Among the other tax changes that you need to be aware of in 2000 are the following:

- ❖ The estate and gift tax exemption increases from \$650,000 to \$675,000.
- ❖ The luxury tax on cars drops to 5% on amounts above \$38,000, a decrease from the 1999 tax of 6% on amounts over 36,000.
- ❖ The amount of business equipment that can be expensed in 2000 increases from \$19,000 to \$20,000.
- ❖ The maximum interest deduction on college loans increases from \$1,500 to \$2,000.
- ❖ The threshold at which payroll taxes must be paid on household workers increases from \$1,100 to \$1,200.

Your IRA Nest Egg: What Happens At Age 70?

Like all good things, the tax deferral opportunities of an individual retirement account (IRA) eventually come to an end.

Reaching age 70½ is the event that triggers the beginning of the end. Mandatory withdrawals must begin no later than April 1 of the year following the year in which you reach age 70½. (Withdrawals may start as early as age 59½.) For example, if you reach age 70½ in 2000, mandatory withdrawals must begin by April, 2001. Required withdrawals can be a lump sum or periodic over a number of years.

If annual distributions are chosen, they can be based on your life expectancy or the combined life expectancies of you and your beneficiary (within limits), but you must decide this up front. You could also have the choice of "locking in" your life expectancy at age 70½ or recalculating it every year.

If periodic distributions are chosen, they must be made each year. The initial distribution can be made in the year you turn 70½ or delayed until April 1 of the following year. If you delay the first distribution, you must take and pay tax on two distributions in the same year.

The minimum withdrawal requirement for IRAs does not apply to Roth IRAs.



Before making important financial or business decisions this year, be sure to contact your accountant or tax consultant to discuss these changes and any other tax concerns you may have.

Tax Update information should not be acted upon without further details and/or professional assistance. Tax Update is provided by Wells, Coleman & Co., L.L.P., 3800 Patterson Ave., Richmond, Virginia.

Can You Mix Business And Luxury?

fyi Your 2000 Tax Numbers

Are you aware that there are limitations on the tax deduction allowed for business use of "luxury cars?"

The definition of a luxury car may surprise you. It doesn't depend on manufacturer or model, or even on price, it depends on weight.

For cars (with certain exceptions, such as hearses and taxis), annual depreciation expense is limited for any vehicle with an **unloaded** gross weight of less than 6,000 pounds.



That means that virtually every passenger car manufactured today is subject to the limits. If you buy a business vehicle in 2000 and it meets the "luxury car" definition, first-year depreciation will be limited to \$3,060.

An important exception to these rules exists for certain trucks, vans and sports utility vehicles. The same limit applies if their **loaded** gross vehicle weight is less than 6,000 pounds, but if the manufacturer's specified gross vehicle weight, **including load**, is more than 6,000 pounds, they escape the depreciation limitation.

As a result, if you buy for your business a truck, van or sport utility vehicle with a loaded gross weight over 6,000 pounds, your first-year deduction won't be limited by the luxury car rules. Your vehicle may also qualify for the Section 179 deduction of up to \$20,000 in 2000. But if you buy a passenger car instead, your first-year deduction will be much lower.

Inflation adjustments are made to various tax numbers each year. The numbers for 1999 apply to your 1999 returns and the numbers for 2000 should be used in your 2000 tax planning.

	2000	1999
* Standard deduction		
- Single	\$4,400	\$4,300
- Married, filing jointly	7,350	7,200
- Married, filing separately	3,675	3,600
- Head of household	6,450	6,350
- Additional deduction -		
Single 65 & older/blind	\$1,100	\$1,050
Married 65 & older/blind	850	850
* Personal exemption	\$2,800	\$2,750
* Kiddie tax limit	\$1,400	\$1,400
* Social security wage base	\$76,200	\$72,600
* Medicare tax wage base	No limit	No limit
* Personal exemption phase-out (AGI)		
- Single	\$128,950/251,450	\$126,600/249,100
- Joint returns & surviving spouses	193,400/315,900	189,950/312,450
- Married filing separately	96,700/157,950	94,975/156,225
- Head of household	161,150/283,650	158,300/280,800
* Limit on itemized deductions (AGI)		
- Single/joint/head of household	\$128,950	\$126,600
- Married filing separately	64,475	63,300
* Automobile standard mileage rate		
- Business	32.5 c	32.5 c before 4/1/99 31 c effective 4/1/99
- Charitable work	14 c	14 c
- Medical/moving expense	10 c	10 c
* 401(k) plan contribution limit	\$10,500	\$10,000
* IRA deductibility phase-out (AGI)		
- Single/head of household	\$32,000-42,000	\$31,000-41,000
- Joint returns & surviving spouses	52,000-62,000	51,000-61,000
- Married filing separately	0-10,000	0-10,000
- When spouse has company pension	150,000-160,000	150,000-160,000
* Social security earnings limit		
- Below age 65	\$10,080	\$9,600
- Age 65-69	17,000	15,500
- Age 70 & over	No limit	No limit

Tax Rate	Single	Married (Joint) *	Head Of Household
15%	\$ 1-26,250	\$ 1-43,850	\$ 1-35,150
28%	26,251 - 63,550	43,851 - 105,950	35,151 - 90,800
31%	63,551 - 132,600	105,951 - 161,450	90,801 - 147,050
36%	132,601 - 288,350	161,451 - 288,350	147,051 - 288,350
39.6%	Over 288,350	Over 288,350	Over 288,350

* Married separate amounts are 50% of joint amounts.

