

Fall 2001

VIRGINIA FAMILY PHYSICIAN

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God Bless



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Virginia Family Physician

*Fall
2001*

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.

Joseph A. Leming, MD
VAFP President

“Our nation’s elected official’s focus was suddenly changed from discussions of Social Security, to issues of National Security...” I listened to these familiar words as Dr. Warren A. Jones, M.D. our AAFP President-Elect addressed the Congress of Delegates at the Opening Session of the American Academy of Family Physicians in Atlanta, Georgia on Monday, October 1, 2001. They were familiar because Dr. Jones was quoting me from my testimony that I had given the evening before at a Town Hall Meeting discussing the American Academy’s Assuring Health Care Coverage for All. Of course, Dr. Jones and I were referring to the events of September 11, 2001.

Our Academy’s focus has also changed. Your Virginia Academy will present a comprehensive conference entitled “Bioterrorism: What Family Physicians and other Health Professionals Must Know” on Saturday, November 10, 2001 in Richmond Virginia. We have been fortunate to have secured both military and civilian leading authorities to better inform and equip the “front-line” providers of care to the citizens of the commonwealth in a timely fashion. This conference does not provide the usual “lead time” but instead provides time-sensitive and time-now needed information. Further information and registration may be found on our web site @ www.vafp.org.

Your Virginia Academy had a high profile at the recent meeting of the Congress of Delegates of the American Academy of Family Physicians in Atlanta, Georgia. Our two delegates served on reference committees. One of our alter-

nate delegates served as a liaison to another reference committee. Your Academy brought 9 (nine) resolutions to the Congress. Two resolutions passed, three passed with substitute resolutions, three were referred to the board and only one was not adopted as it was considered a state resolution. The impact of the Virginia delegation was obvious to all in attendance.

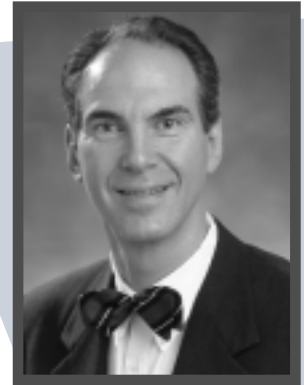
We are now planning to take the appropriate resolutions to the upcoming meeting of the Medical Society of Virginia in Crystal City, Virginia November 1-3, 2001.

I was honored to represent our Academy at a small private ceremony acknowledging the immense contributions to our Academy and to the citizens of Virginia that Dr. Jim Ghaphery made during his time at the General Assembly Building. We all mourn the loss of our dear friend and colleague and wish him Godspeed in the next life.

The Virginia Academy has executed perhaps the biggest political “coupe” so far in our career in entering an agreement with Marshal Cook to represent us as our general counsel and lobbyist. Marshall also attended the Congress of Delegates meeting in Atlanta as well as the recent Board of Directors meeting in Alexandria, Virginia.

I remind all of our members that our Midwinter meeting will again be in Wintergreen, Virginia. This meeting continues to grow in popularity and will be better than ever this year. This means that if you are interested you need to get your hotel reservations and submit your registration(may be done on-line) as soon as possible in order to secure appropriate accommodations for you and your family.

We continue to plan for our annual



scientific assembly in Virginia Beach next summer and it is shaping up to be the best yet.

Finally, now more than ever it continues to be important to be a Family Physician. Patients and staff are trying to make sense out of our current national situation. There is an ever growing uncertainty about so many things in all our lives. Our patients and our staffs need to know that we care for and about them, that we share in their insecurities, that we are constantly trying to improve ourselves for their benefit and that we are there for them and their families as their Doctor. I cannot emphasize enough how important you are to your patients and to your community and to your Academy.

I continue to strive to serve each of you as members of the Academy to the best of my ability. If I can be of service to you please do not hesitate to call me. I look forward to seeing you at the next Academy function that you chose to attend.

In Memoriam James L. Ghaphery, MD

It is with deep sadness that the Academy acknowledges the loss of James L. Ghaphery, M.D., VAFP Physician Representative. Dr. Ghaphery passed away on June 9, 2001.

Dr. Ghaphery's outstanding efforts on behalf of the VAFP elevated the Academy's legislative and regulatory influence to heights never before achieved. Dr. Ghaphery's 6 ½ years of exemplary service was recognized by the VAFP Board of Directors on May 12 when Dr. Ghaphery was awarded Honorary Membership in the VAFP. He was the first ever selected for this award. The VAFP will miss greatly Dr. Ghaphery's dedication and tireless efforts on behalf of Virginia's family physicians.



Necrology Report

The Academy also acknowledges the loss of VAFP members who passed away during the last twelve months including VAFP Past President Robert S. Smith, MD. The Academy's thoughts, prayers and sympathies are with the members of their families.

Walter A. Campbell, MD

Robert S. Smith, MD

Fleming Wood Gill, MD

Girard V. Thompson, Sr., MD

David L. Hudson, MD

Frederick Louis Troxel, MD

Melvin B. Lamberth, Jr., MD

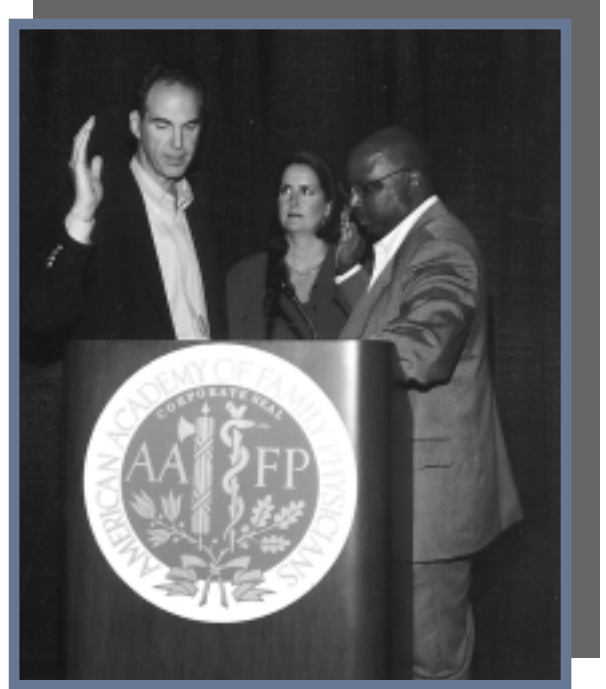
Herbert M. Zikel, MD

Alan M. Smith, MD

Joseph A. Leming, MD, Colonial Heights, Installed As VAFP President



Dr. and Mrs. Leming receive congratulations from Dr. Jones.



AAFP President-Elect Warren Jones, MD officially installs Dr. Leming as his wife Mary looks on.



Newly installed VAFP President Joseph Leming, MD and his family.



Outgoing VAFP President J. Douglas Smith, MD and his family.

Virginia Family Physician Of The Year

During the Academy's Annual Business Meeting, **Randolph V. Merrick, MD** of Orange was named Virginia Family Physician of the Year.

The Virginia Family Physician of the Year Award is presented annually to a Virginia Family Physician whose commitment to his or her patients, family and community are unparalleled.

In recognition of Dr. Merrick's selection, he was presented a plaque which states "In recognition of unparalleled dedication and commitment to his patients, family and community and in appreciation for possessing those unique and special qualities of a truly outstanding family physician."



The James P. Charlton, MD Teacher Of The Year Award



In memory of James P. Charlton, M.D., the VAFP Board of Directors created an award in 1995 to recognize excellence in teaching family medicine. The James P.

