

VIRGINIA FAMILY PHYSICIAN

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An Ounce Of Prevention...With A Medicare Compliance Plan

K. Marshall Cook

Principal, Hirschler, Fleischer, Weinberg, Cox & Allen

It's been nearly three years since the Department of Health and Human Services Inspector General June Gibbs Brown invited the nation's health care providers to join her in a "national campaign to eliminate fraud and abuse from Medicare, Medicaid and the more than 200 other Federal health and human development programs that serve some of our most vulnerable citizens."

Since then, the OIG and the Department of Justice (DOJ) boast increased administrative, civil and criminal enforcement activities, including some recent, highly-publicized convictions and sentencing of hospital executives for federal health care program fraud. The Inspector General also has issued a series of compliance guidances for various sectors of the health care industry designed to educate pertinent staff involved in the claims process, prevent improper billings before they occur and foster a willingness to recognize and report fraudulent claims activity.

Data released by the Inspector General shows that the Medicare program alone paid \$12.6 billion in improper claims during FY98, or about 7.1% of the \$176.1 billion fee-for-service claims processed that year. Approximately \$3.2 billion of the \$12.6 billion (or 25.5%) of improper claims identified by the OIG related to physician services. Nearly one half (47.1%) of these improper claims by physicians to Medicare resulted from coding errors. Of the remainder, 17.3% contained no documentation, 12.3% contained insufficient documentation, 12.3% lacked medical necessity and 11.1% were not covered services.

Many Improper Claims Merely Are "Overpayments"

Many improper claims submitted to Medicare are "overpayments" or Medicare funds a physician or beneficiary has received in excess of amounts due and payable under the Medicare statutes and regulations. When an overpayment to a physician is identified, the physician will receive an overpayment demand letter from the Health Care Financing Administration (HCFA) or one of its contractors, requiring the physician to refund the overpaid amounts. In practice, overpayment demands directed to physicians and medical practices normally are handled by the local Medicare carrier, the entity that has contracted with HCFA to process Medicare Part B claims.

It is important to remember that overpayment demand letters generally do not involve the assessment of civil or criminal penalties. The amount demanded usually is limited to the amount that HCFA or the carrier alleges has been overpaid to the provider. Cases involving potential civil penalties or criminal liability, on the other hand, generally are brought under one or more of the federal "false claims" laws and are prosecuted by the OIG or the DOJ, rather than HCFA or the carrier.

The Health Insurance Portability and Accountability Act, passed by Congress in 1996, includes a provision establishing the Medicare Integrity Program (MIP). Under the MIP, HCFA may contract with private companies to provide specialized services to HCFA relating to the integrity of the Medicare program. MIP provides for three new types of Medicare contractors, including Program Safeguard Contractors (PSC)

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Editor's Note: Mr. Cook's article was selected as the cover article because of the contemporary nature of the subject material.

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David A. Ellington, MD

Quite a bit has happened since the Annual Meeting this past summer. Most important is the emergence of the issue of how the money from the **Tobacco Settlement** will be appropriated. Virginia is projected to receive approximately 4.1 billion dollars over the next twenty to twenty-five years from the lawsuits against the tobacco manufacturers. With this money on the line, it should come as no surprise to anyone that everyone wants money for a favorite project.

Virginia is projected to receive approximately 4.1 billion dollars over the next twenty to twenty-five years from the lawsuits against the tobacco manufacturers.

The Governor, Republicans and Democrats alike are proposing that this money be spent on transportation, education, parks, and a myriad of other issues. Although these issues are important to the future of the Commonwealth, the money from the Tobacco Settlement was never intended to be used in this manner.

With 9,500 Virginians dying each year from tobacco related illness; with 155,000 present teenage smokers projected to die from tobacco related illness in the future; with direct costs of tobacco related illness in Virginia exceeding \$1.2 billion and a state and federal tax burden of \$700,000,000, it is time that our Governor and Legislators spend the money for the purposes for which it was intended.

You have each received information on the Tobacco Settlement and a request

to contact your legislator with the message to use the money for its intended use. **I have included on page 5 of this newsletter a revised proposed letter, which I urge you to put on your letterhead and mail to both your Senator and Delegate.** I cannot emphasize how difficult this fight will be or how important the contact with your legislator is. Please take the time to do this. It is of vital importance to the future health of our patients.

Cynthia Romero was a candidate for a seat on the AAFP Board of Directors at the AAFP Annual Meeting in Orlando. In spite of what was felt to be the best speech of any of the candidates, Cynthia was unfortunately not elected. However, she so impressed everyone that she has been selected for a four year term on the AAFP Commission on Continuing Medical Education. She joins Mike Ponder who was selected to serve as Chair of the AAFP Communications Committee. Additionally, other AAFP appointments include VAFP Resident Board member Ron Labuguen who was selected to serve as the Resident member on the AAFP Communications Committee and outgoing Student Board member Nancy Pandhi who was selected to serve as FMIG Regional Coordinator for Region 8. Michelle Whitehurst Cook continues her service on the AAFP Commission on Membership and Member Services. Speaking of the AAFP, the VAFP welcomes Charles Driscoll, MD to Virginia as the new Director of the Lynchburg Family Practice Residency Program. Dr. Driscoll currently serves on the Board of Directors of the AAFP. We are fortunate to have this degree of representation and influence at the AAFP level and thank each of these physicians for their time and efforts.