Center For Injury And Violence Protection

Submitted by Alfred E. Adams, MD, MPH, Virginia Department of Health

Violence, as well as unintentional and intentional injuries are major public health issues because of their tremendous impact on the overall health and well being of all member of society. Violent injury and premature death disproportionately affect children, adolescents, young adults and the elderly throughout the United States. In Virginia, 3500 persons die each year as a direct result of various injuries and another 35,000 persons are hospitalized at a cost to the tax payers in excess of \$340 million dollars per year. The vast majority of these injuries are the result of motor vehicle accidents, accidental poisonings, falls, fires in the home, burns, drownings, firearm-related injuries, self-inflicted injuries and assaults.

One of the first steps towards preventing both injury and violence, according to the public health approach, is to clearly identify and understand the various factors that place a person at risk for injury, violent victimization and perpetration.

Violence is a learned behavior that is subject to change, and in many instances can even be prevented. One of the first steps towards preventing both injury and violence, according to the public health approach, is to clearly identify and understand the various factors that place a person at risk for injury, violent victimization and perpetration. Prior research has shown that there are a number of "individual" (ie., history of early aggression), "familial" (ie., poor supervision of

(cont. on page 18)

Injury And Violence Survey

Center for Injury and Violence Prevention Virginia Department of Health

For the first two questions, please use the following scale to rank your answers:

- 4 = Extremely Important
- 3 = Important
- 2 = Somewhat Important
- 1 = Not Important

1. How important is it for you as a healthcare provider to intervene in the following areas?

- 1. Youth Violence
- 2. Suicide
- 3. Domestic Violence
- 4. Injury Prevention

2. For each of the following areas, please identify the significance of your resource or professional training needs according to the above scale.

- 1. Domestic Violence
- 2. Motor Vehicle & Bicycle Safety
- 3. Suicide
- 4. Home Safety
- 5. Firearm Safety
- 6. Sexual Assault / Rape
- 7. Youth Violence
- 8. Falls (Child & Elderly)
- 9. Depression
- 10. Water Safety

3. Do you feel you could benefit from continuing professional education in any of the following areas? (Check all that apply)

- 1. Identifying depression in ambulatory patients
- 2. Counseling victims (and family members) on issues of domestic violence
- 3. Discussing suicide with a patient or the surviving family members of a patient who has successfully completed a suicide
- 4. A review of the most current mechanisms and prevention of intentional injury
- 5. A review of the most current mechanisms and prevention of unintentional injury ("violence").

4. Where do you currently derive your continuing professional education regarding each of the following topics? (Include all numbers-1 through 6 below- that apply)

- Domestic Violence
- Youth Violence
- Injury Prevention
- Suicide

- 1. Continuing Education Workshops
- 2. Medical Conferences
- 3. Hospital Grand Rounds
- 4. Professional Journals
- 5. Distance Computer Learning Courses
- 6. Other

5. Are you aware of any effective community-based resources for the referral of patients who are victims of domestic violence, youth violence, or who are potentially suicidal?

- Yes No

6. Would you like to receive patient education materials for any of the following? (Check all that apply)

- 1. Overall Injury Prevention Materials
- 2. Water Safety
- 3. Rape & Sexual Assault
- 4. Youth Violence
- 5. Accidental Poisonings
- 6. Firearm Safety
- 7. School Violence
- 8. Suicide
- 9. Depression
- 10. Domestic Violence

Please take a moment to fill out this survey. You may fax the completed survey to us at (804) 786-0917.

TrailBlazer Health Enterprises, LLC To Assume Virginia Carrier Duties From United Health Care

TrailBlazer Health Enterprises, LLC, will become the Medicare Part B carrier for Virginia in September 2000, taking over for the present carrier, United Health Care (UHC). TrailBlazer currently holds the Medicare Part A contract for Texas, New Mexico and Colorado and the Medicare Part B contract for Texas, Maryland, Delaware, the District of Columbia and northern Virginia.

TrailBlazer plans to assume UHC's Richmond, Virginia based operation that includes approximately 180 employees. The HCFA Part B Standard System (HPBSS), which is the computer system utilized by UHC, will continue to be used by TrailBlazer following the transition. Current UHC policies and procedures will also be maintained after the transition occurs.

Within the next few years there will be a systems conversion to the Multi Carrier System (MCS), which is currently used by numerous carriers nationwide, including TrailBlazer. All carriers will eventually be using MCS as the Health Care Financing Administration (HCFA) continues to standardize the Medicare program.