Charlton, MD Teacher of The Year Award is presented annually at the VAFP Scientific Assembly. Dr. Charlton was an exemplary teacher of family medicine, imparting upon his residents the qualities of academic excellence, strong clinical skills and compassionate care. He served the Academy well for many years and as its President from 1981 to 1982.

The recipient of the award for 2001 is **Meredith B. Rose, MD.**, Virginia Beach. His award states "In recognition of your exemplary skills as a

teacher of family medicine and in appreciation of your dedication to teaching and mentoring medical students. Your efforts continue to contribute immeasurably to enhancing medical students interest in family practice and exemplify the high ideals for whom this award is dedicated."

President's Awards

During the Academy's Annual Business Meeting, **Shane J. Kraus, MD** of Glen Allen and Kurtis S. Elward, MD of Charlottesville were presented with the President's Award. The award is given annually to the individual or individuals who have been of invaluable assistance to the Academy and to the current VAFP President.

Dr. Kraus' award states "In recognition and appreciation for your outstanding service as a Chair of the VAFP Legislative Committee. Your leadership and diligence have contributed immeasurably to enhancing the Academy's legislative presence."

Dr. Elward's award states, "In recognition and appreciation for your outstanding efforts focused on quality initiative issues and for your leadership and creativity in guiding the VAFP Quality Task Force."



Dr. Kraus receives the President's Award.



Dr. Elward receives the President's Award.

Annual Scientific Assembly Highlights

The Annual Scientific Assembly of the VAFP continued its tradition of offering outstanding Continuing Medical Education and fun-filled social events for the entire family. Almost 300 family physicians, family practice residents and other health care professionals attended this year's conference. In addition, 108 exhibiting organizations offered the latest in product and service developments. Special thanks are in order to Mitchell B. Miller, MD, Virginia Beach, Continuing Medical Education Committee Chair and committee members Dena Hall, MD, Norfolk, Richard Hoffman, MD, Chesterfield, Cynthia Romero, MD, Virginia Beach and Laurie Goldsticker, MD, Virginia Beach for planning an outstanding conference. In addition to pictorial highlights noted on page 8 and 9, a sample of comments from members who attended the conference are noted in quotation marks.



AAFP President-Elect Warren Jones, MD enjoys the beach barbeque with family and friends.



"Excellent - thank you for including women's topics."

Oceanfront dining was the place to be for the beach barbeque.



The new Beach Club at Duck Inn was the sight of the All Member Party.



"A great meeting - definitely will impact the way I practice."



Lori Heim, MD, Lt. Col. USAF MC and VAFP Past President David Ellington, MD.

"Excellent content and social activities, beautiful setting, good amount of family time."



Over 800 family physicians, family members and exhibitors enjoyed the All Member Party at the Duck Inn, especially the outstanding crabcakes.



Over 108 exhibiting organizations participated in this year's conference.

"Timely subjects, good variety - speakers were excellent."



"Excellent educational program - great place for family, too."

Exhibit Hall a hit with meeting registrants.



"very excellent and helpful - in practice 40 years - one of the best meetings I have attended."

A Special Thanks To Sponsors And VAFP Partners

The Academy expresses its sincerest appreciation and thanks to the following organizations for their invaluable support of meeting related activities. The involvement of these organizations has enabled this meeting to become the premier CME event of the year.

Abbott Laboratories	Janssen Pharmaceutica
Arthritis Foundation - Virginia Chapter	Medshares Home Care/Soleus Home Care
AstraZeneca Pharmaceuticals	Merck & Company, Inc.
Aventis Pharmaceuticals	Novartis Pharmaceuticals
Bayer Corporation	Olympus
Boehringer Ingelheim	Ortho Biotech
Carilion Healthcare Corporation	Pharmacia Corporation
Children's Hospital of the King's Daughters	Prime Source Healthcare/BSN Medical
Cytoc Corporation	Professionals Advocate
Daiichi Pharmaceuticals	Roche Laboratories
Doctors Insurance Reciprocal	Schering/Key
Dupont Pharma	Schwarz Pharma
ECR Pharmaceutical	Searle
Ellman International, Inc.	Wallach Surgical
GlaxoSmithKline	Wyeth-Ayerst
HCA Richmond Market	

VAFP Partners

The Academy wishes to express special recognition to its Partners.

These organizations have committed significant resources and are deserving of our highest levels of appreciation.

The levels of Partnership include
Platinum - \$15,000+
Silver - \$5,000+
Bronze - \$2,500+

Noted below are this year's VAFP Partners and their level of support.

Platinum Level Contributors

Aventis Pharmaceuticals
Schering/Key
Bayer Corporation

Silver Level Contributors

Boehringer-Ingelheim
HCA Richmond Market
Merck & Co.
Pharmacia Corporation
Wyeth-Ayerst

Bronze Level Contributors

Alza Pharmaceuticals
Arthritis Foundation
GlaxoSmithKline
Novartis



A Special Thanks To Exhibitors

The Academy gratefully acknowledges the participation and support of those organizations that choose to display their products and services at the Annual Meeting.

Abbott Laboratories	GlaxoSmithKline	Professionals Advocate Insurance Company
Alcon Laboratories, Inc.	GlaxoSmithKline Pharmaceuticals	Quest Diagnostics Incorporated
Alliance for the Prevention and Treatment of Nicotine Addiction	Hampton Roads Radiology Associates	Reliant Pharmaceuticals
Alza Pharmaceuticals	HealthServ, Inc. - Cardiac Monitoring Systems	Riverside Rehabilitation Institute
American Cancer Society	Healthy Communities Loan Fund	Roche Pharmaceuticals
American College of Nuclear Physicians	Home I.V. Care/Roberts Home Medical	Salomon Smith Barney
American Home Patient	Inpath Solutions	Sankyo Pharma
Arthritis Foundation	Interim Health Care	Schering/Key
AstraZeneca	Janssen Pharmaceutica	Schwarz Pharma
Aventis - Advanced Therapeutic Division	Janssen Pharmaceutica - Eldercare	Sentara Healthcare
Aventis Pasteur	KOS Pharmaceuticals	Studies of Healthcare in Virginia
Aventis Pharmaceuticals	March of Dimes, Virginia Chapter	Sydian Solutions, Inc.
Bayer Corporation	McNeil Consumer Healthcare	Tap Pharmaceuticals
Benchmark Systems	Medical Society of Virginia	Trigon Blue Cross Blue Shield
Boehringer Ingelheim	Medical Society of Virginia Insurance Center	U.S. Army Health Care
Bristol-Myers Squibb	Medicare B	UCB Pharma
Caligor	Medshares/Soleus Home Care	Valley Health Plan
Carilion Health System	Merck & Co., Inc.	VDH: Center for Primary Care and Rural Health
Celltech Pharmaceuticals	Merck & Co., Inc. - Urology	Virginia Army National Guard Medical Department
Children's Hospital of Richmond	Monarch Pharmaceuticals	Virginia Beef Industry Council
Children's Hospital of the King's Daughters	Mountainside Software	Virginia Department of Health, Division of Child and Adolescent Health
COSMOS/Dynamic Medical Technology, Inc.	National Network of Libraries of Medicine	Virginia Health Quality Center
Daiichi	NIKKEN Independent Wellness Consultant	Virginia Home Medical
Doctors Insurance Reciprocal	Novartis Pharmaceuticals	Wallace Laboratories
DuPont Pharmaceuticals	Organon	Wallach Surgical Devices
ECR Pharmaceuticals	Ortho-McNeil Pharmaceutical	Watson Pharma, Inc.
Eisai, Inc.	Ortho Biotech	Wyeth-Ayerst
Elan Pharmaceuticals	Purdue Pharma	
Eli Lilly and Company	Pfizer, Inc.	
Ellman International, Inc.	Pharmacia Corporation	
Fleming & Company	PhillipsCox Insurance Services	
Forest Pharmaceuticals	Physicians Management Advisors	

Marshall Cook Appointed VAFP General Counsel

The VAFP is pleased to announce the appointment of Marshall Cook as its General Counsel. Marshall will provide general corporate representation, health care and employment consulting and legislative and regulatory assistance.