Although the Tobacco Settlement has

taken a high priority, I hope you will not forget the emphasis on volunteerism that was mentioned at the Annual Meeting. In response to this, Schering-Key Pharmaceuticals has established an annual grant of \$1000 to be given to the organization of choice by the Virginia Family Physician selected Volunteer of the Year at our Annual Meeting. I encourage each of you to continue to provide regular volunteer services to the cause of your choice and to also start thinking about a worthy Family Physician to be honored this summer.

Please **mark your calendar** to attend the VAFP Annual Scientific Assembly scheduled **July 20-23, 2000** in Virginia Beach. This outstanding meeting continues its tradition as being the premier continuing medical education conference and this year's family activities will be second to none. I look forward to seeing many of you in Virginia Beach.

Schering-Key Pharmaceuticals has established an annual grant of \$1000 to be given to the organization of choice by the Virginia Family Physician selected Volunteer of the Year at our Annual Meeting.

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Virginia Family Physician

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2000*

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.

(cont. from page 1)

that will provide Medicare medical review, fraud investigation and other program integrity support efforts. In May 1999, HCFA awarded PSC contracts to 12 companies, four of which are based in Northern Virginia.

In February 1999, HCFA released a Comprehensive Plan for Program Integrity and established a goal of reducing the claims payment error rate by 50% by 2002. One of the four key strategies for implementing the Comprehensive Plan is increased "medical review and post-pay data analysis." In July 1999, the Virginia Medicare carrier announced that the OIG would be conducting an audit of Medicare claims paid during the third quarter of 1999, and that some providers would be receiving requests for supporting documentation during the fourth quarter.

OIG Compliance Guidances

Following the Inspector General's announcement of increased audit activity in 1997, the OIG issued Medicare compliance guidances for various sectors of the health care industry. These guidances will be largely organizational for a medical group practice and center on the development of a pre-violation corrective action plan to anticipate and correct claims problems before they occur. It is expected that the OIG will issue draft compliance guidance for physicians by March 2000, with a final rule out in early summer. The OIG solicited comments last September 16 on developing such guidance and received 83 comments by the November 8 closing date.

In the compliance guidances issued to date for each sector of the health care industry, the OIG has identified seven common elements. It is anticipated that these seven elements also will be contained in the compliance guidance for physicians and should be the basis for any compliance plan developed by a medical group.

1. Written policies and procedures should be developed and distributed that promote a commitment to compliance (for example, by including adherence to the compliance program as an element in evaluating employees) and that address specific areas of potential fraud, such as the claims submission process, coding, etc.

2. Designation of a compliance officer and a compliance committee, charged

with the responsibility of operating and monitoring the compliance program and who report directly to the head of the organization. The compliance officer probably will be the first point of contact for auditors or investigators.

3. The development and implementation of regular, effective education and training programs for all affected employees.

4. The creation and maintenance of a process guaranteeing open lines of communication between the compliance officer and billing personnel, as well as written confidentiality and non-retaliation policies that encourage communication and reporting of incidents of potential misconduct or fraud. Hotlines often are suggested for employee use in reporting potential violations of laws.

5. An enforcement of developed standards through well-publicized disciplinary guidelines.

6. An ongoing auditing and monitoring process.

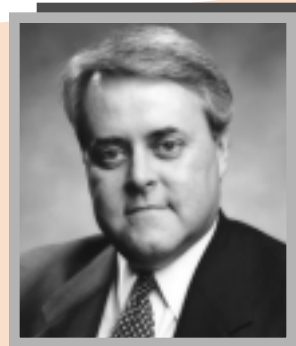
7. The development of methods to ensure responsiveness to detected non-compliance and to correct identified problems.

While these elements may seem intimidating at first, especially for a small medical group practice, the OIG recognizes that its guidance must make business sense for the group practice as it satisfies federal regulatory requirements. As these compliance plans are established, it is important to ensure genuine buy-in from physicians, practice managers and appropriate medical group staff in the early planning and organizational stages. Any plan that is the subject of internal office ridicule or inactivity is easily recognized as a sham.

Areas Of Greatest Physician Risk

A review of compliance guidances issued by the OIG to other sectors of the health care industry, comments to the OIG on the upcoming physician guidance and advisory opinions issued by the OIG to physicians and other providers demonstrates a number of risk areas to which physicians should pay particular attention. It is likely that any of these billing actions by a medical group will portend heightened audit or investigative activity.

• Unbundling (for instance, billing multi-channel set of lab tests as if individual tests



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were performed)

- Soliciting, offering or receiving kickback, bribe or rebate for referrals or for ordering tests
- Routine waiver of copays and deductibles, regardless of need
- Billing for services not rendered ("no shows")
- Double billing Medicare and private insurance
- Billing for physician services rendered by non-physicians or residents
- Lack of documentation of medical necessity
- Misrepresenting diagnoses to justify services
- Completing certificates of medical necessity for patients not personally and professionally known by the physician
- Billing Medicare or Medicaid for investigation research, medications and procedures without proper authorization
- Billing for noncovered service

Following the issuance of the OIG's final compliance guidance to physicians as early as this summer, the development of an effective, business-wise compliance plan for medical groups with significant Medicare and other federal health care program billings is important. The plan need not be costly or burdensome to implement. It should be largely educational, focused on prevention and embraced by every physician, practice administrator and billing staff member in the medical group. Developing a Medicare Compliance Plan that satisfies the OIG's standards will be time well spent. An ounce of prevention—in this case to promote trust of a medical group's claims processes—may be rewarded if an audit occurs.

Sample Letter

Dear Senator/Delegate:

During this session of the General Assembly, you are considering how the Tobacco Settlement's money will be distributed. It has been proposed that 50% be targeted for tobacco farmers, 10% for youth smoking cessation and 40% on transportation.

