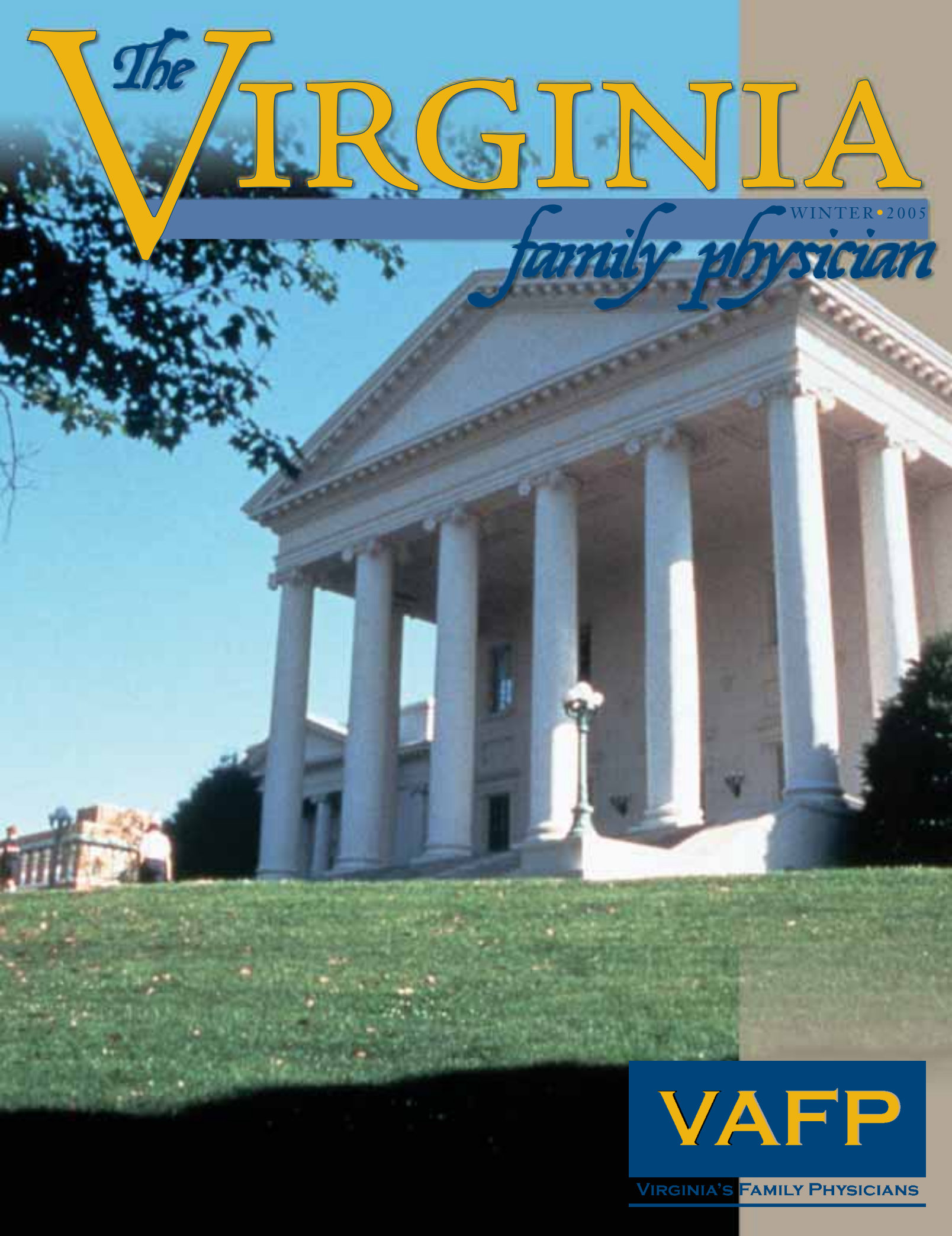


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& Exposition,
July 21 - 23, 2006
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VAFP MISSION STATEMENT

The mission of the VAFP is to:

- Improve the health care of patients, their families and the citizens of Virginia.
- Serve the unique needs of members with professionalism, leadership and creativity.
- Advance and represent the specialty of family medicine.

VAFP VISION STATEMENT

The Virginia Academy of Family Physicians strives to ensure quality, accessible health care, dedicated to the dignity and well being of the citizens of Virginia and guided by the principle that the family physician is the specialist of choice.

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The Virginia Family Physician is published by the Virginia Academy of Family Physicians
2301 North Parham Road
Suite 4
Richmond, VA 23229



Created by

PUBLISHING CONCEPTS, INC.

Virginia Robertson, President

vroberson@pcipublishing.com

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The year for the VAFP has become quite busy, and focused on issues on which our members have placed priority. I hope to update you on the progress being made by your academy's leadership.

Streamlining your Maintenance of Certification

The process of Maintenance of Certification continues to develop, and your VAFP has taken steps to prepare you for this process. We have developed a group format for self assessment modules (SAMs), allowing better learning experiences and more efficient completion of the SAMs requirements. We will pilot this project in Roanoke in January 2006, and then consider extending this to a variety of sites for our members.

Work also continues on the development of a group format for the Part 4 process (Performance in Practice). Dr. Mark Greenawald and I met with five members of the American Board of Family Medicine in September and received their strong support for key aspects of the format and content of such a program. The goal is to offer our members the best options available.

Best practices - Fulfilling the Future of Family Medicine

By the time you read this, I hope you will have completed the survey of the VAFP membership about "Best Practices". It is an attempt to hear from members who are doing innovative things in their practices, and fulfilling the spirit of the Future of Family Medicine Report (or perhaps extending it!), while being economically successful in the process. Best practices will be showcased in ways that other family physicians can learn from and enhance their practices.

Legislative Issues

We support the Medical Society of Virginia's legislative agenda for 2006 and believe it holds potential for family physicians. However, YOU have to participate - members of the General Assembly tell me how little they hear from family physicians, and how much they regularly hear from lawyers and other well organized groups. We have to make our issues known to every delegate and senator in Richmond. To do this, I encourage you to avail yourselves of the following resources:

AAFP Speak Out! Go to <http://capitol.aafp.org> - this is a superb resource for state, local and national efforts.

www.MSV.org - for updates and calls to action during the regular General Assembly Sessions.

AMA Grassroots Hotline to call your members of Congress. Simply dial **1-800-833-6354** and press 1, then enter your zip code.

Key legislative targets will include the following:

- Preventing the governor's office from again transferring physician license fees from the Board of Medicine to fund other projects - and potentially raising your fees to make up the difference.
- Increasing funding for physician Medicaid reimbursements.
- Significant changes to the Fair Business Practices Act.

Now is the time to sign up for Family Physician of the Day during the General Assembly! This is a very important opportunity to increase the visibility of family physicians. Make a positive difference! Sign up by calling the VAFP Headquarters 1-800-THE-VAFP!

EHR Issues

Electronic health records have moved from abstract to reality for an increasing number of family physicians. Your AAFP has provided leadership nationally, and your VAFP has initiated several actions to advocate for you as policy decisions develop. There are major challenges in implementation and interoperability that have to be met. Will you be able to use your EHRs for performance measurement programs? For vaccination reporting? For recertification activities? Given the public health advantages for EHRs, what is the role for state government incentives to physicians in adoption and maintenance of EHRs?

Studies by CMS and others have shown that most of the benefit from EHRs accrues to the payors and the state first and to physicians much later. What type of collaboration and support for EHR use might come from employers and insurers? The VAFP's EHR Task Force, headed by Dr. Dena Hall, is taking steps to address these issues and to better prepare our members for EHR selection and use. We have begun an interface with the Governor's EHR Task Force to be actively involved in the next few years as policy develops.

There must be incentives to allow primary care physicians, who care for the vast majority of the underserved, to successfully and economically acquire and maintain key elements of their systems. We expect support for legislation to develop funding mechanisms for “best practice projects” to identify ways of implementing and sustaining EHRs and using them in public health and quality improvement efforts.

