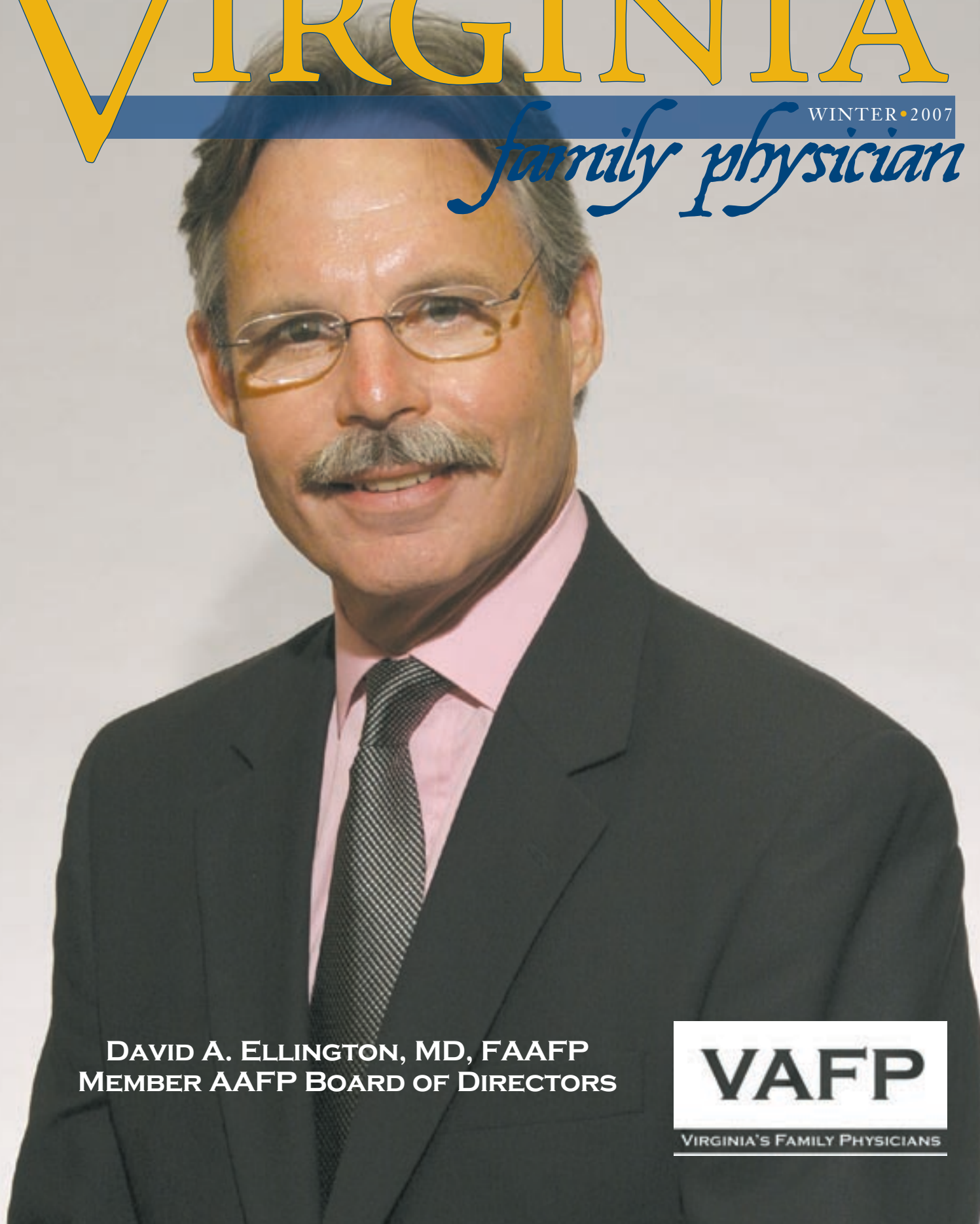


# The VIRGINIA

WINTER • 2007

*family physician*



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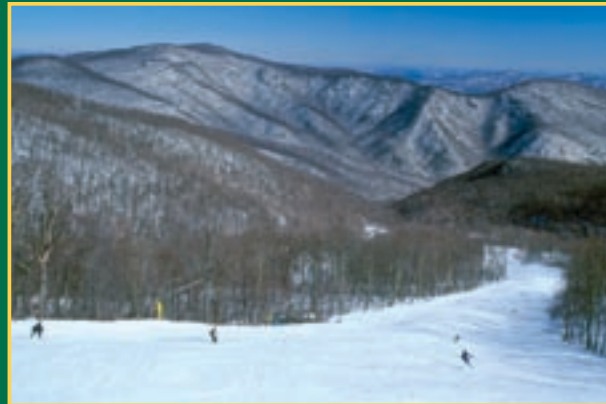
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# VAFP

VIRGINIA'S FAMILY PHYSICIANS

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## The VIRGINIA family physician

WINTER • 2007

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- *Newport News*

### 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

1503 Santa Rosa Road  
Suite 207  
Richmond, VA 23229

Edition 9



Created by  
**PUBLISHING CONCEPTS, INC.**

Virginia Robertson, President  
vrobertson@pcipublishing.com  
14109 Taylor Loop Road • Little Rock, AR  
72223

501.221.9986 or 800.561.4686

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# VIRGINIA ACADEMY OF PHYSICIAN ASSISTANTS

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- Provide a broad range of diagnostic and therapeutic services
- May also perform educational, research, and administrative activities

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ALEXANDRIA, VIRGINIA 22314-1552

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# PRESIDENT'S MESSAGE

Sterling N. Ransone, Jr., M.D.



It's that time of year again. The Virginia General Assembly is in session, and our elected representatives are busy making decisions which will affect each of us and the way we are allowed to practice medicine. Though we all strive to take care of each of our patients to the best of our ability, forces outside our sphere of influence are constantly attempting to interfere with what most of us hold sacred, the doctor-patient relationship. Be it third party payors who attempt to save themselves money in the guise of "quality," moralists who try to legislate what we are allowed to discuss with our patients in the privacy of our examination rooms, or untrained "providers" who wish to treat our patients with scientifically invalid measures in the name of access, our profession is constantly the focus of political interest. Plato said "one of the penalties for refusing to participate in politics is that you end up being governed by your inferiors". I fear that if we do not engage more actively in the political process, our patients will be the ones to suffer.

What can we as an Academy do to protect our patients? First, we must protect our own interests. Numerous studies have shown that only by making the practice of family medicine (and primary care medicine in general) financially viable, can we assure that our health care system remains solvent. Therefore, the concept of the patient-centered medical home is one which deserves our support.

Next, we must serve as a unifying voice for Family Physicians at the state level. Due to tax laws, our academy is not allowed to offer financial contributions to those legislators who champion and support issues of concern to us. We should consider forming a political action committee to support our friends at the General Assembly. To some people, monetary donations of this sort may appear unseemly, but this is the way our American political system operates. We can sit on the sidelines and allow others to dictate how medicine is practiced in our Commonwealth and nation, or we can become full, active participants in the political process. This requires money. Although we may be certain of the justness of our thoughts and actions on behalf of our patients, unless our legislators can hear our message, our good intentions will be fruitless.

As an Academy, we must speak out on behalf of those who have no voice. Medicine is still among the most trusted of professions and we must leverage this trust with politicians for the benefit of our patients. Actively supporting a potential ban on tobacco smoking in restaurants and advocating for those without

the ability to afford health insurance are the types of measures we should encourage.

What can you as an individual do to protect your patients? Become an active voice promoting the specialty of Family Medicine and speaking out on issues which may affect their health. Who in your community can better speak out on issues which affect the health of your locality? Fear of losing business seems to be a concern which stifles the voice of many physicians, though I have yet to speak to a family doctor who is suffering from a lack of patients.

How can you make your voice heard? Go to your board of supervisors' or town council meetings and express your concerns. Invite your state legislator to lunch or to spend a day with you in your office. Show him or her the hurdles that you have to deal with every day. Introduce the extra staff you have had to hire in order to interface with the various insurers. Discuss the regulatory burdens with which you have to comply on a daily basis.