I do not take issue with 50% of the settlement money going to tobacco farmers. I do, however, feel strongly that to spend only 10% on health related initiatives violates the intent of the lawsuits, which generated the settlement.

Yes, transportation is important but you do not see what I see daily in my office. Patients with heart disease, cancer, pulmonary disease and stroke victims. All illnesses, which arguably are either caused by smoking or significantly, aggravated by smoking.

We all recognize the current and future economic impact that Virginia tobacco farmers face. I concur they must share in this money. We must also recognize the current and future economic impact of smoking related illnesses and the devastating effects that those with these illnesses and their family members face not to mention the Commonwealth.

I urge you to support legislation presently under consideration which focuses on increased funding for smoking cessation, enforcement of laws forbidding the sale of tobacco products to minors and funding for medical research particularly as it relates to tobacco related diseases.

I understand the importance that transportation plays in the economic future of the Commonwealth. However, as a family physician and a constituent, we must never lose sight of the fact that the health of the citizens of Virginia remains and should always be our number 1 priority and our greatest economic resource.

Sincerely,

Your Name

FOR THE NAME AND ADDRESS OF YOUR SENATOR AND DELEGATE

Log on to: [Http://legis.state.va.us](http://legis.state.va.us)

Click on: State Legislature

Click on: Who's My Legislator

Or

Call the VAFP Headquarters at 1-800-THE-VAFP
and the staff will provide the information for you.

Special Constituencies

Cynthia C. Romero, MD, AAFP New Physician Delegate

Are you a woman, minority, international medical graduate, or new physician? If you are any of the above, then the AAFP has a conference for you...the National Conference for Special Constituencies (previously National Conference for Women, Minority and New Physicians). The 1999 AAFP Congress of Delegates voted to include international medical

graduates at this conference to allow those members of the Academy to have an opportunity to meet as a national group. Such meetings or caucus gatherings serve as forums to share concerns with colleagues from across the country, as training grounds for members to learn about the policy-making mechanisms of the AAFP and as networking opportunities to mingle with fellow AAFP members from other chapters.

This conference celebrated its 10th year anniversary in May, 1999. Just a few years ago, this conference was combined with the Annual Leadership Forum, the leadership conference for national and state chapter officers and leaders. This combination has proven to be quite productive and beneficial to all who participate.

For more information, please contact Mr. Terry Schulte at the VAFP office or visit the websites of the VAFP and the AAFP.

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New Physician Update

Cynthia C. Romero, MD, AAFP New Physician Delegate

At the 1999 AAFP Scientific Assembly in Orlando during hurricane Floyd this past September, I had the privilege of serving as one of the two Delegates for New Physicians of the Academy. Dr. Mitch Finnie from Texas was the other Delegate. We were elected as Alternate Delegates by the New Physician caucus at the National Conference for Women, Minority and New Physicians (NCWMNP) held in Kansas City, Missouri May, 1998, then became Delegates after the 1998 Congress of Delegates in San Francisco. New Physicians are defined as a membership category within the AAFP including physicians within their first seven years of practice. As you can imagine, New Physicians have unique needs and perspectives that are valuable for the Academy.

During the 1999 Congress of Delegates in Orlando, several resolutions regarding ambulatory care, credentialing, reimbursements for treating tobacco use (cessation) and obesity as well as the regu-

lation of dietary/nutritional supplements were adopted. Other resolutions submitted by the Joint Committee (combination of Women, Minority and/or New Physicians) were adopted addressing media violence, violence toward physicians, collective bargaining and gun control.

Clearly, New Physicians have a special view of family medicine that can shape the future of clinical practice. The American Academy and the Virginia Academy of Family Physicians is in need of getting in touch with these New Physicians and drawing them to be involved. If you are within your first seven years of practice and have a comment, suggestion or idea, please feel free to communicate your thoughts to me, any Academy officer (state and national) or any member you feel will listen. Better yet, please come to any of the New Physicians functions hosted by the AAFP or the VAFP. Your input is essential in keeping the Academy responsive to its members.

The next AAFP conference for New Physicians is scheduled for April 27-30,

2000 in Kansas City, Missouri as a part of the National Conference for Special Constituencies (name change from NCWMNP as of September, 1999). This conference is held in conjunction with the Annual Leadership Forum which is a leadership meeting for state leaders thus providing networking opportunities with your own state officers and those from other states.

For more information, feel free to contact me or Mr. Terry Schulte through the VAFP office or visit the websites of the AAFP or VAFP.

Clearly, New Physicians have a special view of family medicine that can shape the future of clinical practice.

It's Better Together: Partnering With The PRO Is To Physicians' Benefit

Sallie S. Cook, MD, Chief Medical Officer

Quality improvement is a constant for your busy practice. But between juggling chart auditors, accommodating site visitors and reviewing practice profiles, when do you get a chance to focus on "real" patient care? That's where the Virginia Health Quality Center (VHQC) comes in. In fact, at its October meeting, the VAFP Board endorsed participation in VHQC quality projects as an efficient, effective, common-sense means of improving the health status of your entire patient population.

Now celebrating its fifteenth year in business, the company once known solely as the "federally designated medical peer review organization for the Commonwealth of Virginia," or Virginia's Medicare "PRO," is claiming new territory. Much has changed since the days when it was known as the Medical Society of Virginia Review Organization, or MSVRO.