Wherever you are in the process, this is the time to let your legislators know that you expect their support in these key areas:

1. There must be legislation to ensure interoperability among physicians, state health agencies and hospital systems.
2. There must be incentives to allow primary care physicians, who care for the vast majority of the underserved, to successfully and economically acquire and maintain key elements of their systems. We expect support for legislation to develop funding mechanisms for “best practice projects” to identify ways of implementing and sustaining EHRs and using them in public health and quality improvement efforts.
3. Family physicians must be assured standardized processes and consistent reporting requirements for all transfers of health information.
4. The state should ensure a standard format for a Personal Health Record (aka Continuity of Care Record) using HL7 as the fundamental format. The patient could then share this record with various providers who may need historical medical information for treatment decision-making. It could also be used as a disease management tool for those with chronic conditions who may need to track treatment compliance.
5. There must be increased reimbursement or management fees to practitioners who are engaged in specified eHealth activities. Pilot projects should be undertaken to conduct financial modeling which can demonstrate the cost/benefit of EHR adoption for physician practices.
6. It is essential to develop and implement a master patient index (MPI), the data integration of a computer-based system that facilitates the tracking of patient information by assigning each patient an identifying series of characters.
7. We should create a business, insurer, state and medical provider coalition that ensures all parties benefiting



from EHRs have a role in development of policy and determining the contributions each should provide for successful transition to widespread use of EHRs.

EHRs are major determinants of your future success in medicine, and it is time to make sure your legislator is on board with our agenda.

Noted on page 22 is the message of Dr. Norris “Ren” Royston, another family physician who has undertaken the presidency of the Medical Society of Virginia, following the outstanding terms of two other family physician leaders, Drs. Mitch Miller and David Ellington. Read his call to action carefully and consider how you can make a difference. Thank you again for being family physicians - the greatest and most important physicians in the field of medicine.

VIRGINIA GENERAL ASSEMBLY FAMILY PHYSICIAN OF THE DAY

Volunteers are needed to serve as Family Physicians of the Day during the 2006 Virginia General Assembly. As the Family Physician of the Day, you will be responsible for staffing the courtesy medical station for 9:00 a.m. – 3:30 p.m. on your chosen day. Directions and more specific information will be provided with confirmation of your assigned date. Reimbursement for participation as family physician of the day includes \$100.00 per day per diem and mileage.

Name: _____

Address: _____

City/State/Zip: _____

Phone: _____ Fax: _____

E-mail: _____

I have chosen the following three dates from the calendar that I will be able to participate. I have listed the dates in order of preference. NOTE: Every effort will be made to provide your first choice.)

1. _____ 2. _____ 3. _____

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MON	TUES	WED	THU	FRI
			12	
16	17		26	
	24	25		
30				

FEBRUARY 2006

MON	TUES	WED	THU	FRI
		1	2	3
6		8	9	
13		15		
		22	23	
27	28			

MARCH 2006

MON	TUES	WED	THU	FRI
6	7	8	9	10

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BOARD OF DIRECTORS MEETING

KESWICK, VA

OCTOBER 15, 2005

- Approved a motion to accept the board minutes from the July 21 and July 24 Board meetings.
- Heard reports from the VAFP Task Forces on Quality and Performance Measurement, Insurer and Employer Interfaces and Electronic Health Records.
- Approved a motion to move forward with the proposal to the American Board of Family Medicine for development of a group Self Assessment Module (SAM) and Performance Improvement Module.
- Heard report from Terry Schulte, VAFP EVP, on the status of date and location selection for the VAFP 2007 Annual Meeting.
- Heard Report from Mary Lindsay White, VAFP Staff, on the status of the VAFP Winter Family Medicine Weekend scheduled February 3-5, 2006 at Wintergreen Resort.
- Heard report from Marshall Cook, JD, VAFP General Counsel and Shane Kraus, MD, VAFP Legislative Committee Chair on healthcare legislation at the 2006 Virginia General Assembly.
- Heard report from David Ellington, MD, VAFP Treasurer and MSV President on the legislative agenda for the Medical Society of Virginia in 2006.
- Heard report from Student and Resident Board

Representatives on the AAFP National Conference of Family Medicine Residents and Medical Students held July 27-30, 2005 in Kansas City, Missouri.

- Heard update from Kurt Elward, MD, VAFP President and Quality Task Force Chair on fall Asthma Education and SAM's meetings scheduled October 18, 2005 in Richmond and January 14, 2006 in Roanoke.
- Reviewed "Best Practices" survey that was disseminated via e-mail to the VAFP membership.
- Heard report from representatives that attended the 2005 Southeastern Family Medicine Forum held August 12-13 in Young Harris, Georgia.
- Heard report from AAFP Delegates and Alternate Delegates (Drs. Mitch Miller and David Ellington served as AAFP Delegates and Drs. Cynthia Romero and Shane Kraus served as Alternate Delegates) on the AAFP Congress of Delegates meeting held September 26-28, 2005 in San Francisco, California.
- Heard report from Dr. Ellington on the Medical Society of Virginia House of Delegates meetings scheduled November 4-6, 2005 at the Homestead Resort.
- Approved a motion to co-sponsor a health fair with the Virginia Pharmacists Association at the 2006 Virginia General Assembly.



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kschmitt@cejkasearch.com

FYI...

I've been asked to "crystal ball" health care legislation in the 2006 General Assembly. To predict what health care legislation will be introduced and considered is a difficult assignment, especially when this article is written prior to the pre-filing of the Session's very first bill. Several important matters have been discussed since the adjournment of the 2005 Session, however, and many of these matters are likely to be raised in 2006. I have attempted to categorize issues for ease of reference.

MEDICAID REIMBURSEMENT INCREASES. There inevitably will be significant lobbying for across-the-board increases in Medicaid reimbursements for providers to be included in the 2006-2008 state budget. Virginia now ranks 48th among the states in per-capita Medicaid spending. Many provider specialties are difficult to recruit because of these low reimbursements. □

COMMERCIAL THIRD PARTY PAYER ISSUES

- Deadlines for payment of clean claims. Virginia now requires the payment of a clean claim by a payer within 40 days, whether the claim is submitted electronically or not. A number of states have significantly shorter deadlines (for example, Georgia requires payment in 14 days for electronic claims). Legislation is likely this Session to reduce Virginia's payment deadlines, and distinctions should be made between claims submitted electronically and those submitted on paper. Because most payers now process their claims either regionally or nationally and many have agreed to quicker payments as they settle the Florida managed care litigation, there should be little difficulty achieving more restrictive legislation on this issue.

- Deadlines for acknowledgement of claims. Legislation may be introduced to require payers to acknowledge provider claims within a short period of time following their receipt. The distinction again should be included for electronic versus paper claims.

- Deadlines for notice of incomplete claims. Legislation may be offered to require payers to notify providers of incomplete claims within a shorter period of time than the 30 day period that currently is required.

- Deadlines for settlement of coordination of benefit issues. An attempt may be made to require payers to settle all coordination of benefit issues within a certain period of time following their receipt of a clean claim.

- Irrefutable obligation to pay claims. Discussions have taken place to create an uncontestable obligation to pay a claim if the payer fails to pay or deny a provider claim within a designated period of time.

- Closing holes in "all products" legislation. Current Virginia law prohibits payers from requiring provider participation in all payer products if the provider participates in some payer products. As payers merge with or purchase other payers (for example, UnitedHealthcare purchasing MAMSI), they are requiring provider participation in all similar products offered by the purchasing and purchased entity (in the example above, for instance, in both UnitedHealthcare and MAMSI HMO products) if the provider participates in any of these products. An attempt should be made to preclude this payer requirement. □

DEPT. OF HEALTH PROFESSIONS/BOARD OF MEDICINE ISSUES
A number of issues have arisen with the Department of Health Professions and the Board of Medicine over the past year, including:

- The public disclosure of all notices and orders concerning providers, even including notices that ultimately result in a provider being exonerated of allegations;

- The current method of such disclosure on the Board's web site, involving a red icon next to the provider's name;

- The tone of the written allegations contained in public notices from the Board;

- The disclosure of Department investigations that ultimately end with the execution of a confidential consent agreement. □

STANDING ORDERS FOR VACCINATIONS Legislation may be offered to permit hospitals to have standing orders to permit flu and pneumococcal vaccinations by appropriately trained nurses. Patients obviously will be permitted to refuse the vaccinations. □

continued on the next page

FYI... is a summary of health care market information that will appear regularly in the Virginia Family Physician. Although it is written by the Academy's General Counsel, it is not legal advice. The Academy and I hope its contents will be informative and helpful in your medical practice.



K. Marshall Cook, Esq.
VAFP General Counsel
p. (804) 784-1900
f. (804) 784-1903
e. mcook@hf-law.com

FYI...