"Marshall Cook is well known to family physicians in Virginia," said Joseph A. Leming, MD, the Academy's President. "He brings a legal and business background in managed care that is rare among lawyers. The VAFP is committed to bringing additional value for the members' dues dollars. We strongly believe the addition of Marshall will help fulfill this commitment."

VAFP Executive Vice President, Terrence J. Schulte, CAE, notes: "Marshall will respond to inquiries from the Academy's membership that may apply to large portions or all of its membership. He can be reached directly at (804) 784-1900 or by E-mail at mcook@hirschlerfleisch.com. In addition, he will publish in each issue of the Virginia Family Physician articles of interest to family physicians concentrating on managed care, legislative and regulatory topics. His first article appears on page 20 of this newsletter."

Mr. Cook and his firm also are available to discuss health care and legal matters that are peculiar to an Academy member or the member's medical group. Separate billing arrangements for this work may be made directly between the law firm and the member for this service, however, and not involve the Academy. Mr. Cook's biographical information is noted below.

Marshall Cook has represented the interests of physicians and other health care providers almost exclusively since 1993. He oversees the health care practice of Hirschler Fleischer, focusing on the representation of physicians, other health care professionals and providers in all aspects of their medical practice and business affairs. His experience in the organization, opera-

tion and management of Virginia's only statewide IPA (6,000+ physicians) and in the negotiation of a joint venture health maintenance organization with the nation's second largest health care company provide him not only with the most current skills in health law, but also with practical, operational knowledge of the practices of health care professionals and insurers alike. Mr. Cook also brings significant business and governmental expertise to the firm and its clients.

► Organized and served as chief operating officer of Virginia's Physician Network, Virginia's only statewide physician IPA (1995-1999).

► Negotiated a joint venture between Virginia's Physician Network and United HealthGroup for the formation of a Virginia health maintenance organization (United HealthCare of Virginia).

► Served as general counsel for the Medical Society of Virginia (1993-1995), performing all legal work for state's only physician trade association, as well as the society's for-profit subsidiary and nonprofit foundation.

► Served as deputy attorney general of Virginia (1990-1993), managing and actively supervising one of four legal divisions of the Office of the Attorney General, including overseeing 7 senior assistant attorneys general and 18 assistant attorneys general.

► Acted as co-leader of the attorney team promoting and defending Virginia's 1991 redistricting plans for congressional, state Senate and state House of Delegates districts. (Virginia was the first state in nation to have congressional and both state legislative redistricting plans approved by U.S. Justice Department.)

► Designated as one of five attorneys to lobby the attorney general's legislative package to the General Assembly. Invited by Senate and House of Delegates to lecture in new member orientation.



► While serving as a senior assistant attorney general (1986-1989), responsible for research, drafting or substantive review, and approval of every official opinion and informal opinion rendered by the attorney general in every area of Virginia law (circa 700 annually).

Marshall was a Phi Beta Kappa graduate of the University of Richmond and received his law degree from Richmond's T. C. Williams School of Law, where he was a Williams Law Scholar. He is a member of the Virginia and American Bar Associations and serves on the board of governors of the Health Law Section of the Virginia State Bar.

Marshall will provide general corporate representation, health care and employment consulting and legislative and regulatory assistance.

The Oxycontin Controversy

Larry Mitchell, MD
Richlands

Is Oxycontin: A Miracle Or A Killer?

This recent headline from a newspaper in Southwest Virginia summarizes the raging controversy about this popular opioid analgesic. On the one hand, Oxycontin and similar agents have been a blessing for many sufferers, who now have the prospect of improved function and quality of life, with extended pain-free intervals. No previously used regimens for chronic pain have approached the safety and efficacy of these agents.

On the other hand, abuse of Oxycontin has skyrocketed in Virginia, especially in the Appalachian region of the Commonwealth. Along with abuse, addiction has increased sharply. The majority of patients in some drug treatment facilities in Southwest Virginia are addicted to Oxycontin. Drug related crime has also risen, ranging from petty theft to burglary to murder. For example, the Commonwealth's Attorney in Tazewell County, where I practice, estimates that 75% of crimes in the county are now drug-related, and of these, 50% pertain to Oxycontin. The sheer number of offenders has nearly overwhelmed the police, drug task forces and the courts. In Western Virginia, 43 deaths have been attributed to Oxycontin overdose since 1998.

Laypeople, as well as the physician community, are sharply divided by this controversy. Newspaper and magazine articles are filled with testimonials by chronic pain patients about the benefits of Oxycontin therapy. One of my own patients stated that he was able to take his grandchild fishing; another, that she was able to go to church for the first time in years. They practically beg authorities to not block their access to appropriate use of

this medication. Oxycontin has many physician defenders as well, who question the extent of the Oxycontin "epidemic" and the interpretation of the statistics quoted above. They maintain that the media has sensationalized the problem, blowing it out of proportion, and that politicians have not been adverse to fanning the flames for their own purposes. They point out that many of the deaths attributed to Oxycontin, in fact, involved multiple drugs and alcohol. They also note that many Oxycontin abusers are not *new* addicts, but have added Oxycontin to a long succession of substances. No one disputes the fact that IV injection of Oxycontin, which is a common mode of abuse, is deadly, but advocates of Oxycontin see no reason to single it out from the field of other commonly abused opioids, such as heroin.

Contrasting these reports (and usually appearing in parallel columns in newspaper articles) are accounts by Oxycontin addicts whose lives have been devastated by the drug, and many of whom have attempted suicide or nearly died from overdoses. The most vehement opponents of Oxycontin, however, are family members of addicts who have suffered as much as the patients themselves. To them, Oxycontin is totally evil, and no perceived benefits could outweigh the dangers of its use. Some physicians agree; a petition is being circulated by the Lee Coalition for Health, headed by Dr. Art Van Zee of Pennington Gap, Virginia, to recall Oxycontin.

Communities are reacting in different ways to the problem of Oxycontin. For example, I was privileged to participate as a panel member in a town meeting in Tazewell about the Oxycontin problem. Police, legal, pharmaceutical and physician representatives were present, as well as,

drug abuse counselors and addicts undergoing treatment. While there was no universal agreement on solutions, at least we were able to sit down and look at the problem.

Virginia Attorney General Mark Earley has organized a Task Force on Prescription Drug Abuse, with a recent public meeting in Abingdon. The FDA is also looking at certain changes in regulations regarding chronic pain medications. The spectrum of possible solutions includes banning Oxycontin entirely, regulating its use more strictly, increasing penalties for misuse and irresponsible prescribing, and restricting prescription privileges for Oxycontin to only pain control specialists and oncologists. The only certainty about the solution is that it will be controversial.

Given this uncertainty, what can we, as family physicians, do to protect our patients and meet their needs for pain control? The following suggestions are based on my own opinions, as a practicing physician and a concerned citizen, and are not the official policy of the VAFP or its Board of Directors.

1. Study the problem closely to see what impact Oxycontin has in your area. Know the facts and do not allow yourself to be swayed by sensationalism and emotion.