For example, the VHQC now employs staff who offer experience in a wide range of specialties, including biostatistics, epidemiology, project management and health education. Nearly 50% of employees hold a master's degree; many have joined the staff from leading Virginia hospitals and health systems. These enhanced capabilities recently allowed the VHQC to attain a national PRO Program role. For the next three years, it will serve as the lead organization supporting HCFA's breast cancer initiative, providing technical assistance to the government and the country's 52 other PROs. In addition, the VHQC has secured independent external appeals contracts with the State of Maryland, the University of Virginia and several private employers.

When they choose to participate in VHQC quality improvement projects, physicians and their office staff benefit from this experience and expertise. Nowhere are the benefits of partnering with the VHQC more evident than in the PRO "Sixth Scope of Work" contract period beginning February 1, 2000. As VHQC Chief Medical Officer, Sallie S. Cook, MD explained at the VAFP's October Board

meeting, the contract will focus on quality improvement, beneficiary outreach and education, plus a small volume of case review.

Improving Care Collaboratively

The Health Care Quality Improvement Program's (HCQIP) emphasis now will be on six national clinical priorities: acute myocardial infarction (AMI), heart failure, pneumonia, stroke/transient ischemic attack/atrial fibrillation, diabetes and breast cancer. It's an outstanding opportunity for physicians to benchmark their performance against statewide data. Practices can also acquire quality improvement tools and training to boost the efficiency of relevant office processes. Project participation also may support network inclusion for physicians and bolster insurance contracting opportunities. Finally, collaborating practices have the unique opportunity to launch HCFA's first national outpatient projects and assist in project design as active advisors in this cutting edge effort.

The VHQC also is developing further incentives. These include the following:

Integrated Approach

By participating in all three outpatient improvement projects—diabetes, breast cancer and flu/pneumonia vaccinations—physicians can be confident that they are improving care not only for their older patients, but also for their entire patient population.

Simplified Processes

In response to feedback on past projects, each practice will enjoy the convenience of a single VHQC contact person. Processes for project sign-on and improvement plan submission are being redesigned to reduce office staff workload and increase face-to-face contact.

Comparative Data

In addition to statewide baseline data, participants in some projects may receive statistically significant data about their own

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clinical performance.

Along with the outpatient projects, individual physicians may also be asked by the hospitals where they practice to participate in the four inpatient projects—AMI, heart failure, pneumonia and stroke.

Partnering For Quality

As it plans HCQIP projects, the VHQC will look to providers for partnership and perspective. Two advisory groups, addressing inpatient and outpatient improvement projects, provide an important channel for physician input. For example, at their first meeting, members of the outpatient clinical advisory panel shared their experience with interventions that support preventive health behaviors. Physicians, including family practitioners Shane J. Kraus, MD and C. Delp Givens, Jr., MD, are key members of both the inpatient and outpatient panels.

Emphasizing its commitment to provider partnerships, the VHQC is planning four regional workshops for the spring of 2000. Potential agenda items include the presentation of statewide baseline data and the opportunity to meet VHQC contact people. Information on dates and locations will be available in January, 2000.

For more information, contact Sallie S. Cook, MD, Chief Medical Officer via the VHQC's Provider Information line at 800-854-5244.

VAFP Members In The News

■ Outgoing VAFP Student Board Representative **Ms. Nancy Pandhi**, has been appointed to serve as one of the Family Medicine Interest Group's (FMIG) regional coordinators for the American Academy of Family Physicians. This appointment is for one calendar year.

■ VAFP Past President **J. Michael Ponder, MD**, Franklin, has been appointed by the AAFP Board of Directors to Chair the AAFP Communications Committee.

■ VAFP Director **Cynthia Romero, MD**, Virginia Beach, has been appointed by

the AAFP Board of Directors to serve a four-year term on the AAFP Commission on Continuing Medical Education.

■ VAFP Resident Board member, **Ronald H. Labuguen, MD**, Richmond, has been appointed by the AAFP Board of Directors to serve as Resident Representative on the AAFP Committee on Communications.

■ VAFP Executive Vice President **Terrence J. Schulte, CAE**, has been appointed to serve on the AAFP Executive Vice President's Advisory Council.

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 this address:

<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.

Managed Care Committee Report

Shane Kraus, MD, Chair, VAFP Managed Care Committee

Our MCC remains hard at work. I wish to share our accomplishments, our progress and our goals with you.

This newsletter contains a spreadsheet that indicates immunization services that you provide your patients. Please see pages 10 & 11. By viewing the columns from left to right, the first column is the Immunization description and current procedural terminology (CPT) code, followed by the third party payor indicators of reimbursement. We realize that your individual practice costs and reimbursements may vary and we hope you find the information helpful in running your practices in the managed care world. Please note that not all plans fully complied with our request for information, so please call your individual

provider representative if you need more details about particular immunizations.

We have added several areas of involvement with our committee members: Susan Miller, MD, Frank Bain, MD, and Ronald Goings, MD, form the physician component of CIGNA's appeals panel. Anup Gokli, MD, has agreed to work with Lynn Williamson, MD, Medical Director for Trigon HMO's to develop a comprehensive delineation of services that are provided under capitation verses fee for service reimbursement. Mark Greenwald, MD, serves on Carillion's Pharmacy and Therapeutics Committee and Jai Cho, MD serves on CIGNA's Western Region Credentials Committee.

As you can see from the leadership matrix below, there are additional opportunities for Family Physicians to have a

positive impact on the lives of those patients who participate in managed care.

Andrew White, MD, Chair of the VAFP Ethics Sub-Committee continues to finalize his report on in-office retail sales and promotions of medically related sundries. Once completed, we will publish it in the newsletter.

The year 2000 sees your Managed Care Committee more involved with the third party payors that ever before. We hope that placing Family Physicians in leadership roles within managed care organizations will make your delivery of medical care to your patients more patient oriented, hassle free, and fairly reimbursed to your practice.