E-mail or call the staff of the Virginia Academy, Dr Jesus Lizarzaburu, the chairman of our legislative committee, or me with questions or concerns about issues, so we may more effectively represent you in Richmond. Join the legislative discussion group in the "Doctor's Lounge" forum, which you can access through our academy's web site at [www.vafp.org](http://www.vafp.org).

Visit the web site of the Virginia General Assembly at <http://legis.state.va.us/>. There you can find the contact information for both your Delegate and your State Senator. Governor Kaine can be reached through <http://www.governor.virginia.gov/>. I encourage you to enter this information into your e-mail contact list or little black book for easy access. When there is an issue of concern, send them a note detailing that issue and potential remedies.

The A.A.F.P. has an excellent resource in "Speak Out" through which you can easily reach your elected representatives in Washington, D.C. There you can send a customized e-mail to your Senator or Representative to express your views on numerous federal matters. You can connect through the hot button on our academy's web site or at <http://capitol.aafp.org/>.

In conclusion, I urge you to not remain silent. Become an advocate for your fellow Family Physicians and for your patients. Let your voices be heard, for only then will we be able to ensure quality, accessible healthcare for our patients, their families and the citizens of Virginia.

# DAVID A. ELLINGTON, M.D., FAAFP, ELECTED TO THE AAFP BOARD OF DIRECTORS

David A. Ellington, M.D., FAAFP, serves on the board of directors of the American Academy of Family Physicians (AAFP) and was elected to a three-year term in October 2007 by the AAFP's governing body, its Congress of Delegates. The AAFP represents nearly 94,000 physicians and medical students nationwide.

Dr. Ellington has been in private practice in Lexington since 1984. In 1992, he co-founded the Rockbridge Area Free Clinic where he has served as volunteer medical director for the past 15 years. He also has served locally on the boards of directors for Stonewall Jackson Hospital and Rockbridge Community Services.

At the state level, Dr. Ellington served for many years on the boards of both the Virginia Academy of Family Physicians (VAFP) and the Medical Society of Virginia. He has been president of both organizations. Ellington also has served as secretary of the Virginia Physicians Network and was chair of the Quality Council for Anthem Blue Cross and Blue Shield. He presently serves as chair of the Governance Committee of the Medical Society of Virginia Foundation.

At the national level, Ellington has served on the AAFP Commission on Health Care Services as the AAFP advisor to the Current Procedural Terminology Panel and is now a delegate to the AAFP Congress of Delegates. He also serves as an alternate delegate to the American Medical Association.

Dr. Ellington graduated from the Virginia Military Institute in 1971 with a degree in biology. He was a distinguished military graduate and was commissioned into the U.S. Army Reserve upon graduation. He graduated from the Medical College of Virginia in 1975. Ellington completed his family medicine residency while on active duty in the Army at Silas B. Hays Hospital at Fort Ord, Calif. He then served three years overseas at the 67th Evacuation Hospital in Wuerzburg, Germany. Ellington returned to Fort Ord in 1981 and served first as a staff physician in the residency training program before becoming director of residency training and then chairman of the department of family medicine.

Dr. Ellington is board certified by the American Board of Family Medicine and has the AAFP Degree of Fellow, an earned degree awarded to family physicians for distinguished service and continuing medical education.



## SPECIAL THANKS TO DAVID'S TEAM

David Ellington's campaign and subsequent election to the AAFP Board of Directors was truly a Virginia team effort. Special thanks and accolades are in order for Dr. Mitch Miller, Virginia Beach, who served as David's campaign Committee Chair. Joining Dr. Miller in Chicago in support of the campaign, the other members of David's team were AAFP Alternate Delegates Cynthia Romero, M.D., Virginia Beach, Dena Hall, M.D., Suffolk, VAFP President Sterling Ransone, M.D., Deltaville, VAFP Immediate Past President Wayne Reynolds, DO, Gloucester Point, VAFP President-Elect, Mark Watts, M.D., Roanoke, VAFP Board members Jesus Lizarzaburu, M.D., Grafton, and Chris Lupold, M.D., Charlottesville, and Sam Jones, M.D., Fairfax. David's partner since 1984 Bob Pickral, M.D., Lexington, and his wife Nancy were on site to support David, as were David's wife Jane, his son Peter and his son and daughter-in-law David and Megan.

# VIRGINIA ACADEMY OF FAMILY PHYSICIANS BOARD OF DIRECTORS MEETING

Board Briefs November 10, 2007, Williamsburg, VA

Approved minutes from the August 10 and 12, 2007, VAFP Board of Directors meeting held in Hot Springs, Virginia.

Formally congratulated David Ellington, M.D., on his election to the American Academy of Family Physicians Board of Directors.

Approved a motion to appoint Roger Hofford, M.D., as Treasurer of the Academy for the unexpired term of Dr. David Ellington. The term concludes in the summer of 2009.

Heard report on the 2007 Southeastern Family Medicine Forum held August 16-18, 2007, in Ashville, NC.

Heard report from AAFP Delegates Drs. Mitch Miller and David Ellington on the 2007 AAFP Congress of Delegates meeting held October 1-3, 2007, in Chicago, Ill.

Heard report from VAFP MSV Delegate Dr. Sterling Ransone on the Annual Meeting of the Medical Society of Virginia House of Delegates held October 26-28, 2007, at The Homestead.

Heard update from VAFP Board members Chris Lupold, M.D., and Andrew Macfarlan, M.D., on sponsoring a VAFP Residency Fair.

Approved a motion that the Academy budget up to \$10,000 for a VAFP sponsored Residency Fair with a specific proposal to be presented from the work force at the Wintergreen Board meeting.

Heard report from VAFP CME Chair, Mitch Miller, M.D., on the plans and programming for the 2008 Winter Family Medicine Weekend scheduled February 1-3, 2008, at Wintergreen Resort.

Heard report from VAFP CME Chair, Mitch Miller, M.D., on the plans and programming for the 2008 VAFP Annual Meeting scheduled July 24-27, 2008, at The Cavalier Hotel in Virginia Beach.

Heard report on the 2007-2008 VAFP sponsored Self Assessment Module Group Learning sessions.

Heard report from VAFP Legislative Committee Chair, Jesus Lizarzaburu, M.D., on the telephone conference call held October 30, 2007, and from VAFP Lobbyist, Mr. Seth Ginther, on the 2008 Virginia General Assembly health care agenda.

Charged VAFP Reimbursement Task Force Chair, Marlene Capps, M.D., with creating a tool to promote the medical home to local large employers and discussing the possibility of having a VAFP sponsored CME weekend focused on practice management.

Heard report from VAFP Practice Enhancement/Redesign Task Force Chair, Tony Kuzel, M.D., on practice management survey that was distributed at the 2007 VAFP Annual Meeting and on the practice management sessions that will occur at the 2008 Wintergreen meeting and 2008 VAFP Annual Meeting.

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for patients: [www.smokefreevirginia.org](http://www.smokefreevirginia.org)  
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for nurses: [www.tobaccofreenurses.org](http://www.tobaccofreenurses.org)  
free quit kits: 1-877-856-5177 (toll-free)

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Urge your patients who smoke or use tobacco to call the Virginia quitline and speak to a trained counselor today!

\*Funded by the Virginia Department of Health Tobacco Use Control Project [www.vahealth.org/cdpc/tobaccouse](http://www.vahealth.org/cdpc/tobaccouse)



On November 6, 2007, every member of the Virginia General Assembly stood for reelection. The results of election day include a change in control of the Virginia Senate – it is now controlled by the Democrats. The Republicans maintained control of the House of Delegates. The VAFP will be well prepared to work with the new leadership in the Senate as well as the leadership in the House. Here are a few examples of the initiatives we will be working on during the 2008 General Assembly session:

## **FAMILY PHYSICIAN OF THE DAY PROGRAM**

Again this year, the VAFP will sponsor the “Family Physician of the Day” program where the medical clinic located inside the General Assembly building will be staffed by a volunteer family doctor. Last year, we started a new program where the doctor of the day was introduced to his or her Delegate and Senator while they were staffing the clinic. This provided an excellent opportunity for the VAFP to raise its profile with legislators and this program will be repeated again this year.