COORDINATION OF PROFESSIONAL CORPORATION AND LIMITED LIABILITY COMPANY STATUTES Virginia statutes pertaining to professional limited liability companies are clear that members or managers who are responsible for the management of the company rendering health care services must be licensed professionals. This is not true with state statutes concerning professional corporations. Legislation may be introduced that will clarify that professional corporation directors and professional limited liability company managers must be licensed professionals if their entities provide health care services. □

CONFIDENTIALITY OF MENTAL HEALTH RECORDS AND CHILD CUSTODY DISPUTES Virginia law currently prohibits the introduction of testimony or records of a therapist without parental consent in a child custody proceeding. This can be an issue since child custody statutes require consideration of the mental health of the parent and the child. Legislation is likely in an attempt to solve this problem. □

NON-COMPETE AGREEMENTS Most physician employment agreements contain non-compete provisions. Virginia law pertaining to these contract provisions has developed through court decisions rather than by statutes. Legislation has been developed by the Virginia Bar Association at the request of a legislator to codify Virginia rules on non-competes. This is something that should be monitored closely. □

Although each of the issues discussed in this article have been the subject of continuing discussions since the 2005 Session of the General Assembly adjourned, it is impossible to predict if some (or any) of these issues will surface in the upcoming Session of the legislature. The VAFP will keep its members informed as the Session approaches. □

Mark Your Calendars!

**VAFP Winter Family
Medicine Weekend**

February 3-5, 2006

Wintergreen Resort,

Wintergreen, Virginia

Register online at www.VAFP.org

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MEDICARE CARRIER ADVISORY UPDATE

JENNY SHARP-WARTHAN, MD

MANAGED CARE & INSURANCE COMMITTEE CHAIR

At the recent Medicare Carrier Advisory Committee meeting with Trailblazers, the following items were discussed. The fee schedule on CD-ROM should have been received in physicians' offices around November 15, 2005. Many of you may have been approached by various insurers offering Medicare HMO products. These are not associated in any way with Trailblazers.

At issue, some physicians felt threatened or intimidated that if they do not participate with these plans they will not be able to see Medicare patients. This is not true. The only patients you would not be able to see are those participating with that particular insurer. Those with Medicare and not associated with an HMO would still be able to be seen by you.

OSTEOPOROSIS SURVEY

A survey has been designed by the Virginia Academy of Family Physicians and the Mid Atlantic Osteoporosis Board to better understand the educational needs of family physicians diagnosing and treating patients with osteoporosis.

Osteoporosis management has changed radically over the last ten years! This survey will help provide the needed direction to ensure the highest quality of osteoporosis CME programs in the future. Results will be presented at the VAFP Winter Family Medicine Weekend in February 2006.

Survey participants will be eligible to enter the free raffle for twenty five (25) Seca Bodymeters Stadiometers. The raffle will be held at the VAFP Winter Family Medicine Weekend in February. You do not need to be in attendance to win. To enter the free raffle, please follow the easy instructions at the end of this survey.

To access the survey, please go to this link:
<http://www.surveymonkey.com/s.asp?u=957021504402>
Your participation is greatly appreciated!

GUIDELINES FOR THE USE OF OPIOIDS IN THE MANAGEMENT OF CHRONIC NONCANCER PAIN

VIRGINIA BOARD OF MEDICINE, BOARD BRIEFS, SPRING 1999

All practitioners with the authority to prescribe controlled substances Schedule II-V must have a clear understanding of their obligations and responsibilities when using these agents. As the medical community promotes the new advances in the management of the patient with chronic pain, all practitioners must understand not only that the use of opioids is an important part of the armamentarium for managing the chronic pain patient, but also that opioids must be prescribed, dispensed and administered in good faith for accepted medicinal or therapeutic purposes.

The Code of Virginia permits the use of opioids in large amounts for patients with intractable pain. The Drug Control Act Virginia Code § 54.1-3408.1 states, *"In the case of a patient with intractable pain, the attending physician may prescribe a dosage in excess of the recommended dosage of a pain relieving agent if he certifies the medical necessity for such excess dosage in the patient's medical record. Any person who prescribes, dispenses or administers an excess dosage in accordance with this section shall not be deemed to be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for accepted medicinal or therapeutic purposes. Nothing in this section shall be construed to grant any person immunity from investigation or disciplinary action based on the prescription, dispensing or administration of an excess dosage in violation of this section."*

In 1995, § 54.1-2971.01 was added to the Medical Practice Act:

- A. Consistent with § 54.1-3408.1, a physician may prescribe a dosage of a pain-relieving agent in excess of the recommended dosage upon certifying the medical necessity for the excess dosage in the patient's medical record. Any practitioner who prescribes, dispenses or administers an excess dosage in accordance with this section and § 54.1-3408.1 shall not be in violation of the provisions of this title because of such excess dosage, if such excess dosage is prescribed, dispensed or administered in good faith for recognized medicinal or therapeutic purposes.
- B. The Board of Medicine shall advise physicians of the provisions of this section and § 54.1-3408.1.

In 1997, the Medical Society of Virginia, at the request of the Joint Subcommittee of the General Assembly, appointed a special committee to develop a guideline document to meet the needs of physicians in the Commonwealth regarding the prescribing of opioids for chronic, noncancer pain management. These guidelines were passed by the House of Delegates of the Medical Society during an annual meeting in November 1997.

The Virginia Board of Medicine welcomes these guidelines. These guidelines, although they do not carry the weight of law or regulation, will be of help to those who treat pain patients as to the proper use of opioids and the documentation required.

Guidelines for the Use of Opioids in the Management of Chronic, Noncancer Pain

For the purpose of this document the following terms shall have the following definitions:

- Addiction is a disease process involving the use of opioid(s) wherein there is a loss of control, compulsive use, and continued use despite adverse social, physical, psychological, occupational, or economic consequences.
- Substance abuse is use of any substance(s) for nontherapeutic purposes; or use of medication for purposes other than those for which it is prescribed.

- Physical dependence is a physiologic state of adaptation to a specific opioid(s) characterized by the emergence of a withdrawal syndrome during abstinence, which may be relieved in total or in part by re-administration of the substance. Physical dependence is predictable sequelae of regular, legitimate opioid or benzodiazepine use, and does not equate with addiction.
- Tolerance is a state resulting from regular use of opioid(s) in which an increased dose of the substance is needed to produce the desired effect. Tolerance may be predictable sequelae of opiate use and does not imply addiction.
- Withdrawal syndrome is a specific constellation of signs and symptoms due to the abrupt cessation of, or reduction in, a regularly administered dose of opioid(s). Opioid withdrawal is characterized by three or more of the following symptoms that develop within hours to several days after abrupt cessation of the substance: (a) dysphoric mood, (b) nausea and vomiting, (c) muscle aches and abdominal cramps, (d) lacrimation or rhinorrhea, (e) pupillary dilation, piloerection, or sweating, (f) diarrhea, (g) yawning, (h) fever, (i) insomnia.
- Acute pain is the normal predicted physiological response to an adverse (noxious) chemical, thermal, or mechanical stimulus. Acute pain is generally time limited and is historically responsive to opioid therapy, among other therapies.
- Chronic pain is persistent or episodic pain of a duration or intensity that adversely affects the function or well-being of the patient, attributable to any nonmalignant etiology.

Co-Assessment, Documentation and Treatment

A. History and Physical Examination – The physician must conduct a complete history and physical exam of the patient prior to the initiation of opioids. At a minimum, the medical record must contain documentation of the following history from the chronic pain patient:

1. *Current and past medical, surgical and pain history including any past interventions and treatments for the particular pain condition being treated.*
2. *Psychiatric history and current treatment.*
3. *History of substance abuse and treatment.*
4. *Pertinent physical examination and appropriate diagnostic testing.*
5. *Documentation of current and prior medication management for the pain condition, including types of pain medications, frequency with which medications are/were taken, history of prescribers (if possible), reactions to medications, and reasons for failure of medications.*
6. *Social/work history.*

B. Assessment – A justification for initiation and maintenance of opioid therapy must include at a minimum the following initial workup of the patient:

1. *The working diagnosis (or diagnoses) and diagnostic techniques. The original differential diagnosis may be modified to one or more diagnoses.*
2. *Medical indications for the treatment of the patient with opioid therapy. These should include, for example, previously tried (but unsuccessful) modalities/medication regimens, diverse reactions to prior treatments, and other rationale for the approach to be utilized.*
3. *Updates on the patient's status including physical examination data must be periodically reviewed, revised, and entered in the patient's record.*

C. Treatment Plan and Objectives - The physician must keep detailed records on all patients, which at a minimum include:

1. *A documented treatment plan.*
2. *Types of medications(s) prescribed, reason(s) for selection, dose, schedule administered and quantity.*
3. *Measurable objectives such as:*
 - a. Social functioning and changes therein due to opioid therapy.
 - b. Activities of daily living and changes therein due to opioid therapy.
 - c. Adequacy of pain control using standard pain rating scale(s) or at least statements of the patient's satisfaction with the degree of pain control.