Let's all roll up our sleeves and **get involved!**

MC Company	Leadership Position						
	Board of Directors	Credentialing	Medical Advisory & Medical Review	Medical Director	Pharmacy & Therapeutics	Quality Management	Utilization Management
Aetna USHC		Dan Cobaugh MD					
Carillion				Kipper Nottingham, MD	Mark Greenwald MD		
Cigna		Jai Cho MD	Shane Kraus MD	Doug Hadley MD		Anna Bittner MD	Susan Miller, MD Frank Bain, MD Ron Goings, MD
Coventry			Ron Goings MD				
Inova							
Qualchoice						Doug Smith MD	Kurtis Elward MD
Sentara			John Bryant MD	Dan Crabtree MD			
Trigon		Shane Kraus MD	Shane Kraus 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				
Medicaid							

Immunization Reimbursement

Immunization Description / CPT Code	Trigon	Trigon PPO	Cigna	Aetna	United	Qualchoice	So.Health	Carilion
Admin Immunization, single 90471	No	No	No	No	No	Yes	Yes	Yes
Admin Immunization, 2+ 90472	No	No	No	No	No	Yes	Yes	Yes
Adenovirus vaccine, type 4 90475	IC	IC	No	?	No	?	No	?
Adenovirus vaccine, type 7 90477	IC	IC	No	No	No	?	No	?
Anthrax vaccine, sc 90581	IC	IC	No	No	No	?	No	?
Bcg vaccine, percut 90585	Yes	Yes	No	No	Yes	?	Yes	Yes
Bcg vaccine, intravesical 90586	Yes	Yes	No	No	Yes	?	Yes	Yes
Cholera vaccine, oral 90592	IC	IC	No	No	No	?	No	Yes
Hepa vaccine adult, im 90632	Yes	Yes	No	Yes	Yes	Yes	Yes	Yes
Hepa vaccine ped/adol-2 dose 90633	Yes	Yes	No	Yes	Yes	?	Yes	Yes
Hepa vaccine ped/adol-3 dose 90634	Yes	Yes	No	Yes	Yes	?	No	?
Hepa/hepb vaccine adult, im 90636	IC	IC	No	No	No	?	No	?
Hib vaccine, hboc, im 90645	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Hib vaccine, prp-d, im 90646	Yes	Yes	Yes	Yes	Yes	?	Yes	Yes
Hib vaccine, prp-omp, im 90647	Yes	Yes	Yes	Yes	Yes	?	Yes	Yes
Hib vaccine, prp-t, im 90648	Yes	Yes	Yes	No	Yes	?	Yes	Yes
Flu vaccine, 6-35 mo, im 90657	Yes	Yes	Yes	Yes	Yes	?	Yes	Yes
Flu vaccine, 3 yrs, im 90658	Yes	Yes	Yes	Yes	Yes	?	No	Yes
Flu vaccine, whole, im 90659	Yes	Yes	Yes	Yes	No	Yes	Yes	Yes
Flu vaccine, nasal 90660	IC	IC	No	No	No	?	No	?
Lyme disease vaccine, im 90665	No	Yes	Yes	Yes	Yes	Yes	No	Yes
Pneumococcal vaccine, ped 90669	Yes	Yes	No	?	Yes	?	Yes	?
Rabies vaccine, im 90675	IC	IC	Yes	No	Yes	?	Yes	?
Rabies vaccine, id 90676	IC	IC	Yes	No	Yes	?	Yes	Yes
Rotavirus vaccine, oral 90680	Yes	Yes	Yes	Yes	Yes	?	Yes	Yes
Typhoid vaccine, oral 90690	Yes	Yes	?	No	No	?	Yes	Yes
Typhoid vaccine, im 90691	Yes	Yes	No	No	Yes	?	Yes	Yes
Typhoid vaccine, h-p, sc/id 90692	Yes	Yes	No	No	Yes	?	Yes	Yes
Typhoid vaccine, akd, sc 90693	IC	IC	No	No	No	?	No	?
Dtap vaccine, im 90700	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

Immunization Reimbursement

Immunization Description / CPT Code	Trigon	Trigon PPO	Cigna	Aetna	United	Qualchoice	So. Health	Carilion
Dtp vaccine, im 90701	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dt vaccine, im 90702	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Tetanus vaccine 90703	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mumps vaccine, sc 90704	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Measles vaccine, sc 90705	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rubella vaccine, sc 90706	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Mmr vaccine, sc 90707	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Measles-rubella vaccine, sc 90708	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Rubella & mumps vaccine, sc 90709	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
MmrV vaccine, sc 90710	Yes	Yes	Yes	IC	Yes	Yes	Yes	Yes
Oral poliovirus vaccine 90712	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Poliovirus, ipv, sc 90713	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Chicken pox vaccine, sc 90716	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Yellow fever vaccine, sc 90717	No	Yes	No	No	Yes	Yes	?	Yes
Td vaccine, im 90718	Yes	Yes	Yes	Yes	Yes	Yes	?	Yes
Diphtheria vaccine, im 90719	Yes	Yes	Yes	No	Yes	Yes	No	Yes
Dtp/hib vaccine, im 90720	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Dtap/hib vaccine, im 90721	Yes	Yes	Yes	Yes	Yes	?	Yes	Yes
Cholera vaccine, injectable 90725	IC	IC	?	?	Yes	?	Yes	Yes
Plaque vaccine, im 90727	No	No	Yes	No	Yes	?	Yes	Yes
BCG immunization 90728	No	No	Yes	No	Yes	?	Yes	Yes
Hepatitis A vaccine 90730	No	No	IC	No	Yes	?	Yes	Yes
Pneumococcal vaccine 90732	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Meningococcal vaccine, sc 90733	Yes	Yes	Yes	No	Yes	Yes	Yes	Yes
Japanese Equine Encephalitis vaccine, sc 90735	IC	IC	Yes	No	Yes	?	Yes	Yes
Hepb vaccine, ped/adol, im 90744	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes
Hepb vaccine, adol/risk/, im 90745	Yes	Yes	IC	Yes	Yes	Yes	Yes	Yes
Hepb vaccine, adult, im 90746	Yes	Yes	IC	Yes	Yes	Yes	Yes	Yes
Hepb vaccine, ill pat, im 90747	Yes	Yes	IC	Yes	Yes	?	Yes	Yes
Hepb/hib vaccine, im 90748	Yes	Yes	Yes	Yes	Yes	Yes	Yes	Yes