## **ANTI-SMOKING LEGISLATION**

The VAFP will play a central role this coming General Assembly session in an effort to eliminate smoking in restaurants and other food establishments. We have signed on to a coalition that includes the American Heart Association as well as the American Cancer Society. We are in the process of finding bipartisan

sponsors for the legislation in the House and the Senate and will be calling on each family physician in Virginia to contact their legislators urging them to support this legislation. The VAFP will also provide expert medical testimony on the adverse effects of second hand smoke as this legislation moves forward.

## **MEDICAL MALPRACTICE CAP**

On July 1, 2008, Virginia’s medical malpractice cap will mature to its legal maximum of \$2 million. As early as the 2008 General Assembly Session, groups in opposition to the cap could seek to eliminate or increase Virginia’s malpractice cap. The VAFP is monitoring this issue and what effects it may have on the practice of family medicine.

Each year, there are over 3,000 pieces of legislation filed for consideration during the legislative session. We review every piece of legislation that could impact family medicine and then in consultation with the Board of Directors, we advance the VAFP’s position on that legislation.

The best way to advance an interest at the General Assembly is for legislators to hear directly from their constituents on the issues that are important to them. Accordingly, as VAFP issues arise, we will be contacting you with talking points and draft letters for you to call and write your legislators on issues that are important to family medicine.

# 2008 VIRGINIA GENERAL ASSEMBLY

## FAMILY PHYSICIAN OF THE DAY

Volunteers are needed to serve as Family Physicians of the Day during the 2008 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.

The VAFP has expanded its legislative representation efforts with the addition of Mr. Seth Ginther with HF Consulting to our team. Seth will make appointments for the Family Physician of the Day to meet with his or her Delegate and/or Senator, pending the legislator's availability. We hope this effort will provide those who serve as the Family Physician of the Day the opportunity to meet their legislator. Please select the date you are available and indicate it below. The calendars reflect dates that have already been assigned. You may also sign up for the Physician of the Day Program on the VAFP Web site at [www.vafp.org](http://www.vafp.org).

Please return the completed Participation Form to:

VAFP  
 1503 Santa Rosa Road  
 Suite 207  
 Richmond, VA 23229  
 Phone: 800-843-8237  
 Fax: 804-968-4418  
 E-mail: [mschulte@vafp.org](mailto:mschulte@vafp.org)

### JANUARY 2008

MON	TUES	WED	THU	FRI
		X	10	X
14	15	X	X	18
21	22	X	X	25
28	29	X	X	

### FEBRUARY 2008

MON	TUES	WED	THU	FRI
				1
4	5	X	X	8
X	12	X	14	15
X	19	X	X	X
X	X	27	28	29

### MARCH 2008

MON	TUES	WED	THU	FRI
3	4	5	6	X

Preferred Date(s): \_\_\_\_\_

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State/Zip: \_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

E-mail: \_\_\_\_\_

# FYI...

**NON-COMPETE RESTRICTION HELD UNENFORCEABLE.** The Supreme Court of Virginia has ruled that a medical group professional corporation, the ownership of which had transferred from a deceased, sole-shareholder physician to his non-physician spouse upon the shareholder's death, was converted to a business corporation by state law and could not enforce a restrictive covenant because it could not "practice medicine." Such a corporation has no enforceable interest in a physician non-compete, the court said in *Parikh v. Family Care Center*.

There are several issues that remain open after the court's decision. It is unclear whether a non-professional entity lawfully may employ a licensed physician to practice medicine. Also, the court did not indicate whether its holding would have been different if Dr. Parikh's employment agreement had provided that the entity-employer rendered medical services through its licensed, employed physicians.

**WRITTEN WAIVER OF RIGHT TO SUE FOR FMLA VIOLATION HELD INVALID.** When a person's employment is terminated by a medical group and a severance payment is offered to the employee, the medical group often will require that the employee sign a release of claims against the group before it pays the severance. Terms of the release may include a waiver of any claim the terminated employee may have pursuant to the Family Medical Leave Act ("FMLA").

A panel of the Fourth Circuit Court of Appeals now has ruled that such a waiver is ineffective and that, even though such a waiver was signed voluntarily by the employee so that she could receive a better severance, the employee still may sue the employer for violations of the FMLA.

In *Taylor v. Progress Energy, Inc.*, the appellate court's panel held that the Department of Labor's own regulation dictates the result. The right to sue for past violations is plainly a "right under the FMLA." To be valid, the waiver would have to be approved in advance by the labor department or a court, the Fourth Circuit said.

The practical effect of the Fourth Circuit panel's decision may be that lawyers now will request court authorization every time the FMLA is implicated in a settlement.

The employee has requested that the U.S. Supreme Court hear the case on appeal.

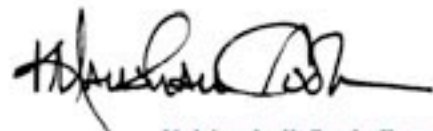
**PHYSICIAN ASSISTANTS' PRESCRIPTIVE AUTHORITY.** Effective July 1, 2007, a licensed physician assistant has the authority to prescribe controlled substances and devices for Schedule II. Physician assistants who wish to add Schedule II to their existing protocol must submit a written request to the Board of Medicine office to include their name, license number, and signature of their primary supervising physician, or complete the prescriptive authority request form. This form can be found at the Virginia Board of Medicine's Web site under forms and applications.

**UPDATE YOUR PRACTITIONER PROFILES.** All Virginia physicians should remember that Virginia law and Board of Medicine regulations effectively require them to update their Practitioner Profile with the Board at least annually or within 30 days following any change in the information on the profile. To update your profile online, visit [www.vahealthprovider.com/edit](http://www.vahealthprovider.com/edit) and enter your license number and personal password. If you need technical assistance to update your online questionnaire, or if you do not have internet access, you may call (804) 367-4444 for assistance.

My experience is that every time the Department of Health Professions investigates a complaint made against a Virginia physician, the Department's investigator checks the accuracy of the physician's online profile as well. Failure to keep a physician profile updated ultimately may result in financial sanction by the Board of Medicine. A word to the wise.

---

*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](mailto:mcook@hf-law.com)

# Meet us at the Beach



Mark Your Calendars to Attend  
the 2008 VAFP Annual Meeting  
& Exposition

July 24-27, 2008  
The Cavalier Hotel  
Virginia Beach, Virginia



Registration materials  
available in May 2008.

# INSURANCE & MANAGED CARE

Jennifer Sharp-Warthan, M.D.  
Chair  
Insurance & Managed Care

## NPI/MEDICARE PIN NUMBER MISMATCH PROBLEMS

Medicare Part B Claims and the National Provider Identifier TrailBlazer Health Enterprises, LLC, the Medicare Part B contractor for Virginia, announced that effective October 07, 2007, a Medicare system, known as the National Provider Identifier (NPI) Crosswalk, will validate provider claims if they contain a legacy number such as a Medicare Provider Identification Number (PIN) and an NPI. If the NPI/PIN combination on Medicare claims does not match an NPI/PIN combination in the NPI crosswalk, your claims will reject. All Medicare carriers will be rejecting Part B claims if they are unable to match an NPI and a PIN combination submitted on a claim to an NPI/PIN combination in the Medicare NPI crosswalk. The NPI/PIN combination may be used to identify the billing, pay-to or rendering provider (the pay-to provider is identified only if it is different from the billing provider). This applies to claims submitted by corporations that physicians and non-physician practitioners have formed, or by physicians and non-physician practitioners who bill Medicare directly.

If you have not yet applied for your NPI number, please do so by going to [www.nppes.cms.hhs.gov](http://www.nppes.cms.hhs.gov).

If you use a clearinghouse to submit your claims electronically to Medicare, please contact the clearinghouse to make certain that the clearinghouse has tested a few claims by submitting the test claims with only the NPI number or with the NPI/PIN combination. The testing of live claims will determine if the NPI crosswalk information is correct or whether action is required to correct the crosswalk. If a provider's clearinghouse is currently stripping the NPI from the transaction, providers should encourage their clearinghouse to test transmission of claims with the NPI number before NPI numbers are mandated on all inbound claims.