D. Informed Consent and Written Agreement for Opioid Treatment

Written documentation of both physician and patient responsibilities must include:

1. *Risks and complications associated with treatment using opioids.*
2. *Use of a single prescriber for all pain related medications.*
3. *Use of a single pharmacy, if possible.*
4. *Monitoring compliance of treatment;*
 - a. Urine/serum medication levels screening (including checks for nonprescribed medications/substances) when requested.
 - b. Number and frequency of all prescription refills.
 - c. Reason(s) for which opioid therapy may be discontinued (e.g. violation of written agreement item(s)).

E. Periodic Review - Intermittent review and comparison of previous documentation with the current medical records are necessary to determine if continued opioid treatment is the best option for a patient. Each of the following must be documented at every office visit.

1. *Efficacy of Treatment*
 - a. Subjective pain rating (e.g. 0-10 verbal assessment of pain)
 - b. Functional changes.
 - i) Improvement in ability to perform activities of daily living (ADLs)

- ii) Improvement in home, work, community or social life
2. *Medication side effects.*
3. *Review of the diagnosis and treatment plan.*
4. *Assessment of compliance (e.g. counting pills, keeping record of number of medication refills, frequency of refills and disposal of unused medications/prescriptions).*
5. *Unannounced urine/serum drug screens and indicated laboratory testing, when appropriate.*

F. Consultation – Most chronic noncancer patients, like their cancer pain counterparts can be adequately and safely managed by most physicians without regard to specialty. However, the treating physician must be cognizant of the availability of pain management specialists to whom the complex patient may be referred. The physician must be willing to refer the patients to a physician or a center with more expertise when indicated or when difficult issues arise. Consultations must be documented. The purpose of the referral should not necessarily be to prescribe the patient opioids.

G. Medical Records – Accurate medical records must be kept, including, but not limited to documentation of:

1. *All patient office visits and other consultations obtained.*
2. *All prescriptions written, including date, type(s) of medication, and number (quantity) prescribed.*
3. *All therapeutic and diagnostic procedures preformed.*
4. *All laboratory results.*
5. *All written patient instructions and written agreements.*

A licensed practitioner who prescribes opioids in the Commonwealth of Virginia does not need a license from the Virginia Board of Pharmacy, but he must have a valid controlled substance registration from the Drug Enforcement Agency of the United States Department of Justice.

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radiotherapy management of an aging appearance or other cosmetic issues, or body contouring of fatty bulges with **Phosphatidylcholine mesotherapy** restore facial and body cosmetic improvements without resorting to the risks, cost and agonies of surgical treatment.

All this at **American Self, PLC** by Board certified and experienced Orthopaedic and Cosmetic Plastic Surgeons, through modern, convenient office facilities in Richmond's West End.

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***PERTUSSIS** transmission*

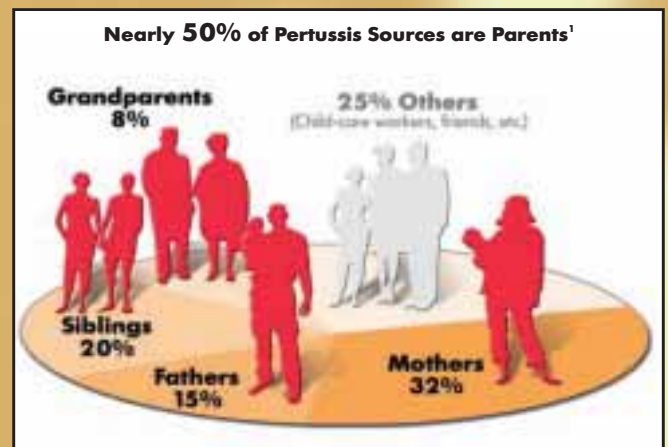
*How do infants get
PERTUSSIS?*

They get it from their family.

*That's right — their
MOMS and*

*dads, brothers and sisters,
even grandma and grandpa!*

Nearly 75% of the time, a family member is the source of pertussis disease in infants¹



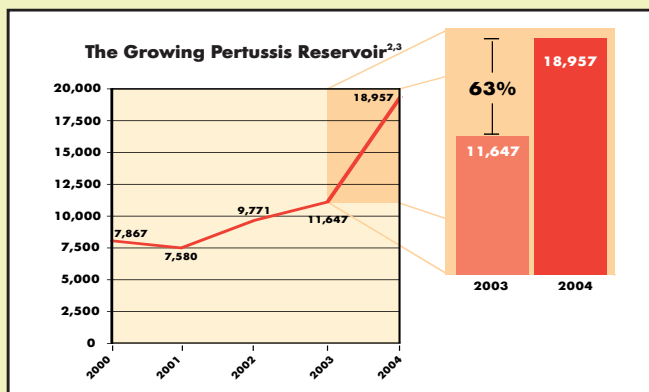
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According to a recent study of pertussis in 264 infants, a family member was identified as the source of the disease in three quarters of the cases. In fact, the infant's mother was positively identified as the source in 32% of the cases. In addition to Mom, other confirmed sources included Dad 15% of the time, Grandma/Grandpa 8% of the time, and a sibling 20% of the time. This study provides clear documentation of the threat of pertussis within the family setting and serves as a window to the growing problem of pertussis in the general population.¹

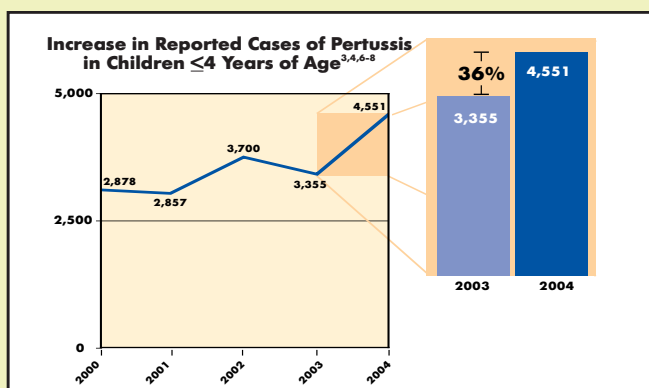
begins at home

The growing threat of pertussis — an often silent disease reservoir

Long thought to be nearly eradicated, pertussis case reports are at a 40-year high.² Today pertussis is the only communicable disease that is on the rise in all age groups for which a routine immunization is available. In 2004 there were 18,957 cases reported to the CDC, a 63% increase over 2003 and a startling 1000% increase from 20 years ago when incidence reached its nadir.^{2,3}



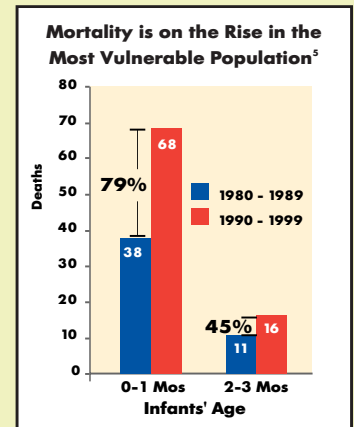
Especially troubling are two facts: first, there has been a 36% increase in reported cases among children ages 4 years or less^{3,4}; second, over the last decade, 80% of deaths attributed to pertussis occurred in infants under 6 months of age.⁵



Among the many explanations on the explosion of pertussis in the United States are better reporting, better diagnosis, and waning immunity. What they all have in common is the acknowledgment that there exists a reservoir of disease among adolescents and adults, and more importantly, from this reservoir pertussis transmission occurs. Pertussis is most

contagious during the first few weeks of illness before it is recognizable.⁹ In both adolescents and adults the disease is often mild in nature, and not associated with the trademark “whooping cough.”^{9,10} However, studies have reported significant morbidity

including pneumonia, rib fractures, urinary incontinence, weight loss, otitis media, and sinusitis.¹¹ People with pertussis are also at risk of hospitalization and other complications such as seizures and encephalopathy. Beyond the morbidity are the social, financial, and psychological costs of pertussis disease. One recent study reported that 70% of affected adolescents lost 5 to 10 days of school while 49% of afflicted adults were out of work for 5 to 10 days.¹¹ In addition, 49% of adults reported that their sleep was disturbed for more than 21 consecutive nights with 9% reporting disturbed sleep for an astounding 60+ nights.¹¹ It’s no wonder the ancient Chinese called pertussis “the cough of 100 days.”