1 This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines as of 11/1/99. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

2 **Infants born to HBsAg-negative mothers** should receive the 1st dose of hepatitis B (Hep B) vaccine by age 2 months. The 2nd dose should be at least one month after the 1st dose. The 3rd dose should be administered at least 4 months after the 1st dose and at least 2 months after the 2nd dose, but not before 6 months of age for infants.

Infants born to HBsAg-positive mothers should receive hepatitis B vaccine and 0.5 mL hepatitis B immune globulin (HBIG) within 12 hours of birth at separate sites. The 2nd dose is recommended at 1 month of age and the 3rd dose at 6 months of age.

Infants born to mothers whose HBsAg status is unknown should receive hepatitis B vaccine within 12 hours of birth. Maternal blood should be drawn at the time of delivery to determine the mother's HBsAg status; if the HBsAg test is positive, the infant should receive HBIG as soon as possible (no later than 1 week of age).

All children and adolescents (through 18 years of age) who have not been immunized against hepatitis B may begin the series during any visit. Special efforts should be made to immunize children who were born in or whose parents were born in areas of the world with moderate or high endemicity of hepatitis B virus infection.

3 The 4th dose of DTaP (diphtheria and tetanus toxoids and acellular pertussis vaccine) may be administered as early as 12 months of age, provided 6 months have elapsed since the 3rd dose

and the child is unlikely to return at age 15-18 months. Td (tetanus and diphtheria toxoids) is recommended at 11-12 years of age if at least 5 years have elapsed since the last dose of DTP, DTaP or DT.

Subsequent routine Td boosters are recommended every 10 years.

4 Three Haemophilus influenzae type b (Hib) conjugate vaccines are licensed for infant use. If PRP-OMP (PedvaxHIB(r) or ComVax(r) [Merck]) is administered at 2 and 4 months of age, a dose at 6 months is not required. Because clinical studies in infants have demonstrated that using some combination products may induce a lower immune response to the Hib vaccine component, DTaP/Hib combination products should not be used for primary immunization in infants at 2, 4 or 6 months of age, unless FDA-approved for these ages.

5 To eliminate the risk of vaccine-associated paralytic polio (VAPP), an all-IPV schedule is now recommended for routine childhood polio vaccination in the United States. All children should receive four doses of IPV at 2 months, 4 months, 6-18 months, and 4-6 years. OPV (if available) may be used only for the following special circumstances:

1. Mass vaccination campaigns to control outbreaks of paralytic polio.
2. Unvaccinated children who will be traveling in <4 weeks to areas where polio is endemic or epidemic.
3. Children of parents who do not accept the recommended number of vaccine injections. These children may receive OPV only for the third or fourth dose or both; in this situation, health-care providers should administer OPV only after discussing the risk for VAPP with parents or caregivers.
4. During the transition to an all-IPV schedule, recommendations for the use of remaining OPV supplies in physicians' offices and clinics have been issued by the American Academy of Pediatrics (see Pediatrics, December 1999).

6 The 2nd dose of measles, mumps, and rubella (MMR) vaccine is recommended routinely at 4-6 years of age but may be administered during any visit, provided at least 4 weeks have elapsed since receipt of the 1st dose and that both doses are administered beginning at or after 12 months of age. Those who have not previously received the second dose should complete the schedule by the 11-12 year old visit.

7 Varicella (Var) vaccine is recommended at any visit on or after the first birthday for susceptible children, i.e. those who lack a reliable history of chickenpox (as judged by a health care provider) and who have not been immunized. Susceptible persons 13 years of age or older should receive 2 doses, given at least 4 weeks apart.

8 Hepatitis A (Hep A) is shaded to indicate its recommended use in selected states and/or regions; consult your local public health authority. (Also see MMWR Oct. 01, 1999/48(RR12); 1-37).

NOTE: This schedule is provided by the American Academy of Family Physicians only as an assistance for physicians making clinical decisions regarding the care of their patients. As such, they cannot substitute for the individual judgment brought to each clinical situation by the patient's family physician. As with all clinical reference resources, they reflect the best understanding of the science of medicine at the time of publication, but they should be used with the clear understanding that continued research may result in new knowledge and recommendations.

Enjoy Giving And Cutting Taxes

Few financial dreams are as honorable or endearing as the one that includes “leaving something to the kids and grandkids.” Unfortunately, the IRS can turn your financial dreams into nightmares by assessing up to a 55% tax on your assets when you die.