## CARE OVERSIGHT PLAN

Are you aware you can receive payment when doing home health forms for your patients? From a coding prospective, this is called care plan oversight. These rules below are for Medicare patients only.

Care Plan Oversight allows separate payment for services involved in physician certification/recertification and development of a plan of care of Medicare-covered home health services.

Codes to use when billing Medicare patients for Care Plan Oversight are:

- G0180 Physician certification of Home Health Agency Services – **Initial**

The Initial Certification code (G0180) can be used when the patient HAS NOT received *Medicare-covered home health services for at least 60 days*.

The 2007 Medicare allowable for G0180 is \$62.30.

- G0179 Physician recertification of Home Health Agency Services – **After initial**

The Recertification code (G0179) is used after a patient has received services *for at least 60 days, one certification period, AND may be billed once each 60-day period after the initial.*

The 2007 Medicare allowable for G0179 is \$47.36.

Certification and recertification services *would not be expected to be billed more than **three times a year*** for most patients.

Conditions to be Met for Coverage of Home Health Services:

Care Plan Oversight should be billed by physicians providing primary or comprehensive medical care to the patient.

Physicians certifying a plan of care for a patient receiving home health services ***must have provided a Medicare-covered face-to-face visit within the six months prior to the certification.***

Patient **must** be a Medicare beneficiary receiving Medicare-covered Home Health Agency services.

Patient **must** be covered by **Medicare as primary insurance.**

Only one physician may bill for CPO services for a beneficiary in a 60-day period.

The home health services **must** be medically necessary.

Only a Doctor of Medicine, Doctor of Osteopathy or Doctor of Podiatric Medicine is permitted to bill CPO.

Documentation Requirements:

The physician must maintain documentation of the development of a plan of care and data review in the patient's medical records. These are the records you sign and should **keep a copy of the record in the patient's chart.**

All progress notes, orders, verbal orders, summaries of phone calls, etc. must be maintained including periodic summary reports provided by the Home Health Agency.

It is not sufficient that the Home Health Agency maintain documentation for the physician.

The physician's contribution to the development of the plan and review of specific items entered into the plan must be documented in the patient's medical record. Again, keep copies in the chart.

Utilization Guidelines:

It is expected that Home Health Agency services are intermittent and not continuous.

Services that exceed the accepted standard of medical practice may be deemed not medically necessary.

Billing Requirements:

When billing G0179 or G0180, use your site location number.

Use the appropriate diagnosis for the reason the patient requires home health.

Enter the appropriate "G" code, then on the next line at procedure enter:

HCFA19 HHA, then enter the home health agency's Medicare provider number.

Many of the forms the home health agency supplies for the provider to review and sign include their Medicare provider number. If not, call the home health agency to get that information so you can include it with the charge, as required by Medicare.

SERVICE	HCPSCS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
<b>Initial Preventive Physical Examination (IPPE)</b> <i>Also known as the "Welcome to Medicare Physical Exam"</i>	G0344 – IPPE G0366 – EKG for IPPE G0367 – EKG Tracing for IPPE G0368 – EKG Interpret & Report	No specific diagnosis code required for IPPE & corresponding EKG Contact local Medicare Contractor for guidance	All Medicare beneficiaries whose first Part B coverage began on or after January 1, 2005	Once in a lifetime benefit per beneficiary Must be furnished no later than 6 months after the effective date of the first Medicare Part B coverage begins	Copayment/coinsurance Deductible
<b>Ultrasound Screening for Abdominal Aortic Aneurysm (AAA)</b>	G0389 – Ultrasound exam AAA screen	No specific code Contact local Medicare Contractor for guidance	Medicare beneficiaries with certain risk factors for abdominal aortic aneurysm <i>Important – Eligible beneficiaries must receive a referral for an ultrasound screening for AAA as a result of an IPPE</i>	Once in a lifetime benefit per eligible beneficiary, effective January 1, 2007	Copayment/coinsurance No deductible
<b>Cardiovascular Disease Screenings</b>	80061 – Lipid Panel 82465 – Cholesterol 83718 – Lipoprotein 84478 – Triglycerides	Report one or more of the following codes: V81.0, V81.1, V81.2	All asymptomatic Medicare beneficiaries <i>12-hour fast is required prior to testing</i>	Every 5 years	No copayment/coinsurance No deductible
<b>Diabetes Screening Tests</b>	82947 – Glucose, quantitative, blood (except reagent strip) 82950 – Glucose, post-glucose dose (includes glucose) 82951 – Glucose Tolerance Test (GTT), three specimens (includes glucose)	V77.1 <i>Report modifier "TS" (follow-up service) for diabetes screening where the beneficiary meets the definition of pre-diabetes</i>	Medicare beneficiaries with certain risk factors for diabetes or diagnosed with pre-diabetes <i>Beneficiaries previously diagnosed with diabetes are not eligible for this benefit</i>	<ul style="list-style-type: none"> <li>2 screening tests per year for beneficiaries diagnosed with pre-diabetes</li> <li>1 screening per year if previously tested but not diagnosed with pre-diabetes, or if never tested</li> </ul>	No copayment/coinsurance No deductible
<b>Diabetes Self-Management Training (DSMT)</b>	G0108 – DSMT individual session, per 30 minutes G0109 – DSMT group session (2 or more), per 30 minutes	No specific code Contact local Medicare Contractor for guidance	Medicare beneficiaries at risk for complications from diabetes, recently diagnosed with diabetes, or previously diagnosed with diabetes <i>Physician must certify that DSMT is needed</i>	<ul style="list-style-type: none"> <li>Up to 10 hours of initial training within a continuous 12-month period</li> <li>Subsequent years: Up to 2 hours of follow-up training each year</li> </ul>	Copayment/coinsurance Deductible
<b>Medical Nutrition Therapy (MNT)</b>	97802, 97803, 97804, G0270, G0271 <i>Services must be provided by registered dietitian or nutrition professional</i>	Contact local Medicare Contractor for guidance	Medicare beneficiaries diagnosed with diabetes or a renal disease	<ul style="list-style-type: none"> <li>1st year: 3 hours of one-on-one counseling</li> <li>Subsequent years: 2 hours</li> </ul>	Copayment/coinsurance Deductible
<b>Screening Pap Tests</b>	G0123, G0124, G0141, G0143, G0144, G0145, G0147, G0148, P3000, P3001, Q0091	V76.2, V76.47, V76.49, V15.89, V72.31	All female Medicare beneficiaries	<ul style="list-style-type: none"> <li>Annually if high-risk, or childbearing age with abnormal Pap test within past 3 years</li> <li>Every 24 months for all other women</li> </ul>	Copayment/coinsurance for Pap test collection <i>(No copayment/coinsurance for Pap lab test)</i> No deductible
<b>Screening Pelvic Exam</b>	G0101 – Cervical or vaginal cancer screening; pelvic and clinical breast examination	V76.2, V76.47, V76.49, V15.89, V72.31	All female Medicare beneficiaries	<ul style="list-style-type: none"> <li>Annually if high-risk, or childbearing age with abnormal Pap test within past 3 years</li> <li>Every 24 months for all other women</li> </ul>	Copayment/coinsurance No deductible
<b>Screening Mammography</b>	77052, 77057, G0202	V76.11 or V76.12	All female Medicare beneficiaries age 40 or older Female Medicare beneficiaries ages 35 - 39	Annually One baseline	Copayment/coinsurance No deductible

This quick reference information chart was prepared as a service to the public and is not intended to grant rights or impose obligations. This chart may contain references or links to statutes, regulations, or other policy materials. The information provided is only intended to be a general summary. It is not intended to take the place of either the written law or regulations. We encourage readers to review the specific statutes, regulations and other interpretive materials for a full and accurate statement of their contents.