Soon pertussis prevention will begin in the home too

Building on the heritage of the proven pediatric acellular DTaP vaccines, acellular Tdap vaccines for adolescents and adults will soon be available. This intervention will allow health-care providers to protect a broad spectrum of people from the morbidity of primary disease, as well as limit the morbidity and mortality in vulnerable infants by curtailing disease transmission.

You can find out more about pertussis by visiting any one of the following Web sites:

www.pertussis.com, www.cdc.gov,
www.nfid.org, www.napnap.org, www.aap.org

Brought to you as a public health service by Sanofi Pasteur Inc.

Update

Medicare Preventive Services Educational Guide

The CMS Educational Guide “Determining a Medicare Beneficiary’s Eligibility for Medicare Preventive Services” is now available on the CMS Web site on the MedLearn Network’s Preventive Services Education Resource Web Guide page under the Provider Education header. This page can be viewed at: <http://www.cms.hhs.gov/medlearn/preventiveservices.asp>.

Frequently Asked Questions (FAQs) - Mid-Atlantic Provider Contact Center

1. Why didn’t we receive a secondary payment from Medicare when the primary payer did not pay the submitted charge?

Answer: Medicare does not make payment when the primary EOB indicates the provider was obligated to accept the allowed amount as their payment in full. Therefore, an additional payment will not be made by Medicare.

2. How can I obtain a report to show how often my peers are billing certain codes?

Answer: You can obtain a Comparison Report by writing to the Freedom of Information Act (FOIA) Coordinator.
Ms. Tasha Smith, P.O. Box 5798, Timonium, MD 21094-5798

3. What percentage of the physician’s fee schedule are non-physicians practitioners allowed?

Answer: The percentages are as follows: a Nurse Midwife is allowed 65%, a Clinical Social Worker is allowed 75%, a Nurse Practitioner is allowed 85%, a Clinical Nurse Specialist is allowed 85% and a Physician Assistant is allowed 85%.

4. What should I do when I see that Medicare denied my claim stating “missing/incomplete/invalid entitlement number and or name shown on claim?”

Answer: You should resubmit the claim with the exact name and HIC # that appear on the Medicare card.

5. Is it true that I must accept assignment for Medicare beneficiaries who also have Medicaid when I am a “Non-

Participating” provider?

Answer: Yes, physicians who provide services to individuals who are dually entitled to Medicare and Medicaid must accept assignment. These claims can only be paid on an assignment basis.

6. How do I determine what is missing from the claim when I receive the “CO-16” message on my remittance notice?

Answer: The remittance notice should provide additional remark messages that will explain the reason for denial.

7. What information is needed on the claim when I submit an unlisted procedure code?

Answer: A narrative or description should be indicated in item 19 of the CMS 1500 claim or in the narrative field on the EMC claim if the description will fit in the area provided. If not, an attachment must be submitted with paper claims.

8. Recently, all my diagnostic services billed globally to Medicare are being denied, “Rebill separately as the professional and technical component.” Why?

Answer: The HPSA/Scarcity bonus can only be paid on the professional component and not the technical component. Effective for claims received on or after Oct. 1, 2005, claims received for a service with a PC/TC of 1 and the service is provided in an HPSA or PSA bonus payment area, we will accept the claim and pay the bonus on the professional component of the service.

9. Patient was seen for an E/M visit during a global period. What range of global modifiers can be used?

Answer: Modifiers 24, 25, or 57.

Modifier 24 - Unrelated evaluation and management service by the same physician during the post operative period for reasons unrelated to the original procedure.

Modifier 25 - Significant separately identifiable evaluation and management service by the same physician on the date of a procedure.

Modifier 57 - An evaluation and management service that resulted in the initial decision to perform a major surgery either the day before or the day of the surgery.

NETWORKING OPPORTUNITIES

Board Certified Family Physician looking to join a group practice, preferably but not limited to private practice, in the northern Virginia and greater DC area. Would like to practice the full scope of family practice excluding OB and with or without inpatient medicine. Ultimately, hoping to join a group with a progressive vision and work culture to grow and excel. If interested, please contact Jitesh Chawla, MD via e-mail at jiteshchawlamd@yahoo.com or at (360) 970-0653.

Seeking a family physician for an independent, traditional inpatient/outpatient group practice in the Newport News, Yorktown area of Hampton Roads. Call is 1 in 5. If interested, please fax resume to (757) 599-6893 to arrange for further consideration. (DO or MD acceptable)

IMPROVING COMMUNICATION WITH PRE-PAID CME CREDIT PROGRAM

KEVIN FERGUSSON, MD

MEDICAL DIRECTOR, VIRGINIA HEALTH QUALITY CENTER

The federal government has paid for and is making available an easy-to-take, on-line program that promotes cultural competency and offers 9 CME credits. The Virginia Health Quality Center (VHQC) is coordinating this training for the Commonwealth of Virginia as part of a national effort. This program is designed to improve understanding, communication, and care for patients from diverse backgrounds.

Interested in learning new skills for communicating with patients from diverse backgrounds? Curious about how minority populations and immigrant groups may experience their interaction with you? Are you aware of the healing practices of other cultures and how patients incorporate beliefs into recommended treatment plans? Have you encountered frustration when you can't make out what a patient is saying? Or, have you wondered if your patient understands what you said?

For many Americans, regular medical care is expensive, inconvenient, and not always comfortable. Imagine the potential problems associated with adding language and

cultural barriers to this already frustrating experience.

Providers can take the first step to improve the quality of health care services given to diverse populations With growing concerns about **racial and ethnic disparities in health** and the need for health care systems to accommodate **increasingly diverse patient populations**, cultural competence has become more and more a matter of national concern and attention.

Improving patient understanding and patient appreciation for recommended treatment fosters compliance and patient satisfaction. Additional benefits include recognition as a proactive provider, an enhanced ability to manage diverse populations, and a decrease in medical errors.

To learn more and apply for in this convenient, valuable, and pre-paid opportunity, contact Kevin Fergusson, MD, Medical Director, for the Virginia Health Quality Center at (804) 289-5320 or kfergusson@vaqio.sdps.org. We invite you to take the lead in promoting understanding and delivering culturally competent care to all patients.

VAFP *Welcomes* OUR NEW MEMBERS

The VAFP welcomes the following new members.

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STUDENT

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MR ALI KHAN
MR ANDREW DONLAN
MR BIJAN NAVIDI
MR CHRISTOPHER HARTNESS
MR CHU LU
MR JAMES C WILSON
MR JOSHUA BUTLER
MR JUDSON FRYE
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MR KHOA NGUYEN
MR KUNAL KARIA
MR MICHAEL A HARTMAN
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MS SUSAN JUNG LEE
MS VAN TA

The Spinal Column

A syndicated column provided by the Mid Atlantic Osteoporosis Board, dedicated to improving the prevention, detection, and treatment of osteoporosis in the Mid-Atlantic Area.

WHY WORRY ABOUT OSTEOPOROSIS?

RALPH E. SMALL, PHARM.D, PROFESSOR EMERITUS,
VIRGINIA COMMONWEALTH UNIVERSITY, RICHMOND, VA

Osteoporotic fractures are a major health problem seen in approximately 55 percent of the U.S. population aged 50 and older. The most important clinical consequences of fragility fractures, or fractures that can occur at low-level trauma, are hospitalization for acute care, long-term care in nursing homes, or even death.

Vertebral fractures are the most common osteoporotic fractures. Twenty percent of women who develop a vertebral fracture are at substantial risk for an additional fracture within the following year. Hip and vertebral fractures are a significant cause of increased morbidity and mortality rates. As many as 25% of hip fracture patients will require long-term nursing care, and mortality rates post-hip fracture range from 10-20%, as reported by the National Osteoporosis Foundation. It is estimated more women die in a year from hip fractures than breast, cervical and uterine cancers combined.

Although screening, diagnosing, and treatments add to the cost of the disease, most of the costs associated with osteoporosis are related to the treatment of fractures.

Building Better Bones

The most important factors necessary for achieving and maintaining maximal bone health are good nutrition, with a diet rich in calcium and vitamin D, plus regular weight-bearing or resistance exercises.