Gift And Estate Taxes

The IRS currently allows individuals to give away up to \$650,000 of property tax-free, either during life or at death. This tax-free giving amount is scheduled to gradually increase to \$1 million by the year 2006. Once you surpass the tax-free limit, you will be subject to very costly taxes. It's important to note that these taxes are the direct responsibility of the individual who makes the gift, not the person who receives it.

Gift Tax Exclusion

You can minimize and possibly avoid gift and estate taxes by taking advantage of the “annual gift tax exclusion.” This is a special allowance in the tax code that lets you give up to \$10,000 tax-free each year to as many people as you want—children, grandchildren, family members, friends or anyone else. Regardless of how many \$10,000 gifts you make in a year, you do

not have to pay tax on the gifts.

Equally important, these gifts do not reduce your lifetime tax-free giving limit of \$650,000. Example: Before the end of the year, you make five \$10,000 gifts to five individuals. You continue to do this for ten years. You will have given away \$500,000 tax-free and will still have your lifetime exemption (\$1 million) available for use at the time of death. In contrast, if you wait to transfer the \$500,000 when you die, the full amount (plus appreciation or earnings) will be included in your taxable estate.

College And Medical Costs

In addition to the \$10,000 per person annual gift tax exclusion, you can also pay anyone's college tuition and/or medical bills tax-free, regardless of the amount. However, you must make your payments directly to the educational or medical institutions. This can be an excellent way to make tax-free gifts, remove assets from your estate and help those you care about.

Tax Planning

While you should not give away assets that you may need later, lifetime giving can result in significant tax savings. To achieve such savings, however, lifetime gifts should be part of a complete estate plan.

Don't Sell, Exchange!

Although the tax code can often be unforgiving, there is one area that provides a bonanza to taxpayers. This is the tax-free exchange. Such transactions allow taxpayers to postpone paying the tax on the disposition of their business or investment property. This “postponement” of tax can be temporary or permanent, depending on the circumstances.

Trade For “Like-Kind” Property

For sales of property held for business or investment purposes, an individual can lock in substantial economic gain without incurring the tax bit which applies to most sales. The rules for tax-free exchanges are precise, however. A business or investment property must be traded for another piece of “like-kind” property or properties (business or investment real estate for business or investment real estate) of equal or greater value.

Unfortunately, there is one major catch: the person exchanging the property may not receive cash in the transaction and may not let the buyer assume a mortgage greater than the one he is giving up. If either of these conditions exist, a taxable gain is triggered.

Expand To A Three-Party Exchange

In an exchange, matching two parties whose properties are suitable to each other is rare. Where the parties aren't happy with each other's properties, like-kind exchanges often expand from a two-party exchange to a three-cornered exchange.

With proper planning and professional advice, individuals with highly appreciated property can often trade into another property without having to take care of Uncle Sam in the bargain.



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.

Six Investment Rules Could Keep You From Making Costly Mistakes

Learning from mistakes can be good... unless those mistakes result in a large dent in your net worth. How can an investor avoid these expensive errors? You can start by learning from the financial blunders of others. Here are six investment rules learned from the most common mistakes people make in investing.

1. Don't Make Emotional Decisions

Try to develop a long-term investment strategy and stick with it. Patience is the key. Hold a stock or mutual fund for as long as the good things you recognized in the first place are still there.

2. Don't Invest Without Research

Carefully consider all aspects of a new investment. For example, one famous investor only buys stock of companies with consistent operating histories and only in industries he understands. He looks for high profit margins from strong, brand name products or services which dominate their industries. He avoids companies selling competitive products with many substitutes.

3. Avoid Overly Speculative Investments

Occasionally, people do make money investing in long shots. However, discipline is crucial. If you speculate, make sure that

How can an investor avoid these expensive errors? You can start by learning from the financial blunders of others.

you invest only a small portion of your portfolio and that it's money you can afford to lose.

4. Don't Be Overly Afraid To Lose Money

Being too "loss averse" can be as bad as being overly speculative. This manifests itself in selling successful investments because of an unreasonable fear that they may dip in value, or trying to make up for a bad investment by going for the jackpot on an overly risky issue. If you are too cautious as an investor, you may find that you

(cont. on page 16)

Carilion Healthcare Corporation is searching for a BE/BC FP with a specialty interest in Obstetrics to join a 10-person, health system-affiliated group practice with six internists, four family practice physicians, a physician assistant and three nurse practitioners. This position is in Galax, a town of 8,500 located in Southwest Virginia 65 miles north of Winston-Salem, North Carolina, and approximately 80 miles from Roanoke. Galax is nestled in the Blue Ridge Mountains next to the Mount Rogers National Recreation Area, a 117,000-acre recreation area that sprawls through four Virginia counties, offering cycling, hiking and horseback riding trails, camping, boating and fishing on the New River. Galax is situated in an area of Virginia known for the quality of life it offers for young families, plus the benefit of being close to cultural amenities.

The practice has a very impressive on-site laboratory and x-ray suite, plus equipment for minor office procedures such as sigmoidoscopy, colposcopy, EST, echocardiography, etc. The practice is further complemented by Logician electronic medical records. Medicine call 1:8; OB call 1:3. fifty to 60 deliveries annually within the group, with OB back-up available for C-sections.

Carilion Family Medicine - Blue Ridge Health Associates is a primary care practice site of Carilion Healthcare Corporation, an affiliate of Carilion Health System, Western Virginia's leading not-for-profit healthcare system with 12 hospitals, 55 primary care practices and 6 residency programs which are affiliated with the University of Virginia. Incentives and benefits offered in our four-year employment contracts include interview expenses, sign-on bonus, Student Loan Repayment Program (up to \$40k), CME allowance, vacation days, health/life/disability and malpractice insurance, professional fees and licenses, and relocation expenses. Interested candidates may contact Rhonda Creger, CMSR, Physician Recruiter, Carilion Healthcare Corporation, PO Box 40032, Roanoke, VA 24022-0032, by telephone at 540-921-6124, or by e-mail at rhondac@carilion.com. Visit Carilion's web site at www.carilion.com.