2. Keep abreast of legislative issues involved in pain control. Don't assume that, if Oxycontin is not a major problem in your area, then your practice will not be affected by state or federal legislation affecting pain control. Join the VAFP in opposing legislation which could have a negative impact on your ability to treat chronic pain.

(Cont. on page 23)

National Conference Of Special Constituencies

Cynthia Romero, MD
Virginia Beach

Greetings, everyone. This year's National Conference for Special Constituencies was the largest thus far with 155 physicians in attendance. The 2000 Congress of Delegates approved of two additional constituencies (groups) to meet during this caucus: Gay, Lesbian, Bisexual and Transgender Physicians and International Medical Graduates. Each constituency had very lively discussions. The following are a summary of resolutions derived from each constituency.

New Physicians

1. Resolution for AAFP Board to investigate the liability and risk of family physicians as they facilitate transfer of medications to patients from the patient assistance drug programs and to encourage state chapters (including Virginia) to change laws which prohibit physicians from dispensing medications received from the pharmaceutical companies' indi-

appropriate heading for family practice that defines our scope of practice.

4. Resolution for the AAFP Board to identify state chapter mentoring programs and make them model programs for other chapters.

5. Resolution for the AAFP Board to consider the following election considerations for the New Physician on the AAFP Board - active AAFP member, attended one NCSC, not have served as student or resident director, nominated by state chapter, elected by New Physician constituency at NCSC, candidate's name forwarded to Congress of Delegates, and if COD not approve, then Board shall designate another New Physician to fill the position.

Women Constituency

1. Resolution for continued AAFP support of the special constituency and caucuses for women physicians (our 2 seats on the Congress of Delegates will sunset (expire) in 2002, but the AAFP will continue to guarantee opportunities for us to meet at NCSC and the AAFP Scientific Assembly.

2. Resolution to improve attendance at AAFP meetings by offering more family-oriented activities.

3. Resolution for appropriate analysis and interpretation of health work force statistics on the practice patterns of female physicians to support rather than potentially discriminate against female family physicians.

4. Resolution to educate members and provide patient education materials on all forms of contraception, including

emergency hormonal contraception (for both office and emergent/rape settings).

5. Resolution opposing limitation of RU486 prescriptive authority to physicians who can also provide surgical abortions.

6. Resolution to support gender equity in insurance companies' coverage of prescription medications (i.e. AAFP should oppose coverage of Viagra but not oral contraceptives).

7. Joint Resolution with New Physician Constituency: to educate states on current laws regarding distribution of indigent drug program medications to patients without Board of Pharmacy licensure, and assist with legislative efforts to change laws where this practice is currently a Code violation (i.e. Virginia).

8. One topic debated fervently but not adopted was for the AAFP to oppose OTC availability of emergency contraception. Feelings for and against this issue were so strong that this topic will resurface at the Scientific Assembly or NCSC, 2002.

Joint Constituency (combined)

1. Resolution to develop an online database or catalog of PowerPoint presentations for community education by family physicians.

2. Resolution to encourage states to oppose legislation allowing pharmacists to dispense medications beyond the prescription expiration date for more than emergency purposes.

3. Resolution to educate family physicians on proper coding for preventive services and work with insurance carriers on improved reimbursement for these services.

4. Resolution to improve identifica-

This year's National Conference for Special Constituencies was the largest thus far with 155 physicians in attendance.

gent medication programs.

2. Resolution for the AAFP to host an essay contest for its membership at large pertaining to all aspects of family medicine. These essays can relay the special points about family practice and hopefully be distributed to encourage high school, college and medical students to choose family practice as a specialty.

3. Resolution for the AAFP Board to request the Yellow Pages to have an

tion, prevention and treatment of physician burnout.

5. Resolution to improve resident education in sports medicine and nutrition.

6. Resolution to develop coding and reimbursement systems that include time spent on telephone calls, e-mail communications, referral processing, etc.

International Medical Graduates Constituency

1. Resolution to improve uniformity in selection criteria for Residency Programs.

2. Resolution to authorize IMG Constituency to elect delegate and alternate delegate to the AMA IMG section.

3. Resolution to reimburse IMG delegates and alternate delegates to the 2001 Congress of Delegates.

Gay, Lesbian, Bisexual and Transgender Physicians

1. Resolution for general anesthesia criteria to be defined for rural physicians.

2. Resolution for developing an online database or catalog of PowerPoint presentations for use by members for community education.

3. Resolution for dialogue with HCFA and other commercial insurers to ensure fair reimbursement for preventive care services.

4. Resolution calling for a change in federal immigration and naturalization laws to extend to resident alien status to those meeting the AAFP definition of family for same sex couples to participate in adoption and immigration procedures.

5. Resolution to develop mecha-

nisms to allow members of the constituency to self-identify and share information within the AAFP and promote mentoring opportunities.

Minority Constituency

1. Resolution to develop a web site link on Minority Health Issues via the AAFP website.

2. Resolution to consider sending representatives to exhibit and represent the AAFP at the National Summit on Elimination of Health Disparities in Underserved Populations,

3. Resolution for AAFP to participate in National Minority Health Initiative.

4. Resolution for issues of Cultural Competency to be available through the Internet and other media, and support of legislation to make funding available to hospitals and providers for culturally sensitive interpretive services.

5. Resolution to increase the representation of minority physicians and patients in its publications and advertisements.

6. Resolution to encourage constituent chapters to work with local and State Department of Corrections' Medical Directors to develop and implement educational resources for promotion of healthy lifestyles, and substance abuse prevention in prisoners and ex-offenders, and the AAFP provide family physicians with CME opportunities pertinent to the needs of this at-risk group.

7. Resolution to encourage HCFA to provide reimbursement for transportation for Medicare patients who have no other form of transportation with a limit of 12 visits per year.

The majority of these resolutions were sent to the AAFP Board of Directors,

but a few were requested to be sent to the Congress of Delegates for their session in October in Atlanta, GA. If you would like more information, please feel free to log onto the AAFP website at www.aafp.org or contact Dr. Ginger Boyle or Dr. Cynthia Romero.

One topic debated fervently but not adopted was for the AAFP to oppose OTC availability of emergency contraception. Feelings for and against this issue were so strong that this topic will resurface at the Scientific Assembly or NCSC, 2002.

New Law Delivers Tax Relief, But Slowly

The *Economic Growth and Tax Relief Reconciliation Act of 2001* was signed into law on June 7. Some of the new law's provisions take effect this year, but most of the changes are phased in over the next nine years. To meet budget constraints, the new law contains a "sunset" clause under which all of its provisions will end after 2010 unless Congress acts to extend them.

The following are some highlights of the new law.

Tax Rebate

One of the most widely publicized provisions of the new law is the tax rebate. The rebate is the result of a new 10% tax bracket that applies to a slice of income previously taxed at 15%. The *2001 Tax Act* provides for a maximum rebate of \$300 for singles, \$500 for heads of household and \$600 for joint filers. Instead of making taxpayers wait until they file their 2001 tax returns to receive the refund, Congress decided to mail out advance refund checks beginning this past July.

Tax Rate Reductions

In addition to the new 10% bracket, the law gradually lowers all rates except the 15% rate. Effective on July 1, 2001, the old 28%, 31%, 36% and 39.6% tax brackets dropped 1% and will continue to drop gradually until they reach 25%, 28%, 33% and 35% in 2006.

Tax Credits

The new law expands several tax credits available to families. This year, the child tax credit for dependent children under 17 increases from \$500 to \$600.

More taxpayers will be eligible for a refund of the credit, and the credit will be protected from alternative minimum tax. This credit will gradually increase to \$1,000 per child in 2010.