To keep providers informed about this transition, TrailBlazer will publish two transition newsletters. These newsletters will provide information on transition activities as well as answer questions submitted by providers. After September, providers and professional associations will receive the TrailBlazer Medicare Part B newsletters.

TrailBlazer staff members and UHC are committed to ensuring the smoothest possible transition for providers and beneficiaries.

TrailBlazer Health Enterprises, LLC Establishes Transition Consulting Team (TCT)

During the transition, TrailBlazer Health Enterprises, LLC, will be working closely with a group of Medicare B physicians and representatives from various medical organizations who comprise the Transition Consulting Team (TCT).

The TCT serves in an advisory capacity on Medicare Part B transition activities, plans, issues, etc., that have a direct impact on the provider and beneficiary communities.

Responsibilities of the team include but are not limited to:

- Functioning as a "sounding board" for planned transition activities affecting Virginia providers and beneficiaries
- Identifying potential problem areas or issues
- Providing suggestions on draft transition policies to the provider and beneficiary communities
- Providing feedback on provider educational activities
- Discussing any rumors that are circulating and, to the extent possible, assisting in dispelling such rumors
- Assisting the incoming carrier in identifying mechanisms for continually improving communications with provider and beneficiary communities
- Assisting the outgoing carrier in communicating with beneficiary and provider communities

Local Medical Policy And The Carrier Advisory Committee

The continuity of established local Medicare B medical policies and the ongoing participation of the Carrier Advisory Committee are often raised as concerns by participants in TrailBlazer transition meetings. TrailBlazer would like to stress that established local medical policies will remain unchanged. Throughout the transition, any changes to policies will be made through the Carrier Advisory Committee after September, 2000.

Carrier Advisory Committee (CAC)

The CAC is the direct physician advisory body to the carrier that helps form local medical review policy for the Medicare Part B program. Local medical review policy is policy formed locally, within each state, in the absence of HCFA national medical policy. When national policy on a subject exists, the Medicare carrier is contractually required to abide by it.

The CAC is composed of physicians and other health care professionals who represent specialty and sub-specialty physician groups and certain other groups whose input is felt to be crucial in forming good medical policy for Medicare. In addition, there is a representative of the Medicare beneficiary community on the committee.

The CAC meets three or four times annually. At the CAC meeting, the draft

medical policies are discussed and comments noted. There is a forty-five (45) day comment period following the CAC before the medical policy can be finalized.

Following the meeting, it is the responsibility of the CAC members to disseminate the draft policies to the medical community for comments during the 45-day comment period. Thus, the CAC is the central mechanism by which medical policy can be discussed, disseminated and commented on by each state's medical community before it is finalized by the carrier.

The final outcome on medical policy formation is published in TrailBlazer newsletters.

The Virginia CAC will remain intact and continue to meet during their regularly scheduled times each year, as they have in the past.

Transition Questions And Answers

During the transition, TrailBlazer Health Enterprises, LLC, will make every effort to keep physicians and suppliers informed, either through their professional associations or through direct publications to the provider community. Providers are encouraged to submit their questions about the transition to TrailBlazer. Any questions regarding the current claims processing should continue to be sent to UHC. Send your transition questions to:

Susan Williams
TrailBlazer Health Enterprises, LLC
Transition questions
Executive Plaza III
11350 McCormick Road, 3rd Floor
Hunt Valley, Maryland 21031

Here are commonly asked questions about the transition and implementation.

Q When will TrailBlazer assume full responsibility for the Virginia Contract?

A The transition is scheduled to occur on September 15, 2000.

Q Will the current phone numbers and addresses change after the transition?

A No. Providers will continue to utilize the same phone numbers and addresses they have utilized with UHC.

Q Will the local medical policies change for processing Part B claims?

A No.

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FOR Service To Your Country

Center For Injury And Violence Protection

(cont. from page 14)

children), "peer and school" (ie., association with those involved in high-risk behaviors) and "community" (ie., poverty) factors that appear to increase the probability of injury or the expression of violent behavior during adolescence and young adulthood.

The Center for Injury and Violence Prevention is a multidisciplinary unit within the Virginia Department of Health. It seeks to address the above noted risk factors in a proactive manner. One of the goals of the center is to provide parents, health care providers, educators, law enforcement agencies, centers of worship, community leaders, and

others who work closely with youths and their families, with the most current information, skills training and resources which will allow them to increase the overall awareness and prevent both injury and violence within the communities in which they live or serve. The Center's activities include research and assessment, policy development, public information, community education, group training, the dissemination of child safety restraint devices and other local and statewide projects that are designed to prevent injury and sexual assault.

We invite you to look upon us as a

resource for scheduled lectures, workshops, continuing professional education as well as patient information materials and videotapes for injury and violence prevention training. In order that we may better serve you, we ask that you please take a few moments to complete the survey located on page 14. **You may fax the completed survey to us at (804) 786-0917. For questions or further information, please contact us at (804) 692-0104.**



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