SERVICE	HCPSCS/CPT CODES	ICD-9-CM CODES	WHO IS COVERED	FREQUENCY	BENEFICIARY PAYS
<b>Bone Mass Measurements</b>	G0130, 77078, 77079, 77080, 77081, 77083, 76977	Contact local Medicare Contractor for guidance	Medicare beneficiaries at risk for developing Osteoporosis	Every 24 months <i>More frequently if medically necessary</i>	Copayment/coinsurance Deductible
<b>Colorectal Cancer Screening</b>	G0104 – Flexible Sigmoidoscopy G0105 – Colonoscopy (high risk) G0106 – Barium Enema (alternative to G0104) G0120 – Barium Enema (alternative to G0105) G0121 – Colonoscopy (not high risk) G0122 – Barium Enema (non-covered) G0328 – Fecal Occult Blood Test (alternative to 82270) 82270 – Fecal Occult Blood Test	Use appropriate code Contact local Medicare Contractor for guidance	<ul style="list-style-type: none"> <li>Medicare beneficiaries age 50 and older</li> <li>Screening colonoscopy: Individuals at high risk; no minimum age requirement</li> <li>No minimum age for having a barium enema as an alternative to a high risk screening colonoscopy if the beneficiary is at high risk</li> </ul>	<ul style="list-style-type: none"> <li>Fecal Occult: Annually</li> <li>Flexible Sigmoidoscopy: Every 4 years or once every 10 years after having a screening colonoscopy</li> <li>Screening Colonoscopy: Every 24 months at high risk; every 10 years not at high risk</li> <li>Barium Enema: Every 24 months at high risk; every 4 years not at high risk</li> </ul>	No copayment/coinsurance or deductible for Fecal Occult Blood Tests For all other tests copayment/coinsurance apply No deductible
<b>Prostate Cancer Screening</b>	G0102 – Digital Rectal Exam (DRE) G0103 – Prostate Specific Antigen Test (PSA)	V76.44 V76.44	All male Medicare beneficiaries 50 or older (coverage begins the day after 50th birthday) All male Medicare beneficiaries 50 or older (coverage begins the day after 50th birthday)	Annually Annually	Copayment/coinsurance Deductible No copayment/coinsurance No deductible
<b>Glaucoma Screening</b>	G0117 – By an optometrist or ophthalmologist G0118 – Under the direct supervision of an optometrist or ophthalmologist	V80.1	Medicare beneficiaries with diabetes mellitus, family history of glaucoma, African-Americans age 50 and over, or Hispanic-Americans age 65 and over	Annually for beneficiaries in one of the high risk groups	Copayment/coinsurance Deductible
<b>Influenza (Flu)</b>	90655, 90656, 90657, 90658, 90660 – Flu Vaccine G0008 – Administration	V04.81 V06.6 – When purpose of visit was to receive both Flu and PPV vaccines	All Medicare beneficiaries	Once per flu season in the fall or winter <i>Medicare may provide additional flu shots if medically necessary</i>	No copayment/coinsurance No deductible
<b>Pneumococcal</b>	90732 – Pneumococcal Polysaccharide Vaccine (PPV) G0009 – Administration	V03.82 V06.6 – When purpose of visit was to receive both PPV and Flu vaccines	All Medicare beneficiaries	Once in a lifetime <i>Medicare may provide additional vaccinations based on risk</i>	No copayment/coinsurance No deductible
<b>Hepatitis B (HBV)</b>	90740, 90743, 90744, 90746, 90747 – HBV Vaccine G0010 – Administration 90471 or 90472 – Administration (OPPS hospitals only)	V05.3	Medicare beneficiaries at medium to high risk	Scheduled dosages required	Copayment/coinsurance Deductible
<b>Smoking and Tobacco-Use Cessation Counseling</b>	G0375 – counseling visit; intermediate, greater than 3 minutes up to 10 minutes G0376 – counseling visit; intensive, greater than 10 minutes	Use appropriate code Contact local Medicare Contractor for guidance	Medicare beneficiaries who use tobacco and have a disease or adverse health effect linked to tobacco use or take certain therapeutic agents whose metabolism or dosage is affected by tobacco use	2 cessation attempts per year; Each attempt includes maximum of 4 intermediate or intensive sessions, up to 8 sessions in a 12-month period	Copayment/coinsurance Deductible

# THE VAFP WELCOMES NEW MEMBERS

## ACTIVE

Liqaq Said Al-Khozaie, M.D.  
 Amy Aitcheson Cooley, M.D.  
 Joy Caroline Draper, M.D.  
 Pamela Carol Johnson, M.D.  
 Neelima Reddy Marpu, M.D.  
 Tracy Lee Mathena, M.D.  
 Gabriella L. Miller, M.D.  
 Dan Andrew Naumann, M.D.  
 Cissy P. Pottanat, M.D.  
 Jennifer Lynn Ryal, M.D.

## RESIDENT

Tahanie Abu Ahmed, M.D.  
 Mohammed A. Amer, MBBS  
 Aida Atiq, MBBS  
 Sarah Meredith Call  
 Seetha M Durbhakula, MBBS  
 J. Maurice Glick, M.D.  
 Yu Guan, M.D.  
 Adric H. Huynh, M.D.  
 Natavan F. Karimova, M.D.  
 Eugene Lee Kim, M.D.  
 Michael Kihyun Kim, M.D.  
 Adam D. Kruse, DO  
 Tahira Irum Lodhi, MBBS  
 Rabeya Sarker, MBBS  
 Arielle R. Spitze, M.D.

## STUDENT

Rachel Abbott  
 Joanna Adams  
 Bann Al-Shammaa  
 Kim Ancheta  
 Blake Anderson  
 Mark Armstrong  
 Jonathan Sampath Avula  
 Allison M. Baker  
 David Barney  
 Gary Beasley  
 Xavier W. Belcher  
 Mahlet Berhanemeskel  
 Tasneem Bholat  
 Laura Bigoney  
 Georgia Blackwood  
 Anne Bowman  
 Aaron Brady  
 Brian Wesley Burkhart  
 Laura A. Carr  
 James Casey  
 Jing Chen  
 Arun Chhabra  
 Curtis Copeland  
 Chad Courtemanche  
 Jennifer Davila-Aponte  
 Mark Dexter  
 Ali Dhanaliwala  
 Margaret Eason  
 Bethany Evans  
 Tais Farahmand  
 Meetra Farhat  
 Huma Farooq  
 Lindsey Brook Finklea  
 Tiffany Forrester  
 Megan Forster  
 Kathleen Sabina Freund  
 Ryan Gabriel  
 Andreanne Gingvas  
 Robert L. Green

## STUDENT

Neena Gupta  
 Jonathan Hemler  
 Tom Hindsley  
 David John Hryniak  
 Victoria Iakoumina  
 Elena Igwel  
 Brian N. Joliah  
 Justin W. Jones  
 Sarah Marium Kattakuzhy  
 Rishika Kaundal  
 Talene Keshishian  
 Zahra Khalid  
 Amarita Klar  
 Lien-Thanih Kratzke  
 Gregory Lamb  
 Steven Lewis  
 Ashley Nicole Lock  
 Allison Marie Lynch  
 Asena Madison  
 Pramote Malasitt  
 Jonathan Craig Marsh  
 Melissa Alison May  
 Aaron McCoy  
 Douglas Rivington McDonald  
 Chris McNamara  
 Morodak Meas  
 Stephen Merrell  
 Kenneth Sadler Meyers  
 Katherine D. Miller  
 Nathan G. Miller  
 Dana Mueller  
 Takashi Nakamura  
 Tina Navidi  
 Dan-Vinh Nguyen  
 Sarah Nie  
 Mihran Ozbekik  
 Collier Stephens Pace  
 Nicholas Packer  
 Thaddeus Matthew Pajak

## STUDENT

Angela J. Oh Park  
 Sunhee Park  
 Raymond K. Pate  
 Quyen N. Pham  
 Jessica Pope  
 Kaitlin Porcaro  
 W. Michael Pullen  
 Jennifer Rajkumar  
 Marian Royer  
 Michelle Samson  
 Melissa San Julian Mark  
 Tim Sanford  
 Jordan Schooler  
 Yoomie Shin  
 Neera Samuel Singh  
 Anzea L. Smith  
 Austin Smith  
 Mary Vaughn Smith  
 John Earl Snellings  
 Heather Soloria  
 Bethany Michele Spector  
 Joni Corine Stuart  
 Jerome Taylor, Jr.  
 Justin Tokorcheck  
 Kiila Tollerson  
 Michael Tran  
 Michelle Tsai  
 Elizabeth Vance  
 Ajay Vellore  
 Nguyen Thanh Vo  
 Nicole Washington  
 Rachel Whitney  
 Sarah Wilcox  
 Renee Willett  
 Ifreke Williams  
 Laura Willing  
 Christina Wilson  
 Chia-Shing Yang  
 William Yoon

*New Members*

## MEMBERS IN THE NEWS

The VAFP Board of Directors encourages each of you to submit information on VAFP "Members in the News" for publication in the Virginia Family Physician magazine. Please submit "Members in the News" to Mary Lindsay White at [mlwhite@vafp.org](mailto:mlwhite@vafp.org).