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What's The Secret? How To Find The Perfect Employee

Before you can concern yourself with retaining good employees in your business, you must first find and hire them. How do you find the best? Consider these suggestions:

Job Descriptions

Develop a job description that accurately portrays the essential skills and personality characteristics needed for the job. Have current employees participate in writing job descriptions.

Applicants

Soliciting applicants through newspaper ads may not be the most efficient way to find suitable applicants. Instead, try referrals from employees and others (friends, colleagues, ex-employees, family, former professors and former candidates). These candidates are often more compatible and more qualified than "unknown" individuals. Many businesses offer rewards for referrals, with a bonus when the referral stays on the job for a given period of time. Be sure to check out each candidate's credentials, getting confirmation that resume contents are truthful.

Interviews

Train those who do the interviewing to ask questions that elicit critical information. In evaluating applicants, visualize how each might "fit" with other employees and customers. Ask trusted employees to participate in the evaluation of candidates.

The Offer

Be patient. Wrong hires will be costly! For key employees and hard-to-find skills, pay above the market and review salaries quarterly. For others, pay the market rate for your industry and region. Package a benefit plan tailored to individual needs

(but avoid plans which discriminate). Remember that flexibility is critical for many candidates.

New Hires

Assign another employee to act as a personal contact to new employees to help them "fit in." Take time to discuss how the new employee's expectations differ from on-the-job reality.

Establish A Program

Having an active recruitment process in place will reduce the time needed to fill positions when they do become vacant. Keep a file of applicants who were not hired, along with a network for making contacts.

Hiring the right person begins with the right search. Reevaluate your current hiring process and adjust it to improve your chance of hiring employees who are a perfect fit for your company.

Six Investment Rules Could Keep You From Making Costly Mistakes

(cont. from page 15)

haven't accumulated enough capital by the time you are ready to retire.

5. Don't Invest Money That Isn't Yours

As a general rule, you should not borrow money to buy stocks or mutual funds. Investing on margin can skew your judgement by adding undue stress.

6. Avoid Complicated Deals

An example might be a complicated limited partnership marketed as a "tax shelter." The investment is not only complicated, it is likely to be risky and to tie up your money for an extended period of time. This is bad news if you need to pull your cash out sooner than expected.

Mark Your Calendar

February 28

Deadline for payors to file 1099s with the IRS.

February 29

Deadline for employers to send copies of W-2s to the Social Security Administration.

March 1

Deadline for filing 1999 tax returns for farmers and fishermen who did not make 1999 estimated tax payments.

March 15

Deadline for 1999 tax returns for calendar year corporations.

JAMES P. CHARLTON, M.D. TEACHER OF THE YEAR AWARD IN FAMILY MEDICINE REQUEST FOR NOMINATION

In memory of James P. Charlton, M.D., a VAFP Past President, the VAFP awards annually the James P. Charlton, M.D. Award for excellence in teaching in family medicine. Nominees may include teachers of family medicine who participate in teaching at the medical school level, residency faculty level or community preceptorship level. The nomination process is easy. Just complete the nomination form below and mail or fax to the VAFP Headquarters Office with a one or two page letter outlining why you believe the nominee should be selected for the award. Nominating material must be received no later than June 1, 2000. Award recipients will receive a commemorative certificate during the Annual Scientific Assembly, land travel expenses, one night's lodging and a \$100 honorarium to cover additional expenses.

Nominee's Name: _____ Nominator's Name: _____
 Address: _____ Address: _____
 City/St./Zip: _____ City/St./Zip: _____
 Phone: _____ Phone: _____

Send form to: VAFP Headquarters / 2301 N. Parham Rd. Ste. 4 / Richmond, VA 23229 or FAX to: 804-968-4418.

VIRGINIA FAMILY PHYSICIAN OF THE YEAR AWARD REQUEST FOR NOMINATION

Please nominate a member of the VAFP for this prestigious award. Nominees should:

1. Provide his/her community with compassionate, comprehensive and caring medical service on a continuing basis.
2. Be directly and effectively involved in community affairs and activities that enhance the quality of life of his/her home area.
3. Provide a credible role model as a healer and human being to his/her community, and as a professional in the science and art of medicine to colleagues, other health professionals and especially, to young physicians in training and to medical students.
4. Be in good standing in his/her medical community.
5. Be a member of the VAFP.

The nomination process is easy. Just complete the nomination form below and mail or fax to the VAFP Headquarters Office with a one or two page letter outlining why you believe the nominee should be selected for the award. Nominating material must be received no later than June 1, 2000. Award recipients will receive a commemorative certificate during the Annual Scientific Assembly, land travel expenses, one night's lodging and a \$100 honorarium to cover additional expenses.

Nominee's Name: _____ Nominator's Name: _____
 Address: _____ Address: _____
 City/St./Zip: _____ City/St./Zip: _____
 Phone: _____ Phone: _____

Send form to: VAFP Headquarters / 2301 N. Parham Rd. Ste. 4 / Richmond, VA 23229 or FAX to: 804-968-4418.

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Address: _____ City/St/Zip: _____

Signature: _____

Phone: _____

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EDITOR: Terrence J. Schulte, CAE
ASSOCIATE EDITOR: Mary Lindsay McCorkle

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