Clinical studies show that low calcium intake is associated with low bone mass, rapid bone loss and high fracture rates. A major source of dietary calcium is dairy products. Many foods, such as breakfast bars, cereals, and orange juice are now fortified with calcium and are readily available and affordable. Supplementation is sometimes beneficial above dietary consumption of calcium. Calcium supplementation cannot cure osteoporosis, but is an important part of a prevention or treatment program.

Vitamin D plays a major role in calcium absorption and bone health. It is a fat-soluble vitamin found in fortified dairy products, fish and egg yolks. It is also formed in the skin from exposure to ultraviolet light. Usually 10-15 minutes of exposure of uncovered skin two to three times a week to bright sunlight is sufficient to fulfill the body's vitamin D requirement (RDA 400-800 IU).

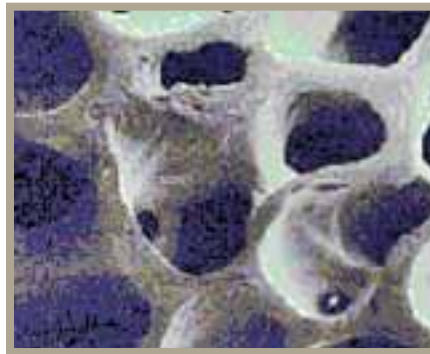
Weight-bearing and resistance exercises are important for building and maintaining bone mass and density. Weight-bearing exercise is exercise performed against gravity, such as jogging or walking. Resistance exercises use muscular strength to improve muscle mass and strengthen bone.



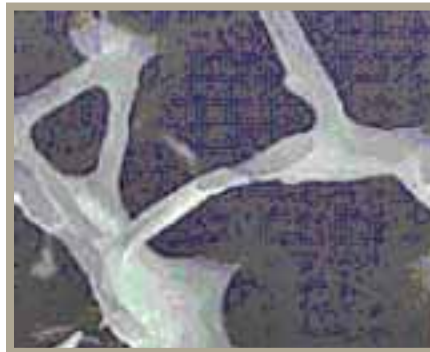
Selecting a Calcium Supplement

Oral calcium tablets are a well-recognized method of receiving adequate doses of supplementation in addition to dietary consumption. However, it is important for you to identify which calcium formulation would be best for your patient.

Things to consider when selecting a calcium supplement product include bioavailability, the amount of elemental calcium in each product, and the side effect profile.



Normal Bone



Osteoporotic Bone

Bioavailability, or the rate and extent of drug absorption, can vary based on stomach acidity. For example, calcium carbonate requires an acidic environment in order for maximal absorption; therefore, it should be taken with food.

However, calcium citrate can be taken on an empty stomach since it does not require such a low pH for maximal absorption. Patients taking gastric acid reducers, such as H2 blockers or proton pump inhibitors, will benefit from calcium supplementation with calcium citrate.

It is also important to consider the amount of elemental calcium that is present in each supplement dose. The amount of elemental calcium is usually indicated on the product label.

The National Academy of Sciences and the National Osteoporosis Foundation recommend daily calcium intake of 1000-1200 mg/day for adult men and women. This total daily dose should be divided throughout the day. The body can only absorb approximately 500mg of elemental calcium at any one time. Additional calcium taken at one time will be wasted by the body.

Side effects associated with calcium supplementation are limited. Constipation may be experienced with calcium

carbonate and can be remedied by using another salt form such as calcium citrate, or increasing water intake or employing a stool softener.

Table 1 below lists examples of over-the-counter products available to consumers. When considering cost, most store brands will be less expensive.

TABLE 1 - Over-the-counter Calcium Supplement Products

Product and Calcium Salt Form	Elemental Calcium per tab	Directions for Use
TUMS (calcium carbonate)	200mg	2 TID (1200mg)
TUMS-Ex (calcium carbonate)	300mg	1 TID (900mg)
TUMS Ultra (calcium carbonate)	400mg	1 TID (1200mg)
Os-Cal + Vit D (calcium carbonate)	500mg	1 BID (1000mg)
Viactiv + Vit D (calcium carbonate)	500mg	1 BID (1000mg)
Citracal + Vit D (calcium citrate)	315mg	2 BID (1260mg)

Calcium Drug Interactions

Calcium absorption can easily be influenced by other medications. It is important to recognize which medicines these are to maximize the benefit of supplemental calcium.



TABLE 2 - Calcium Interactions

Drug/Food	Effect of Interaction	Mechanism of Action	Clinical Management
Tetracyclines ¹	Decreased efficacy of tetracyclines	Chelation of tetracyclines by calcium ions, resulting in a less soluble compound	Take 1-3 hours before calcium
Fluoroquinolones ²	Decreased fluoroquinolone efficacy	Fluoroquinolones form chelate complexes with metal ions, including calcium	Take fluoroquinolones 2 hours before or 6 hours after calcium products
Oxalic foods (spinach and rhubarb)	Decreased calcium effectiveness	Inhibit calcium absorption by forming insoluble compounds with calcium ions	Do not take calcium products within 2 hours of eating oxalic foods
Phytic acid foods (bran and whole cereals)	Decreased calcium effectiveness	Inhibit calcium absorption by forming insoluble compounds with calcium ions	Do not take calcium products within 2 hours of eating phytic foods

1 Minocycline, Doxycycline, Methacycline

2 Levofloxacin, Moxifloxacin, Ciprofloxacin, Norfloxacin, Lomefloxacin, Pefloxacin, Ofloxacin

The Mid Atlantic Osteoporosis Board encourages family physicians to ask all female patients over 50 years of age about their exercise status, calcium and vitamin D intake. The U. S. Surgeon General reports exercise and intake of appropriate levels of calcium and vitamin D are the best steps to maintain and improve bone health. Refer your patients to our website for additional osteoporosis information, www.midatlanticosteoporosis.org.

References available upon request, by contacting the Mid Atlantic Osteoporosis Board, 290 Long Point Rd., Crownsville, MD

Future columns will cover related osteoporosis topics but we would like to hear from you. Please forward topics of interest relating to osteoporosis to Mary Lindsay White at VAFP. We will include your ideas in future columns.

*The Mid Atlantic Osteoporosis Board is supported in part by an unrestricted educational grant from **The Alliance for Better Bone Health***. The content of this column reflects the opinions of the Board or of individual Board members and not that of The Alliance.*

**(Procter & Gamble Pharmaceuticals and Aventis Pharmaceuticals, a member of the sanofi-aventis Group.)*

TAX TIPS

Before making important financial or business decisions, be sure to contact your accountant or tax consultant to discuss these changes and any other tax concerns you may have. Tax Tips information should not be acted upon without further details and/or professional assistance. Tax Tips are provided by Wells, Coleman & Co., LLP, 3800 Patterson Ave., Richmond, Virginia.

More taxpayers are getting the IRS red light

What are your chances of being audited? Nobody can say for sure. But it's certain that the IRS has stepped up its enforcement staff in an effort to collect more tax dollars. The difference between the amount tax-payers owe and the amount they actually pay (known as the "tax gap") runs over \$300 billion per year. That's a staggering amount, and the IRS is aiming to reduce it.

Audit Statistics

According to the IRS statistics, the number of individual audits has increased from 618,000 in 2000 to a little more than one million in 2004. That's an increase of over 60% in just a few short years and equates to a 1 in 130 chance of an audit based upon total returns filed.

If your income is over the \$100,000 threshold, your audit chances increase to about 1 in 70. If you are self-employed and file a Schedule C, your audit chances increase yet again.

As you might imagine, those taxpayers earning virtually all of their income in the form of wages reported on W-2 forms, with no unusual deductions or large losses on their returns, are much less likely to receive an audit notice.

In addition to full-scale audits, the IRS sends out millions of "correction notices" each year. These notices are computer-generated and are a result of a discrepancy between information reported to the IRS and the information reported on your tax return. While these correction letters are less imposing than an audit, they should still cost you additional taxes.

IRS Audit Objectives

The IRS has identifiable audit objectives that include the self-employed and wealthy taxpayers who report big losses on their tax returns. Other areas that receive IRS scrutiny include workers classification issues (employee vs. independent contractors), travel and entertainment expenses, related-party transactions, unreported income and tax shelters. The IRS tries to target tax returns that will return the greatest additional taxes to the Treasury in relation to the audit resources employed.