## NETWORKING OPPORTUNITIES

*Networking Opportunities*

Board certified FP looking for friendly practice in Washington DC area. 15 years experience in a private group practice in Central Valley of CA with unblemished record. Seeking group or clinic position. Looking to start summer of 2008. If interested, call Kathleen Mcloughlin (209) 357-4149 or email [familydrkathie@aol.com](mailto:familydrkathie@aol.com).

# MEDICARE PART D: WHAT TO LOOK FOR IN 2008

by William Rogers, MD, FACEP, Director of the Centers for Medicare & Medicaid Services (CMS)  
Physician's Regulatory Issues Team

2008 will mark the third year that prescription drug coverage is available through the Medicare program. While the Part D program has been challenging for some providers, it's been a success for both beneficiaries and taxpayers. In 2007, more than 90 percent of people with Medicare signed up for Part D or had creditable coverage, and a recent survey found that 85 percent of beneficiaries were happy with the program. The program is good news for taxpayers as well: the 10-year cost of Part D has turned out to be \$200 billion less than original estimates, due primarily to competition among Medicare drug plans and the increased use of generics. The average national monthly premium in 2008 is expected to be \$25 (40 percent lower than the initial estimate), and people with Medicare prescription drug coverage are saving an average of \$1,200 per year.

One reason that Part D costs are lower is that Medicare drug plans are competing for beneficiaries in a very price-sensitive environment. Consumers can visit Medicare's [www.medicare.gov](http://www.medicare.gov) Web site and use the user-friendly "plan compare" Web tools to figure out exactly which of the competing Medicare drug plans can supply them with their medications at the lowest price. Because the market is so price-sensitive, plans have had to aggressively control their costs. They've demanded lower prices from drug manufacturers, and created formularies that encourage consumers to use brands that are less expensive to obtain. As a practicing physician, I know just how much of a hassle these formularies have been, but using the free Epocrates software on my PDA (which you can find at [www.epocrates.com/products/rx/](http://www.epocrates.com/products/rx/)) has allowed me to adapt my prescribing patterns to fit various plan formularies without too much trouble, thereby avoiding the need to file appeals.

Open enrollment for Medicare Part D occurs every year from November 15 -December 31. All Part D beneficiaries are eligible to join, switch or drop their Medicare drug coverage during this period. Once this open enrollment period ends, most Medicare patients are locked into their current plan until the end of the year. New Medicare beneficiaries who "age in" to the Medicare program will of course be able to join a Part D plan when they become eligible, and people with limited income (those receiving Medicaid or SSI, or who applied and qualified for the Low-Income Subsidy) can change plans any time during the year.

Some of your patients who have limited incomes may still qualify for the Low-Income Subsidy, which can help them pay for Medicare Part D. Patients with annual income of less than \$15,355 (individual) or \$20,535 (family) should call Social Security at 800-772-1213 or visit their Web site at [www.socialsecurity.gov/prescriptionhelp/](http://www.socialsecurity.gov/prescriptionhelp/) to see if they qualify for this extra help, which covers a significant amount of the cost of the benefit.

This is what you can expect for 2008.

## VACCINE COVERAGE

Until 2006, Medicare Part B was only permitted to pay for four vaccines: pneumococcal vaccine, flu, Hepatitis B for patients at increased risk, and Tetanus when given as a part of the treatment of a traumatic wound. Part D came along in 2005, and most vaccines became Medicare-covered. However, there was no legal basis to pay for the administration of these "Part D" vaccines. On December 20, 2006, the President signed the Tax Relief and Health Care Act, and among its provisions was legal authority for Medicare to pay for the administration of the Part D vaccines. This new benefit will be implemented in stages. This year, physicians have been able to bill their Part B carrier for the administration fee, but next year they'll no longer be able to do so. Beginning in 2008, the cost of administering vaccines covered by Part D will be the responsibility of the Medicare drug plans. Most physicians will probably elect to bill their patients for the vaccine and the administration, and the patient will have to submit a claim to their Part D plan for reimbursement. Network pharmacies operating in states that allow pharmacists to administer vaccines will be able to bill the Part D plan directly if they administer a vaccine to a covered beneficiary. Both the vaccine and the administration fee for the Part B vaccines mentioned above will continue to be covered under Part B and billed to Medicare. More information on vaccine administration and Part D can be found at [www.cms.hhs.gov/MLN MattersArticles/downloads/SE0727.pdf](http://www.cms.hhs.gov/MLN MattersArticles/downloads/SE0727.pdf).

## FOR PATIENTS WHO CHANGE PLANS

This table lists the steps we have taken to ensure that patients who change plans continue to get their medications during the transition period. New plans must provide patients with at least a 30-day supply of any medication covered by their previous plan. The new plan must also initiate notification processes to give patients time to either get a new prescription for a comparable drug covered by the new plan, or to file an exception request. You can find a copy of the standardized exception form at: <http://www.cms.hhs.gov/MedPrescriptDrugApplGriev/Downloads/PhysicianCoverageDeterminationRequestForm.pdf>.

**Table. CMS transition process requirements and expectations in 2008**

Enrollees: transition process	CMS requirements, expectations
<p>Non-long-term care enrollees who are:</p> <ul style="list-style-type: none"> <li>• New enrollees into prescription drug plans on January 1, 2008, following the 2007 annual coordinated election period.</li> <li>• Newly eligible Medicare beneficiaries from other coverage in 2007 into a Part D plan.</li> <li>• Individuals who switch from one Part D plan to another after January 1, 2008. (also applies to re-assignees and any individual moving to a new plan)</li> </ul>	<p>Plans must provide a temporary 30-day fill (unless enrollee presents with a prescription written for &lt;30 days) when presenting at a pharmacy to request a refill of a non-formulary drug that patient was taking before enrollment (including Part D drugs that are on a plan's formulary but that require pre-authorization or step therapy under a plan's utilization management rules) within the first 90 days of coverage, under the new plan.</p>
<p>New enrollees who are residents of long-term care facilities.</p>	<p>Plans must provide a temporary 31-day fill (unless the prescription is written for &lt;31 days) of non-formulary Part D drugs—including Part D drugs that are on a plan's formulary but require pre-authorization or step therapy under a plan's utilization management rules. Also, plans must honor multiple fills of non-formulary Part D drugs (including Part D drugs that are on a plan's formulary but require pre-authorization or step therapy under a plan's utilization management rules) during the first 90 days of their coverage, under the new plan.</p>
<p>Enrollees who remain in same plan as in 2007 but experience negative formulary changes in 2008 (eg, taking a drug that was on formulary in 2007 but is not on formulary in 2008, or had an exception granted in 2007 that will not be honored in 2008).</p>	<p>After enrollees receive their Annual Notice of Change on October 31st of a given year, CMS expects plan sponsors to select one of the following two options for effectuating an appropriate, meaningful transition for enrollees who experience negative formulary changes:</p> <ol style="list-style-type: none"> <li><i>1. Provide a transition process for current enrollees consistent with the transition process required for new enrollees beginning on January 1, 2008.</i></li> </ol> <p>To prevent coverage gaps, plans choosing this option are expected to provide a temporary supply of the requested prescription drug (where not medically contraindicated), consistent with the 2008 Formulary Transition Guidance, and provide enrollees with notice that they must either switch to a therapeutically appropriate drug on the plan's formulary or get an exception to continue taking the requested drug.</p> <ol style="list-style-type: none"> <li><i>2. Effectuate a transition for current enrollees prior to January 1, 2008.</i></li> </ol> <p>In effectuating this transition, plans must aggressively work to (1) prospectively transition current enrollees to a therapeutically appropriate formulary alternative; and (2) requests for formulary and tiering exceptions to the new formulary had to be completed before January 1, 2008.</p>