Beginning in 2003, the amount of dependent care expenses eligible for the tax credit increases, as does the rate of the credit. Next year, the adoption tax credit is made permanent and increases from the current \$5,000 to \$10,000 per child.

Marriage Penalty Relief

In many cases, a married couple pays higher tax than two single individuals with the same combined income. That's because tax brackets and some deductions and income phase-out limits for couples are less than double those for single taxpayers. The new law gradually expands the 15% tax bracket, the standard deduction and certain phase-out limits for couples to provide partial relief from the marriage penalty.

Education Tax Breaks

The *2001 Tax Act* expands several education tax breaks, starting next year. The law increases the education IRA contribution limit from \$500 to \$2,000, and it expands tax-free withdrawals to include those used for elementary and secondary education.

Next year, qualified distributions from state-run Section 529 plans will be tax-free. Education institutions can offer pre-paid tuition plans for the first time in 2002, and distributions from these plans will be tax-free after 2003.

Starting in 2002, there will be a new "above-the-line" deduction for college expenses. Some restrictions previously placed on the student loan interest deduc-

tion will disappear. The outcome exclusion for employer-provided education assistance is made permanent and will be extended to graduate school expenses.

Retirement Plan Changes

There are extensive changes to individual retirement accounts (IRAs) and qualified pension plans that will gradually be phased in, starting in 2002.

The maximum contribution increases for both IRAs and pension plans, such as 401(k)s. For the first time, the law allows "catch-up" retirement contributions for individuals age 50 and older. Beginning in 2006, employees can choose between making a pre-tax contribution and a Roth contribution to 401(k) and 403(b) plans.

Estate And Gift Taxes

Beginning in 2002, the top estate and gift tax rate will gradually be reduced, and the exemption amount will be increased. The estate tax will be repealed in 2010, but the gift tax will be retained with a \$1 million lifetime exclusion and a top rate of 35%.

Borrow From Your Company With Care

If you're a stockholder in a closely held corporation, it's sometimes tempting to take money out of the corporation in the form of a nontaxable shareholder loan rather than as taxable salary or dividends. But unless you structure the transaction as a genuine loan and repay it accordingly, you're at risk of having the loan reclassified as a taxable transaction by the IRS.

IRS Scrutinizes Loans

Loans to stockholders are a popular target whenever the IRS audits closely held corporations.

To assist their auditors, the IRS has recently issued an audit guide on shareholder loans, detailing twelve factors to be evaluated when determining whether advances made to stockholders qualify as bona fide loans. Fortunately, this audit guide is also available to the general public at <http://www.irs.gov>.

What You Need To Do

If you take loans from your corporation, here's what you need to do. First, do the paperwork. Document that the board of directors has approved the loan, and have a promissory note drafted.

Unless you structure the transaction as a genuine loan and repay it accordingly, you're at risk of having the loan reclassified as a taxable transaction by the IRS.

Don't forget to include a set maturity date as part of the promissory note. Be sure to state a fair market interest rate as

well. To be safe, consider using one of the applicable federal rates published by the IRS each month.

When taking loans, don't get greedy. Taking more than you can reasonably afford to pay back is a red flag to the IRS.

To help support your position that the loan is genuine, making payments towards your outstanding balance is a must. It's a good idea to set up a loan amortization schedule and stick to it until the loan is paid off. Make sure you actually repay the loan; don't just roll it over into a new loan.

Check IRS Guidelines

There are other factors that the IRS will explore when determining if your loan qualifies as a bona fide loan.

The IRS audit guide on shareholder loans instructs the agent to evaluate the extent to which you control the corporation and whether you put up any collateral for the loan. The IRS agent will also review the dividend paying history of your corporation and whether loans were made to other stockholders in proportion to their ownership interest in the corporation.

While sticking to the IRS guidelines for bona fide loans isn't easy, it's better than having the IRS reclassify your loans as taxable dividends or salary.

Tax Talk

Charities Under Scrutiny

Congress is concerned that numerous charities are not following IRS rules and that they are misleading the public about how charitable donations are being used. Some charities raise millions of dollars in donations but only spend small amounts on legitimate charitable activities.

Recently, Congress asked the General Accounting Office to study how charities raise and use their funds and how the IRS enforces the tax laws imposed on charities.

Deadline Approaches For Retirement Plans

An important deadline is approaching for the sponsors of retirement plans, such as 401(k)s, pension plans and profit sharing plans. By the end of their 2001 plan year, businesses must amend their qualified plans to comply with various tax law changes that have taken place since 1994.

The IRS has provided model plan amendments that employers can adopt to comply with the new proposed rules for minimum required distributions and the *2001 Tax Relief Act*.

Don't let this deadline slip up on you. If your business sponsors a retirement plan for your employees, contact your plan administrator for more information.

New Audit Guide Issued

The IRS recently announced a new manual for examiners to use when auditing business consultants. A few of the areas IRS auditors will be targeting include travel, meals and entertainment, and reimbursed expenses.

Choose The Right IRA Investments

Do the assets in your individual retirement account complement your overall financial strategy? Do you know where to invest the additional contributions you'll be permitted to make next year under the Economic Growth and Tax Relief Reconciliation Act of 2001? If not, it may be time to take a look at what's available.

Traditional investments that can fit your needs - and fit into your IRA - include the following:

Stocks And American Depository Receipts (ADRs)

You can purchase individual stocks and ADRs through a self-directed IRA account. ADRs provide an acceptable way to diversify into foreign stocks.

Note: Self-dealing rules may prohibit equity investments in closely held corporations.

Bonds

Treasuries can generate a current income stream within your IRA and help preserve principal. Junk bonds and zero-coupon bonds offer more risk and perhaps more return. All are permissible IRA investments.

Note: Certain types of bonds may not be desirable in an account that is already tax-deferred.

Mutual Funds And Unit Investment Trusts

Mutual funds permit easy diversification and the ability to spread your annual IRA contribution over several installments.

Note: Because withdrawals from the traditional IRAs are generally taxed as ordinary income, the tax benefits of long-term capital appreciation are lost.

Real Estate Investment Trusts (REITs)

This investment provides the opportunity to own real estate through the purchase of securities that trade on established markets.

Note: REITs can furnish more liquidity than the outright purchase of real estate.

Less common investments that might have a place in your IRA include:

Real Estate

Your IRA can own rental properties, trust deeds and mortgage notes.

Note: Holding a mortgage for yourself or a relative is not permitted in an IRA.

Gold, Silver, Platinum or Palladium Bullion

To be a part of you IRA, precious metals must meet specific fineness standards and be held in the physical possession of your trustee.

Note: Storage costs and service fees can be expensive.

Coins

An IRA can own certain gold, silver and platinum coins, generally those minted by the Treasury Department or issued by states.

Note: Coins that have been made into jewelry may not meet the criteria of an acceptable investment.

When making new contributions or rebalancing your IRA, you have a wide range of options. Just remember that some investments are specifically prohibited. For example, an IRA cannot own a life insurance policy or collectibles (art works, rugs, antiques, metals, gems, stamps, alcoholic beverages and some coins).

Do you know where to invest the additional contributions you'll be permitted to make next year under the Economic Growth and Tax Relief Reconciliation Act of 2001?



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.

Splits And Dividends What Do They Mean To You?

Let's say you own 100 shares in ABC Company, and you learn that the firm is planning a two-for-one stock split. Will you be better or worse off as an investor?

Actually, neither. After the split, you will own twice as many shares at half the price. It's like getting two ten-dollar bills for a twenty.