Your Audit Defense

Should you be terrified that your return might be selected for audit? Certainly not. An accurately prepared return is the first line of defense should you be selected for audit, and well-maintained

Learn to maximize reimbursement for your work and eliminate liability for inadequate documentation:

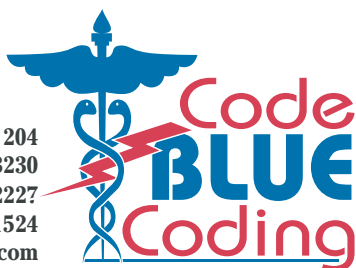
- E & M coding in a medically-based seminar, led by a physician
- Assign correct E & M Codes by objectively determining the appropriate level of medical service of each encounter
- Eliminate undercoding and increase revenues by as much as 30%
- Stop wasting time and money with over-documentation
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- Connect E & M Coding with medical decision making using real-life, clinical examples and case studies

Code Blue Coding seminars teach you to assign *accurate* E & M Codes based on the level of medical care provided in your daily practice. You will gain the important coding skills necessary to maintain proper levels of documentation and maximize billings.



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Seminar Schedule:

Class registration begins at 8:00 a.m. Continental breakfast will be served. Classes run from 8:30 a.m. until 12:30 p.m.

JAN	21	■	E&M for Pediatrics	Northern VA *
	28	■	E&M Coding 101	Northern VA *
FEB	18	■	E&M Coding 101	Williamsburg VA*
	25	■	E&M for Pediatrics	Williamsburg VA*
MAR	4	■	E&M Coding 102	Williamsburg VA*
APR	8	■	E&M Coding 102	Northern VA *
	22	■	E&M Coding 101	Northern VA *
	29	■	E&M Coding 101	Williamsburg VA*

* Please see our website, www.codebluecoding.com, for exact location of seminars.

Professional Faculty

Andrew K. Worthington, MD Board Certified Neurologist, Dr. Worthington left private practice after 16 years and now devotes full time to Evaluation and Management Coding from a practitioner's point of view.

Medical School: *Virginia Commonwealth University School of Medicine, Richmond, VA*
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★ **REGISTER ONLINE AND SAVE \$20** \$ 249 for 1

ATTEND WITH A COLLEAGUE \$ 225 each for 2

(for multiple registrations, please mail, fax or call) \$ 212 each for 3+

substantiation records are the ammunition for that defense.

Audit selection doesn't necessarily mean that additional taxes will be assessed. That's especially true if you receive one of the IRS computer-generated "correction notices." The IRS does make mistakes, especially with notices sent automatically by its computers.

Don't stress about the possibility of an audit. Instead, make sure that you maintain good records and that your accountants prepare complete and accurate tax returns.

Performance Anxiety: How to make employee reviews more effective

The annual employee performance review - usually it's dreaded by both supervisor and employee. The employee knows he'll have to hear about those mistakes from months ago, and the supervisors will finally have to discuss those issues he's been avoiding all year. Too often, the result is discomfort and embarrassment all around. Usually both parties fudge a little and are glad it's over for another year. Too bad, because another chance for open communication and feedback has been lost.

To improve the process, consider holding performance appraisals more frequently, perhaps even quarterly. This can help make the appraisal less of a "special event" and more of a routine exchange of information. It also means your feedback is more directly related to your employee's recent performance, rather than coming months later.

Of course, even quarterly appraisals don't substitute for immediate feedback. If an employee does something wrong, or something good, tell him or her immediately. Point out the problem, make sure the employee acknowledges it, and make clear what you expect in the future. And if it's something good, the employee will appreciate receiving a pat on the back. With immediate feedback, there should never be any surprises at an appraisal.

At the end of every appraisal, summarize the discussion and put the highlights in writing. Make sure your employee gets a copy. Before the next appraisal, ask your employee to review the copy and prepare his thoughts on his most recent performance. Ask him to present his opinions to start the discussion. If there are areas needing improvement, agree on an action plan and put that in writing too. And that might be a two-way street. It could involve your providing training or taking actions to support the employee, so make sure you're living up to the agreement.

Don't limit the appraisal to a scorecard on the employee's achievements. If appropriate, use it to discuss career planning, cross-training, or job enrichment. Solicit ideas from the employee. It can all help turn a judgmental meeting into a constructive exchange of ideas.

Delay paying taxes with a like-kind exchange

Sitting on a piece of investment property that you would like to

sell? By structuring the transaction as a tax-deferred exchange, you can delay paying taxes on the full amount of the gain realized.

Also known as a "like-kind exchange" or a "1031 exchange," these transactions are only available for investment or business assets. Certain types of assets don't qualify for a tax-deferred exchange, including inventory, accounts receivable, stocks and bonds, and your personal residence.

Keep in mind that the like-kind exchange rules only defer the tax. Any gain will be recognized upon a taxable disposition of the replacement property.

Specific steps must be followed for a deferred exchange to be successful. Start by finding a qualified intermediary, such as an escrow agent or a title company, to facilitate this transaction.

You then have 45 days from the date you relinquish your property to the qualified intermediary to name as many as three possible replacement properties. You must take title to the replacement property within 180 days. The rules state that you must replace real property with real property and personal property with personal property. Replacing an apartment building with commercial space, a strip mall, or even undeveloped land all qualify. While deferred exchanges can save you a significant amount of taxes, following the specific rules can be tricky.

Invest with an eye on inflation

Like the boy who cried, "wolf," experts' warnings of inflation have been largely ignored over the last decade. Now, with the recent spike in fuel prices and rising interest rates, people are starting to take notice again. Inflation, even at modest levels, can seriously reduce real investment return. Is your portfolio structured to succeed in periods of inflation? Consider these fresh ways to combat an old foe.

TIPS. A popular investment vehicle used to battle inflation has actually been around since 1997. Treasury Inflation Protected Securities (TIPS) are U.S. government bonds that adjust payout rates in accordance with rises in the Consumer Price Index (CPI). So if you have a low tolerance for risk, but seek protection from rising interest rates, this might be the bond for you.

Corporate bonds. Another option is the inflation-indexed corporate bond. Patterned after the popular TIPS program, these bonds also offer rates that move in tandem with the CPI. The interest rates are higher than TIPS, but they carry the credit risk of the company that issues them.





Tax issues. There are tax issues to consider as well. Inflation-indexed corporate bonds are fully taxable. TIPS, on the other hand, are exempt from state and local tax. Corporate bonds hold a slight edge in that interest rate increases are reflected immediately in the monthly payment. TIPS, instead, reflect rate increases in the principal balance received at maturity. What's more, these increases are immediately taxable, even though you have to wait until redemption to reap the extra earnings. This timing difference could make TIPS better suited for your IRA or 401(k), where interest is not taxed until withdrawn.

I bonds. If your portfolio is in a taxable account, you might consider I bonds instead of TIPS. I bonds are U.S. savings bonds with inflation protection. Like TIPS, I bonds are exempt from state and local income tax. But, unlike TIPS, federal income tax can be deferred until the bond is redeemed.

CDs. Even an old standby, the bank certificate of deposit, is getting into the inflation protection game. Some banks now offer CDs with a fluctuating interest rate. Keep in mind that these investments are fully taxable, and they offer an initial interest rate that is lower than a conventional CD. But during periods of swelling interest rates, these CDs will return higher overall income.

Laddering. Even if your bank does not offer flexible CDs, you can still protect yourself by laddering your CD portfolio with a range of maturity dates. Then, if interest rates climb dramatically, you won't be tied up with one low-yielding certificate.

Inflation can threaten your investment return at any time, so stay alert for ways to protect your portfolio.

Your home mortgage: Pay it off or play it safe?

Is it wise to pay off your mortgage early? As with most financial decisions, this one depends on several factors including your current mortgage rate, tax bracket, balances on credit card and consumer debt, near-term expenses, retirement dates, and potential alternative investments.

Pay it off?

Mortgage prepayment can certainly offer advantages. For example, you'll pay less interest in the long run. Let's say you have a 30-year fixed rate mortgage at 7% with a balance of \$180,000. By paying an extra \$75 per month toward the principal balance, you'll save about \$49,000 in interest and the mortgage will be paid off five years early. Generally, the longer the mortgage term and the higher the interest rate, the more savings you realize by prepaying. Also, because you're paying off a debt you already owe,

the return of mortgage prepayment is risk-free. In addition, with the mortgage out of the way, cash will be available for other things. That's especially important for those heading into retirement.

Play it safe?