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# Medicare Part D

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<p>Enrollees who request an exception, but the plan fails to issue a timely decision on the request by the end of the transition period.</p>	<p>CMS expects plans to make arrangements to continue providing requested drugs via a case-by-case extension of the transition period to the extent that the individual's exception request or appeal has not been processed by the end of the minimum transition period.</p>
<p>Enrollee who remains in same plan as in 2007 and is using a drug as a result of an exception that was granted in 2007.</p>	<p>Plans have the option of "honoring" exceptions granted in 2007 beyond the end of the plan year (ie, a plan may choose to honor an exception for as long as the beneficiary remains in the plan).</p> <p>If a plan is not going to honor an exception beyond the end of the plan year, it must have notified the enrollee in writing at least 60 days before the end of the 2007 plan year and either (1) offer to process a prospective exception request for the 2008 plan year, or (2) provide the enrollee with a temporary supply of the requested prescription drug (if not medically contraindicated) at the beginning of 2008, and notify the enrollee that he/she must either switch to a therapeutically appropriate drug on the plan's formulary or get an exception to continue taking the requested drug.</p>
<p>Enrollee who remains in same plan as in 2007 and is using a drug with a prior authorization requirement that is expiring.</p>	<p>Before the beginning of the new plan year, enrollees may attempt to satisfy the pre-authorization requirement by requesting a coverage determination or by requesting a formulary exception if he/she cannot satisfy the pre-authorization requirement.</p>
<p>Current enrollees experiencing a level-of-care change.</p>	<p>Enrollees who are outside their transition period may experience circumstances that involve level-of-care changes in which a beneficiary is changing from one treatment setting to another. CMS encourages, but does not require, plans to incorporate processes in their transition plans that allow for transition supplies to be provided to current enrollees with level-of-care changes. Thus, beneficiaries and providers must avail themselves of plan exceptions and appeals processes.</p>
<p>Current enrollees entering long-term care settings from other care settings.</p>	<p>These enrollees will be provided emergency supplies of nonformulary drugs (including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules). This transition supply is not limited only to initial enrollment.</p>
<p>Current enrollees in a long-term care setting requiring an emergency supply of a nonformulary drug.</p>	<p>To the extent that an enrollee in a long-term care setting is outside his/her 90-day transition period, the plan must still provide an emergency supply of nonformulary Part D drugs (including Part D drugs that are on a plan's formulary but require prior authorization or step therapy under a plan's utilization management rules) while an exception is being processed. These emergency supplies must be for at least 31 days of medication, unless the prescription is written by a prescriber for &lt;31 days.</p>

CMS= Centers for Medicare & Medicaid Services

Nominate your peers for a 2008 VAFP Award! Annually, the VAFP presents the Virginia Family Physician of the Year Award, the F. Elliott Oglesby, M.D., Volunteer of the Year Award and the James P. Charlton, M.D., Teacher of the Year Award in Family Medicine. The criterion for each award is listed below. Submitting a nomination is easy. Visit <http://www.vafp.org> and click on the Award Nomination Link on the home page. If you have questions, please e-mail [awards@vafp.org](mailto:awards@vafp.org) or call 1-800-THE-VAFP. Nominating material must be received no later than June 2, 2008.

## **VIRGINIA FAMILY PHYSICIAN OF THE YEAR AWARD**

The physician nominated should have the following qualities.

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

### **F. ELLIOTT OGLESBY, M.D., VOLUNTEER OF THE YEAR AWARD**

In honor of former VAFP President F. Elliott Oglesby, M.D., the Virginia Academy of Family Physicians' Board of Directors has established the "F. Elliott Oglesby, M.D., Volunteer of the Year Award." The award is designed to recognize annually a Virginia Family Physician whose service to his or her profession and/or community exemplifies the true nature of volunteerism.

### **JAMES P. CHARLTON, M.D., TEACHER OF THE YEAR AWARD IN FAMILY MEDICINE**

In memory of James P. Charlton, M.D., a VAFP Past President, the VAFP awards annually the James P. Charlton, M.D., Award for excellence in teaching in family medicine. Nominees may include teachers of family medicine who participate in teaching at the medical school level, residency faculty level or community preceptorship level.



## PROGRAM STATUS REPORT • NOVEMBER 6, 2007

To date, there are 16 practices participating in an innovative program for improving cardiovascular care and more easily completing the required maintenance of certification requirements of the American Board of Family Medicine. The VAFP is a partner in this project, directed by family physicians through the excellent work of the Medical Society of Virginia Foundation.

### Objectives & Program Components:

The overall objective of the TO GOAL program is to educate family physicians and their staff in how to incorporate the principles of the chronic care model and practice redesign into their everyday practices and demonstrate improvements in the care of cardiovascular patients.

The TO GOAL program has four components:

- I. **Self Assessment Module (SAM):** Part II of ABFM's Certification for Family Physicians. This is a required disease oriented self assessment test. It has 60 questions and one clinical simulation. Many physicians have needed over 16 hours to complete this individually and navigate the Web site effectively. The TO GOAL process brings all participants through the SAM in four hours, with additional chronic disease management updates and additional CME credit.

Six SAMs were hosted between May and October.

- II. **Practice Enhancement in Cardiovascular Disease:** Part IV of ABFM's Certification for Family Physicians/METRIC module. The current process is: individual chart review, individual development of a QI project, and implementation of this project on an individual basis. The TO GOAL program allows physicians to complete the Part IV program with the support of other physicians and allows their entire practice to participate in the QI process, thereby promoting sustainability. The TO GOAL participants will have access to nationally known faculty in both cardiovascular disease and quality improvement. Participants will receive provider and patient education tools to support their QI efforts.

- (1) **Practice Enhancement Forum:** The Practice Enhancement Forum (PEF) is a continuing medical education (CME) activity and quality improvement initiative developed by the AAFP. In Virginia, the PEF will be offered through MSVF, in cooperation with the Virginia Academy of Family Physicians. It is intended to convey key principles of clinical quality improvement and office redesign, and provide hands-on, practical tools for improving care in a busy office setting.

- III. **Practice Support:** To promote sustainability, participating practices will receive six months of expert assistance in plan implementation and collaboration with other practices undergoing the recertification process. Assistance will include: site visits conducted by QI mentors and program faculty; a community extranet; and monthly conference calls with other participating practices.

### Participating Physicians:

Involvement in this program occurs at several levels.

- Program Faculty:  
Kurt Elward, M.D., MPH, FAAFP, serves as TO GOAL Medical Director. Five additional clinical faculty will participate in this program through the Practice Enhancement Forum.
  - **Bruce Bagley, M.D.**, Medical Director for Quality Improvement, AAFP
  - **Leonard Fromer, M.D.**, Assistant Professor of Family Medicine, University of California Los Angeles School of Medicine
  - **Barbara Johnson, Ph.D.**, TransforMED Facilitator
  - **Cindy Manning, MA**, Team and Leadership Development Specialist
  - **Bertha Safford, M.D.**, Medical Director for Quality Performance, Family Care Network
- Quality Improvement Mentors:  
Nine individuals trained in quality improvement. Each quality improvement mentor will be paired with two practice teams and serves voluntarily. The QI Mentors include:
  - **Sue Forren**, Charlottesville
  - **Mark H. Greenawald, M.D.**, Roanoke
  - **Stephen Horan, Ph.D.**, Richmond
  - **Thomas W. McNamara, DO**, Roanoke

- Nancy J. Misicko, M.D., MPH, Roanoke
- Anthony R. Stavola, M.D., Waynesboro
- Deepak R. Talreja, M.D., FACC, Virginia Beach
- John Taylor, Harrisonburg
- E. Mark Watts, M.D., Roanoke

Additional consultation will be provided by local cardiologists.