If the market value of an ABC share was \$50 before the stock split, your 100 shares would be worth \$5,000. After the split you own 200 shares, but they're valued at \$25 a share. Your shares are still worth \$5,000.

Reverse Splits

A reverse stock split is just the opposite. With a reverse split, the number of shares decreases, and the market price of the shares rises proportionately. As with a stock split, for example, your 100 shares would be reduced to 25, but each share would increase in value to \$200. So your total investment would remain at \$5,000.

Stock Dividends

Some companies issue stock dividends. With a stock dividend, the firm decides to pay dividends in stock instead of cash. For example, if ABC Company declared a 10% stock dividend, you would get one additional share for every 10 shares you own. Your 100 shares would increase to 110 shares.

Let's say you own 100 shares in ABC Company, and you learn that the firm is planning a two-for-one stock split. Will you be better or worse off as an investor?

Tax Consequences

Usually there is no tax impact from a stock split or dividend.

Let's say that two years ago you bought 100 shares of ABC stock for \$50 a share, and this year the company declares a two-for-one stock split. Now you own 200 shares but your cost basis in each share becomes \$25.

When you sell the stock, any gains are measured from this \$25 basis. But remember that the market value of the post-split share should have halved (because there are twice as many shares outstanding), so your total capital gain should be unchanged.

Generally, a stock dividend is not treated as taxable income when received. Instead, it lowers your cost per share.

Using the above example of a 10% stock dividend, you would divide your original investment of \$5,000 by 110 shares instead of 100 shares. Your stock's cost basis drops from \$50 to \$45.46 a share (\$5,000 divided by 110 shares).

Recordkeeping

What's the bottom line to all this stock activity? Keep good records. Document all stock purchases, reinvested dividends, capital gain distributions and changes in cost basis from stock splits and dividends.

Will The AMT Hit You?

For much of its history, the alternative minimum tax has primarily been a concern of high-income individuals.

However, the AMT hits more individuals every year, and the new tax law will subject even more taxpayers to the AMT. The problem: The AMT has never been indexed for inflation, and new lower regular rates will cause many unsuspecting middle-income taxpayers to owe the AMT.

An estimated 1.5 million taxpayers will owe the AMT in 2001, but around 35 million may be subject to the AMT by 2010.

What Is The AMT?

The alternative minimum tax is a separate tax calculation that disallows many of the deductions permitted by the regular tax. This includes deductions such as dependent exemptions, state and local taxes, and certain miscellaneous itemized deductions. If you take large deductions for any of these items, you might be subject to AMT.

The only way to determine if you owe the AMT is to refigure your tax using deductions allowed by the AMT. Because of the adjustments, your AMT may be higher than your regular tax. In that case, you will owe the AMT.

Determining whether you will be subject to the AMT is crucial for year-end tax planning. Many traditional tax planning strategies are not recommended if you are subject to the AMT. If you have incentive stock options, you should take special care. Exposure to the AMT may determine when it's best to exercise or sell your options.

Reimbursements: Not Where They Need To Be

Marshall Cook, VAFP General Counsel

Virginia law now is clear that provider contracts with managed care organizations (MCOs) must disclose what the physician or provider will be paid for a particular service, right? In 1999, the "fair businesses practices act" was passed by the General Assembly and provides:

No provider contract may fail to include or attach at the time it is presented to the provider for execution (i) the fee schedule, reimbursement policy or statement as to the manner in which claims will be calculated and paid which is applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider on a routine basis and (ii) all material addenda, schedules and exhibits thereto and any policies (including those referred to in subdivision B 4) applicable to the provider or to the range of health care services reasonably expected to be delivered by that type of provider under the provider contract. Va. Code Ann. § 38.2-3407.15(B) (7).

Even with this statutory language, however, Virginia physicians still don't know what they will be paid for many services. MCOs have developed reimbursement policies (permitted by current Virginia law) that result in denial or significant reduction in claims payments. Some MCOs call these policies "bundling," "multiple claims" "incident to," and "global processing" rules but, whatever they are called, they result in lower reimbursement than the fee schedule attached to physicians' contracts suggests. This is an issue for physicians in all specialties.

Legal? Probably. Misleading? You bet. The bottom line - physicians and other health care providers, like everyone else, should be paid for what they do. It's fundamental that any written employment agreement, which is what an MCO provider contract effectively is, should describe the compensation to be paid with particularity. Now, it doesn't.

Claims Are Submitted, And Then...

The first step in assuring correct payment is to be certain that claims are coded and submitted correctly and according to

the MCOs' requirements. From there, it becomes more difficult. Problem after problem can occur once a reimbursement claim is submitted that can cost the physician's practice, tens, and perhaps hundreds, of thousands of dollars.

MCOs are not required to abide by CPT (the AMA's Current Procedural Terminology) guidelines and instructions. Although CPT is widely licensed to many organizations, including MCOs, nothing permits the enforcement of an MCO's policies based on its interpretation of CPT. In fact, one Virginia MCO's recent response to a reimbursement appeal based on improper bundling was: "Whereas the AMA and various specialty societies have sole discretion to establish their billing conventions, [the MCO] has sole discretion to determine its payment conventions."

Most provider contracts in Virginia contain obtuse language that permits MCOs to deny or reduce payment for certain services based on the MCO's internal (often proprietary) reimbursement policies. Consider this language from three different MCO provider contracts:

Example 1

(The MCO) reserves the right to rebundle to the primary procedure those services determined by [the MCO] to be part of, incidental to, or inclusive of the primary service.

Example 2

Payment is made according to (MCO's) claims processing policies. The existence of a fee for a given CPT code does not mean the CPT is considered a covered service in every instance. For example, some codes are incidental to other codes. Specific questions about policies can be directed to (MCO's) Provider Relations department. In addition, information about claims issues is included in the Provider Manual and its updates, which are included in (the MCO's) newsletter.

Example 3

When more than one service (represented by more than one service code) is provided to the same patient on the same day (or sometimes, within the same

episode of care), the total Allowable Charge may be less than the Sum of Allowable Charges for individual billed service codes. Aggregations of different service codes may be subject to bundling via [MCO's] multiple, incidental, combination or global processing rules.

What Is Bundling?

Generally, "bundling" occurs when a physician submits a claim for two or more distinct CPT services or procedures performed on one patient in one office visit. MCOs will "bundle" these claims and reimburse for just one, usually the one that costs less.

The AMA's Private Sector Advocacy Unit, in a recent paper entitled "Downcoding and Bundling Claims; What Physicians Need to Know About These Payment Problems," describes how this happens. "The paper notes that a common way of bundling is for MCOs to ignore CPT modifiers. There are several modifiers whose purpose is to signal to the MCO that two or more services or procedures submitted on a single claim and done on the same day are, in fact, distinct and separately reimbursable. Bundling occurs when the MCO ignores the modifier, bundles the two reimbursable procedures together and pays for only one. It's counterintuitive for physicians to be penalized for providing all necessary care during a single office visit. MCOs should reward efficiency. Yet, their primary motivation seems to be financial.

The AMA paper further describes that MCOs ignoring modifiers and bundling separate procedures occur most frequently with modifier -25, although problems also exist with modifiers 51, 57 and 59. Modifier -25 is used when a patient is evaluated and treated for one problem and, during the same visit, the patient is treated for a second, unrelated problem. These are different treatments for different problems, and both should be reimbursed.

MCO Policies Often Unavailable

Many MCOs purchase and customize claims editing software to ignore certain modifiers or to group certain CPT codes together in a manner contrary to CPT

instructions. Some systems are programmed to pay only certain codes, while other codes either are not recognized by the software or paid at the programmed "0" amount. These software program edits are considered proprietary by the MCOs, are kept secret and often are referred to as "black box" edits for that reason. To make matters worse, many MCO payment methodologies are changed semi-annual, and some quarterly. Yes, the target keeps moving.