But prepaying your mortgage isn't always the best idea. Do you have large balances on credit cards or high-interest consumer loans? It's probably a good idea to use extra funds to pay off those debts first, before focusing on your mortgage. Non-mortgage debt generally carries a high interest rate, and the interest isn't tax-deductible.

If your employer matches contribution to your 401(k) retirement account, be sure you're investing up to the matching limit before putting extra cash into your mortgage. Chances are you'll net a higher return on your retirement account than by mortgage prepayment.

Consider also whether you'll need those extra funds for near-term expenses. Money locked up in your home mortgage is much less liquid than in a savings account. It's harder to get at for college tuition, medical bills, or emergencies. Of course, you can open a home equity line of credit or take out a home loan for such expenses, but that just increases your mortgage balance.

You may also consider putting that extra monthly payment into other types of investments. Over the long term the stock market has generated about a 10% return. If you have a 6% mortgage and a long time horizon, you may be better advised to put those extra funds into a mutual fund.

For many people, prepaying a mortgage is a good idea. Just be sure you've considered all the relevant factors.

Flex account rule changes

Flexible spending accounts (FSAs) let workers set aside pre-tax dollars to pay for medical expenses and dependent care costs. The rule, up until now, has been that any money left in these accounts at the end of the year was forfeited - a "use it or lose it" rule that could leave employees with planning headaches in trying to match actual expenses for the year with set-aside funds.

Now the IRS is making things a bit easier for those with FSAs. Employers may modify their FSAs to extend reimbursement deadlines for a given year by 2 _ months, letting employees have until March 15 of the following year to use up funds in their FSAs.

IRS certifies hybrid cars

Among the vehicles the IRS recently certified for the \$2,000 clean-fuel tax deduction are the 2005 models of the Honda Insight, Honda Civic Hybrid, Honda Accord Hybrid, Ford Escape Hybrid, and Toyota Prius. The 2006 Lexus RX 400h and Toyota Highlander Hybrid were also certified for the deduction.

Beginning in 2006, this deduction is replaced by a tax credit for hybrid vehicles.

IRS reduces paperwork

IRS policy on employee withholding forms has changed. Employers must now submit an employee's Form W-4 only when specifically asked to do so by the IRS. The IRS will now use Form W-2 information to identify withholding problems.

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SPEECH OF NORRIS ROYSTON, MD, PRESIDENT OF THE MEDICAL SOCIETY OF VIRGINIA, TO THE MSV HOUSE OF DELEGATES MEETING ON NOVEMBER 6, 2005

Our profession is in trouble. We who came into this profession with high ideals feel disillusioned by today's administrative, regulatory and political demands. The patients we came to cure have become little more than ciphers in what we know as "the process" a process that all too often subverts or takes precedence over the outcomes with which we should be primarily concerned.

How much of the blame for this state of affairs must we shoulder? Were we wrong to believe the nobility of our calling would protect us from interference from without? Were we wrong to believe our agents in Richmond and Washington could successfully defend us against the assaults from big business and big government?

Yes, we were wrong. Well intentioned, yes. Highly principled, yes. Clinically adept, yes. Politically adroit, well, perhaps not so much! And we've got to do something about it. I was reading the other night, trying to get a larger view of medicine and the society we are all here today to support and honor, and I came across this passage:

"More than any other science, do we need to educate the lay mind to the aims and purposes of our professionalism? Without such education, needful legislation in aid to the proper practice of our profession is of no avail. Laws promulgated by medical men and dictated for the good of the body politic are denied enactment because of lack of understanding of the underlying spirit."

That came from the president's address to this society, by one Lomax Gwathmey of Norfolk, on October 9th, 1906.

Ninety-nine years later, we face the same threats to our profession and our practice, writ larger only because the stakes are so much higher. Because our opponents are richer, more aggressive, more visible and much more determined. And because misunderstanding and misinformation within our client and political communities breed mistrust. Too many people look at medicine as a trade association whose crusade it is to protect personal wealth.

Here is my story. I grew up in a small town — Middleburg. My father was a funeral director. I was taught integrity, professionalism, and duty. Most of those who ultimately came to serve the community had also

served as young soldiers in World War II and came home to raise their families. Sense of public service was ingrained in me as far back as I can remember. Our phone was answered 24 hours a day, seven days a week. There were no rescue squads. My father had the only ambulances. There were no central alarms. We set off the fire siren from the top of our basement steps. For the first seven years of my life, all of our dining and living room furniture was moved out each time there was a funeral. My mother was an extraordinary cook. Often relatives of those who died joined us at meals. There was awareness of psychosocial issues in families and how to deal with them from a very early age. My family doctor lived across the street. The community regards his nurse, Miss Virginia Williams, as a saint.

Look how far we're removed from that time. From the model of doctor as trusted friend and healer to the health systems model where everything revolves around "the process." Where we've become the enforcers of restrictions that don't work. Instead of building our business the old fashioned way — giving adequate care and time to our patients — we're forced into corporate service as mid-level employees at that.

Think about our future...our children. Some are considered part of Generation Y — 76 million strong and they are lost in the system. There is no continuity of care. They are educated. They are plugged into the world in ways we could never imagine when we were their age. They find their doctors on the Internet. They have more loyalty to their hair stylist than to their doctor. They are functioning at a high level in a very competitive world. Their healthcare has to be penciled in. In what innovative ways do we reach them and develop meaningful relationships?

It's time we told our patients. It's time we told our communities. It's time we told our politicians that the health care safety net is about to break. We have to explain in simple, no nonsense terms the state of medicine in America: the power structure, the regulations, the care not given. That without administrative, regulatory and financial relief, patient access will be in jeopardy.

We can bring class action suits against carriers. That's what they've done in Northern Virginia with 2000

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doctors. And they've won. That's the good news. It was a worthy cause and a massive effort. The bad news is that last summer Aetna announced record profits and the challenges of dealing with managed care continue.

Or we can try to change the laws that over the years we've let the insurance companies and the trial lawyers write. We can't do it overnight. But we can start.

In the Northern Neck of Virginia they've had to close down access to O.B. That means if you live in Montross, you have to drive all the way to Richmond to have your baby. And not a single complaint from local politicians.

In the Southwest, doctors are picking up and leaving for lack of...it's all Medicare pay. And let's never forget that Virginia ranks 48th among the states in per capita Medicaid expenditures. Why? Because we've let our representatives spend the people's money elsewhere. In North Carolina they receive 97% of Medicare for service to their Medicaid patients, in Virginia absent O.B. it is 60-65%

If we're going to change the laws, we've got to unite. We've got to bring every region to one table — with every kind of practice represented under one roof. And we've made a dramatic start.

First, we've got to buy a seat at the table. I'm sad that money speaks loudest in politics. But that's the real world we live in.

In recent years, the big political action committees have dwarfed the money we've raised.

Where do we raise the money? From every doc in the state. Think on this: last year only 13% of our 8,700 colleagues gave. That means 87 per cent of us turned our backs. We let the few carry the load.

Second, we have to use the money to win elections — to gain access. The days are over when we simply gave to the better candidate. The new mantra must be: "If you don't support us, we won't support you." In fact, we'll try to defeat you.

And last, you've got to give your time. It's no longer enough to send your representatives a form letter, but

sitting down and educating them on the realities of today's medicine in the 21st century, and to give them reason to support our needs and the needs of our patients against those who want us to be their enforcers. Because, in the end, we are our own best and most credible lobbyists.

To those who grouse about traveling to Richmond for [the Medical Society of Virginia's] "White Coat Days" — to take a day out of the office they can't afford — I say it is the cost of doing business. I guarantee that the price you'll pay by not being in Richmond will be far greater than one days billing.

Plus, how fair is it to expect another physician to do your part — to take your place on the line. The House of Medicine has got to stand together to fight these battles. Going AWOL is a shame on all of us.

My goals for the Medical Society in the upcoming year and beyond are simply stated: Set out a legislative strategy. Raise the money that opens doors. Educate our communities. Personally carry our message to Richmond. And that means every one: our families, our friends, our patients, Alliance members, and our support staffs.

And start taking back our reputations.

I'll return to my boyhood...and my father as mentor. And the gut values of caring and healing and service. If we lose that — who are we?

If we fail to take our cause to the public, and to those who represent the public, if we can't change attitudes, if we can't change laws, then we might as well go back and take a degree in business. Because if we fail, that's what our future holds.

I challenge you to join me in this effort. Do you accept this challenge? In the words of Margaret Mead, "Never doubt that a small group of thoughtful, committed citizens can change the world. Indeed, it's the only thing that ever has."

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