- Site Leaders:

Each participating practice is required to designate a lead physician that will engage the whole practice in the TO GOAL program. In addition, this individual serves as a primary contact for program support. The sixteen physician site leaders include:

- Timothy Beirne, M.D.
- Charles H. Coggin III, M.D.
- Robert Glenney, M.D.
- William K. Harris, M.D.
- Christopher Heck, M.D.
- Michael Jeremiah, M.D.
- Matthew A. Johnson, M.D.
- Andy Lockman, M.D.
- Christopher Mertes, M.D.
- Nancy J. Misicko, M.D., MPH
- Patricia A. Pletke, M.D.
- Catherine Rea, M.D.
- Laura M. Robert, M.D.
- Greg Stidham, M.D.
- John W. Timmons, M.D.
- John A. Witman, M.D.

- Participating Practices:

Sixteen practices will participate in this program. These practices include: various Carilion Health System practices; various Carilion Medical Group practices; various Central Virginia Family Physicians practices; Crossroads Family Practice (Charlottesville); Lynchburg Family Practice Residency; and Rockingham Family Physicians.

### Implementation thus far:

#### SAM sessions

Over 85 physicians have completed the CV SAM in Harrisonburg, Roanoke, and Lynchburg. Ratings for the program are 4.97 out of 5. All were able to complete the SAM successfully in a single morning or afternoon course.

## PRACTICE GROUPS

Carilion has been an outstanding group of physicians to work with, and are using the program to enhance solidarity among the Carilion Medical Group as well as within the residency. Our sincere thanks for the leadership of Mark Watts, Mark Greenawald, Tony Stavola, and Tom McNamara. We greatly appreciate the support of Dr. Roger Hofford, who has allowed several of his excellent faculty to have major roles in the program. For the Carilion Medical Group, this is also serving as an opportunity to ensure optimal use of their EHR in performance measurement, and valid data migration to a new system (EPIC).

In the Roanoke residency, they are using this as a focused opportunity to educate their residents on both optimal cardiac care but also performance improvement. Nancy Misicko, Mark Greenawald and Mike Jeremiah are leading these efforts exceptionally well.

In Lynchburg, under the site leadership of Patricia Pletke, the residency has matched a faculty person with a resident to create mentoring opportunities in performance measurement.

Central Virginia Family Physicians, with the leadership of Drs. Epps, Johnson and Coggin, have done great work already. They have organized their nine practices into three teams, each focusing on a certain aspect of CV disease. The goal is to allow each team to learn lessons that can be spread to the rest of CVFP. The AAFP has already shown a great interest in how CVFP has organized itself.

At UVA, the Crossroads site (a TransforMED site) has been recruited and has been well organized and is working with their internal quality leadership. Andy Lockman is the site leader and has been.

The Harrisonburg family physicians in Valley Health Plan were the first to host the CV SAM, with Dr. John Witman co-leading a very successful program. They are tightly linking their efforts to strategic initiatives of their PHO and hospital system. John Taylor is serving as a mentor for the To Goal program as well.

We strongly believe this program will serve to place family physicians at the forefront of meaningful and clinically relevant improvement in cardiovascular care, office redesign, and leadership in taking control of the future in performance, efficiency, and quality.

Respectfully submitted,

Kurt Elward, M.D.

## THOMAS W. EPPES, JR., M.D., NAMED PRESIDENT ELECT OF THE MEDICAL SOCIETY OF VIRGINIA

Thomas W. Eppes, Jr., M.D., was named president-elect of the Medical Society of Virginia (MSV) during the organization's annual meeting at The Homestead. Dr. Eppes previously served as a member of the MSV board of directors. Dr. Eppes has been an active member of the VAFP for many years and currently practices at Central Virginia Family Physicians in Forest. In addition to his role as president-elect, Dr. Eppes currently serves on the Virginia delegation to the American Medical Association and is the chairman of the MSV Management Advocacy Group Task Force.

Other VAFP members serving as Directors on the MSV Board include Kurtis S. Elward, M.D., Charlottesville, Sterling N. Ransone, Jr., M.D., Deltaville, Cynthia C. Romero, M.D., Virginia Beach, and E. Mark Watts, M.D., Roanoke, VAFP member Larry G. Mitchell, M.D., Richlands, serves as an Associate Director.

## VIRGINIA FAMILY PHYSICIANS AND EDUCATORS AWARDED PRESTIGIOUS TEACHING HONOR

Ellen M. Palen, M.D. and Mark H. Ryan, M.D. are among a select group of physicians honored by the American Academy of Family Physicians Foundation for their commitment to education in the field of family medicine. Both were selected to receive the 2007 Pfizer Teacher Development Award based on scholastic achievement, leadership qualities and dedication to family medicine.

The \$1,500 award, supported by Pfizer Medical Humanities Initiatives, recognizes community-based physicians who have chosen to teach family medicine on a part-time basis. The award provides funding for each recipient to attend a seminar, workshop or fellowship to further his or her development and teaching skills.

Dr. Palen received her M.D. degree from the Virginia Commonwealth University (VCU) School of Medicine and completed her residency with VCU Chesterfield Family Medicine Residency Program. Dr. Palen currently serves as a family medicine preceptor for the VCU Department of Family Medicine and will be recognized for this achievement during a ceremony held by her teaching center.

Dr. Palen is currently caring for patients at Virginia Family Physicians in Richmond, Virginia and is a member of the Virginia Academy of Family Physicians, the Medical Society of Virginia, and an assistant clinical professor at Virginia Commonwealth University School of Medicine. Dr. Palen has been purposeful in embracing mentorship of young women as part of her clinical teaching. She also volunteers locally with the Episcopal Church Women who serve at-risk children and assist mothers and children in financial crisis and CARITAS, whose mission is to help feed the homeless.

Dr. Ryan received his M.D. degree from the from the Virginia Commonwealth University (VCU) School of Medicine and completed his residency at the VCU Blackstone Family Medicine Residency Program. Dr. Ryan currently serves as a family medicine preceptor for the VCU Department of Family Medicine and will be recognized for this achievement during a ceremony held by his teaching center. Dr. Ryan is a past Resident Director on the VAFP Board of Directors and is currently an active member of the VAFP.

In addition to teaching family medicine part-time, Dr. Ryan practices at the Hayes E. Willis Health Center of South Richmond, a community health center in Richmond, Virginia. Dr. Ryan began working at this position in August 2007 with a desire to increase his work with Spanish-speaking patients. Prior to this, Dr. Ryan worked at Satori Medical Center in rural Keysville, Virginia. He says that his objective as a family physician is "to provide comprehensive medical care to underserved communities, and to extend medical care to underserved communities in foreign nations, and considers volunteer work an important part of his vocation." Dr. Ryan has volunteered at a local high school football team's games; served on the board of Directors for Piedmont HIV/AIDS Services and Education; has assisted with medical evaluations for U.S. Immigration and Customs Enforcement detainees challenging their detention; currently serves as the medical director for William and Mary Medical Missions Corps; has participated in multiple medical relief trips and led two trips to improve health care in the Dominican Republic; and is a co-founder/board member for the Dominican Aid Society of Virginia.

## PROVIDER PROFILES

The Virginia Board of Medicine Board requires practitioners to update their profiles within 30 days of an address change, an action against any of their licenses, any disciplinary actions or malpractice judgments. The Board suggests updating profiles every two years when your license is renewed, if only to update the number of years in practice.

To edit your profile, please go to [www.vahealthprovider.com/edit](http://www.vahealthprovider.com/edit). Enter your password and access your record. If you do not remember your password, you have the option of having it e-mailed or mailed to you.

### BOARD MEMBERS

Currently, there is a vacancy in District 10 on the Board of Medicine. In 2008, the members in the following districts terms end (can be renewed at the discretion of the governor): District 1, 2, 7, 8, 9, 11. In addition, the DO slot will also come open in 2008. If you are interested in nominating yourself for one of the available slots, please contact Mr. Mike Jurgensen at the Medical Society of Virginia (804-377-1029 or [mjurgensen@msv.org](mailto:mjurgensen@msv.org)). Typically three nominees are selected by the MSV for each district and given to the Governor for the final selection.

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