The federal government has eliminated "black box" edits in the Medicare program by making all coding edits available to the public. Several years ago, Wisconsin considered legislation that would prohibit MCOs from adopting bundling policies more restrictive than Medicare's.

The systematic bundling of claims without reviewing supporting documentation violates the fundamental structure of the CPT coding system. It also results in physicians and other providers not being paid for services they provide. Appealing reimbursements on a claim-by-claim basis is cumbersome and often unsuccessful, due largely to the provider contract language discussed above and broad, vague authority it gives to MCOs with respect to payment of claims.

Precisely drafted legislation may be the only viable solution to the problem created by an MCO's blanket contractual authority to bundle claims.

Admittedly, the practice of bundling should be available to MCOs. The MCO's payment systems, however, either should be available to physicians and providers who contract with them, or these commercial systems should be limited in their effect to Medicare's system (which is public). Otherwise, there's little chance a physician actually will know what he or she is paid by an MCO for what they do.

Physicians face a number of problems every day getting paid, getting paid on time, or getting paid at all. If family physicians receiving this newsletter have encountered significant problems with bundling or similar issues, E-mail details to mcook@hirschlerfleischer.com.

Healthy Communities Loan Fund

Consider obtaining a loan from the Healthy Communities Loan Fund before interest rates climb up again!

The Healthy Communities Loan Fund encourages physicians to practice in medically underserved areas.

Word of mouth conveys how satisfying it is to:

- develop long term relationships not only with individual patients but also with their families
- set up and run your own clinic; or share the workload with appreciative colleagues
- participate in the life of a community where your contributions really matter and people show their gratitude

If these factors appeal to you, we urge you to consider the long term benefits of practicing in a medically underserved area.

To finance relocating, building, expanding a facility, or adding new equipment to accommodate another physician, NP or PA,

Call

Lilia Mayer / Healthy Communities Loan Fund
at the Virginia Health Care Foundation
804-828-7494 or E-mail: loanfund@vhcf.org

Virginia Academy of Family Physicians
First Virginia Banks, Inc.
The Robert Wood Johnson Foundation

A Reminder That Your Recommendations Motivate Patients To Have Mammograms



Recommending mammograms to your patients can guide them toward using this most effective method for detecting breast cancer. This can lead to better health outcomes and satisfaction among your patients.

According to Sallie S. Cook, MD, chief medical officer, Virginia Health Quality Center (VHQC), "The literature repeatedly shows that physician recommendation is the primary reason that women get mammograms and, conversely, lack of physician recommendation has been shown to be the leading reason why women do not."

Breast cancer is the leading cause of cancer incidence and the second leading cause of cancer death for women in the US, with an estimated 182,800 new cases and 40,800 deaths expected to have occurred in 2000. Breast cancer becomes more prevalent with increasing age and more than half of breast cancers occur in women 65 years and older. The incidence increases with each decade of life, such that up to one out of nine 80-year-old women is likely to have breast cancer as opposed to one out of 2,000 30-year-old women.

The National Cancer Institute (NCI) recommends a screening mammogram every one to two years for women aged 40 and older and annually after age 50. In Virginia, only 59% of women aged 50-67 with Medicare had at least one mammogram during the biennial period of 1999-2000 (based on Medicare claims data).

On January 1, 1998, Medicare expanded its coverage of screening mammography to once every 12 months for all

females with Medicare aged 40 and older. Beneficiaries have to pay only a 20% co-payment (about \$14 in Virginia); meeting the deductible is not required.

You can use a number of strategies to increase your patients' use of mammograms. "In my practice I routinely assess each patient's use of preventive and early-detection services, regardless of the reason for their appointment with me," said Shane Kraus, MD, VHQC physician consultant and first vice president of the VAFP. Dr. Kraus also says the following interventions can assist with your efforts to increase the use of mammograms among your patients:

- Establish patient reminder systems, such as postcards and telephone reminders to patients when it's time to schedule their annual screening mammogram.
- Have a system in place with local mammography centers to let you know when your patient does not show up for a mammogram so your office can follow up.
- Be direct with your patients when recommending mammograms and address perceived barriers (medical record prompts can help remind you to do this).
- Don't wait for a preventive check-up to discuss mammograms; view every office visit as an opportunity to assess patients' use of this early-detection service.
- Place posters and brochures in your

waiting area for patient education.

- Schedule the mammogram for patients before they leave your office.

For more information about these and other strategies for increasing the use of mammograms, request a copy of the June 26, 2001 satellite videoconference titled *Beyond The Barriers: Effective Breast Cancer Early-Detection Strategies For Older Women*, available at <http://views.vcu.edu/sahp/gerontology/vgec/breastcancer>. This nationally broadcast program was presented by the VHQC in partnership with the Virginia Geriatric Education Center and the Cancer Information Service, Mid-Atlantic Region of the National Cancer Institute. This activity has been approved for AMA PRA credit.

The VHQC has the expertise and can provide assistance to help make your quality improvement efforts easier, more efficient and more successful. If you would like resources that will enable you to strengthen your efforts to increase the use of mammograms among your Medicare patients or if you would like information on other VHQC-led quality improvement projects, please contact Carol L. Stanley, MS, project manager, VHQC at 804-289-5320.

Statistical data for this article was obtained from the following sources:

Cancer Facts and Figures - 2000, American Cancer Society, *National Cancer Institute Surveillance, Epidemiology, and End Results Program and American Cancer Society, 1995-1997*.

The Oxycontin Controversy

(Cont. from page 13)

3. Remain current in your knowledge of chronic pain control. This area has changed recently, and continues to evolve. Many opportunities for education are available, through local medical society meetings, pharmaceutical company functions, journal articles and on-line presentations. Purdue Pharma (which makes Oxycontin) has many educational materials available. The VAFP and AAFP have offered educational programs and workshops about pain management in the past. For example, the VAFP held a workshop entitled **Pain Management: Medical And Regulatory Issues** during the 2001 Annual Scientific Assembly in Virginia Beach. Watch for mailings regarding similar programs in the future.

4. Monitor your chronic pain patients and their prescriptions closely and keep detailed records. This is mandated by the Board of Medicine, which has Guidelines for the Use of Opioids. Good records are also your best defense if you are accused of improper prescribing. Given the current medicolegal climate, this is a major concern. A physician from Southwest Virginia recently found guilty of improper prescribing of opioids faces not only the possibility of multi-million dollar fines, but also of prison time. Forms for pain control contracts, initial and follow-up evaluations for chronic pain and medication flow sheets are available from many different sources, including most pain control centers, as well as pharmaceutical companies.

5. Talk to your patients about pain control and drug abuse. Help allay the fears of legitimate chronic pain patients about opioid use, and be candid about the risks.

Help drug abusers in your practice find the help they need. Remember, opioid addiction is as fatal a disease as most cancers.

6. Speak out to the media. Cooperate with local law enforcement, drug rehab and educational groups. They need to hear a voice of reason and compassion among the chaos and hysteria. Whose voice will they hear if we family physicians do not offer ours?

7. Don't go it alone. Consult pain control specialists for especially difficult cases (for example, the addict who also has legitimate chronic pain). Seek psychological and drug rehab advice for your patients when appropriate. Pain control, as well as the treatment of drug addiction, is a team approach.

8. Here is a fact we all would like to ignore, but it nevertheless is true: Doctors also abuse drugs. If you have a drug problem, seek help. You are not only hurting yourself, but your family, your patients and your community through your denial. If you know a colleague who is abusing drugs, get them the help they need. The Medical Society of Virginia offers help for impaired physicians, and often the impaired physician may avoid loss of licensure by participating in treatment.

I hope that these pointers will be helpful to you and your patients in dealing with these difficult issues. Some other sources of information include:

Virginia State Board of Medicine Newsletter #54 (Spring, 1998): *Guidelines For The Use Of Opioids In The Management Of Chronic, Noncancer Pain.*

804-662-9908. Information from the Board of Medicine is also accessible from the VAFP website, www.vafp.org.

Federation of State Medical Boards of the United States, Inc. *Model Guidelines For The Use Of Controlled Substances For The Treatment Of Pain.* 817-868-4000.

Website: www.FSMB.org.

Partners Against Pain (sponsored by Purdue Phara) www.partnersagainstpain.com.

The "Poor Man's Heroin" *US And World Reports*, Feb. 12, 2001, p. 27 - one of several recent articles in national publications to bring attention to Oxycontin abuse.

Oxcon Job: The Media Made Oxycontin Drug Scare, by Sandeep Kaushik - a provocative article exploring the sensationalism, myths and misconceptions about Oxycontin abuse, www.freetimes.com/933/features-controversy.php.3.

Lee Coalition for Health, PO Box 572, Pennington Gap, VA 24277 - the group, led by Dr. Art Van Zee, advocating the recall of Oxycontin.

Governor's Office for Substance Abuse Prevention - 804-786-9072; www.gosap.state.va.us.

You are welcome to share your own thoughts and experiences regarding Oxycontin with the VAFP through its website, or with me personally by e-mail: lmitch@pol.net.

Connecting Children With Health Insurance A Role For The Medical Community

As staggering as it may seem, there are over 230,000 children in Virginia without health insurance. Physicians - at the front line of caring for children and their families - are all too familiar with ramifications of growing up without insurance. These children frequently don't receive the proper preventive care to stay healthy, grow strong and learn in school. They often don't receive timely treatment in an appropriate setting when they are ill.

Fortunately, Virginia has two state-sponsored health insurance programs for children, Medicaid and FAMIS (formerly CMSIP) that make comprehensive health care coverage available to tens of thousands of these uninsured children at little or no cost to families. Unfortunately, many working families still do not know about these programs or that their children may be eligible.

Physicians across the state have an important opportunity to help bridge the gap between these insurance programs and uninsured children. To help build that bridge, the Medical Society of Virginia Foundation has developed the **Medical Community Child Health Outreach Project**.

In July, the Medical Society of Virginia Foundation was awarded a \$10,000 grant from the American Academy of Pediatrics under its Reaching Out: Building Systems of Care Program. This grant is helping to fund the Foundation's Medical Community Child Health Outreach Project, one of only twelve projects selected nationally to receive a grant for children's health under the AAP's program.

Through the Medical Community Outreach Project, the MSV Foundation

is tapping into the health care infrastructure as a way to help increase the number of children enrolled in Virginia's insurance programs. Over the next year, it will work with the physician community to increase awareness about the program, providing tools and materials to support them in conducting outreach to families.

To accomplish its goals, the MSV Foundation is reaching out to a number of community-based organizations and state agencies to ensure coordination of effort and tap into the extensive expertise and infrastructure already established across the state. Thomas Sullivan, MD, President of the Virginia Chapter of the American Academy of Pediatrics, encouraged the MSV Foundation's application and will help ensure collaboration with his association. Another key partner is SignUpNow, a statewide, private sector initiative to help communities enroll eligible children in the state's health care programs. SignUpNow provides workshops across the state, training community workers to promote the program, identify eligible children and assist families with the application process.

As one of the MSV Foundation's first initiatives since its reinvigoration, the Medical Community Outreach Project presents an exciting opportunity and illustrates where the MSV Foundation is headed. "I think it is a strong indication of things to come," stated Kenneth Walker, MD, Chair of the MSV Foundation's Program Committee. "The health of the community has always been a priority for those of us in the medical profession, and the MSV Foundation enables us to take deliberate and visible steps to

demonstrate this priority. What better place to start than by connecting children with health services that can ensure they thrive well into the future."

Kurt Elward, MD, VAFP Board Member and the Academy's representative working on this effort says, "Family physicians are in a unique position to identify families for whom FAMIS would be helpful. When we see a patient who has just lost their job, or is in a lower paying service sector position, we have the opportunity to mention the importance of providing for their children's needs through an established program which can maintain the relationship with their family physician. FAMIS provides the safety net for children whose health maintenance as well as acute medical needs may get lost in the shuffle of current employment transitions."

Outreach Ideas For Physicians

Many physicians have special stature with their patients and within their communities. As trusted sources of information, they are in an ideal position to inform and encourage families to apply for health insurance coverage.

Here's how physicians can help ensure that more families know about FAMIS and Medicaid and that more children are enrolled in these programs:

- ◆ Make sure the staff in your office, clinic or hospital knows about Medicaid and FAMIS, who is eligible and how they can apply. Encourage them to attend SignUpNow workshops in your area. Have them take every opportunity to inform parents of the programs.
- ◆ Encourage self-pay patients to apply for coverage for their children.

Include a special letter from you or a flyer about the program in bills.

- ◆ Put up posters in key locations and have materials and applications readily available.

- ◆ Know where in your community you can refer families to get assistance with the application (contact SignUpNow for more information about who is conducting outreach in your community).

- ◆ Work with others in your community to promote outreach for children's health insurance programs and encourage your colleagues in the emdical community to be aware and involved with outreach.

FAMIS Facts

As of August 1, 2001, the Family Access to Medical Insurance Security plan, FAMIS, will replace CMSIP as Virginia's program for uninsured children in low to moderate-income families. Unlike CMSIP which was a Medicaid look-alike, FAMIS is designed to function more like private health insurance plans. All children currently enrolled in CMSIP will be automatically transitioned into FAMIS.

Covered Services

FAMIS provides the type of coverage generally available in comprehensive private health insurance plans. In fact, the benefit package is modeled after the health insurance plan provided to Virginia's state employees. Like private insurance plans, many medical services are covered, but some have annual or lifetime "caps." Some CMSIP benefits such as non-emergency transportation are not covered. Well-child exami-

nations are included, though the services provided are less extensive than the EPSDT program.

Who Is Eligible

FAMIS is designed for children under the age of 19 living in families that earn too much to qualify for Medicaid, but not enough to afford private health insurance. The family income limit for FAMIS is set at 200% of the Federal Poverty Level (FPL).

Costs For The Family

All families with children enrolled in FAMIS are required to pay co-payments for services (usually \$2 or \$5), but there are no co-payments for preventive health care services. In addition, families with income over 150% FPL are also required to pay monthly premiums in the amount of \$15 per month per child, up to a maximum of \$45 per month per family.

How To Apply For FAMIS

Applications for FAMIS are processed by a Central Processing Unit located in Richmond. A family may apply by calling the toll-free number (1-866-87-FAMIS) or by mailing or faxing an application and verification of income. Interpreter services are provided and information is also available at www.FAMIS.org.

REPORTING CME HOURS IT'S A MUST!

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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:

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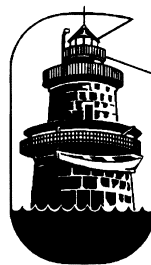
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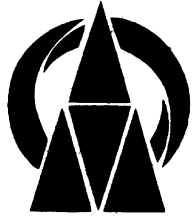
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