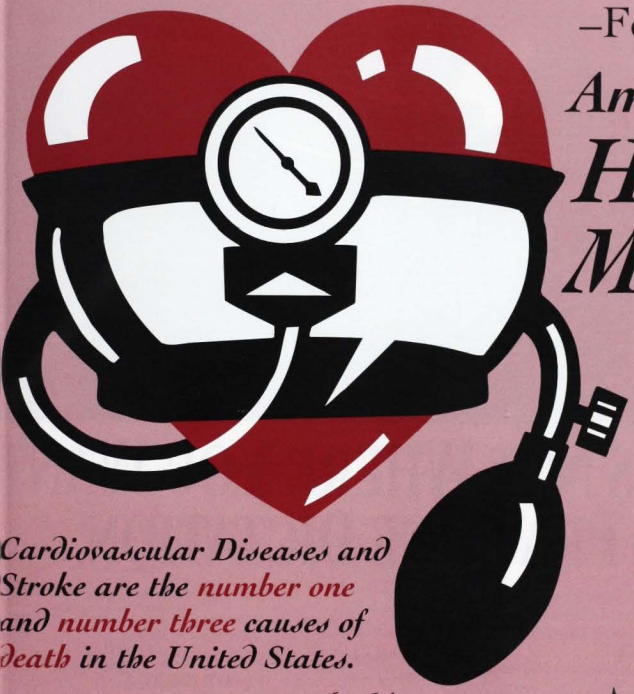
TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

olume LVII, No. 2

February 2000



–February–

American Heart Month

Cardiovascular Diseases and Stroke are the number one and number three causes of death in the United States.

pages 6 – 14

plus

TOMA's 101st Annual Convention & Scientific Seminar details–page 25

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TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association
FEBRUARY 2000

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Copy deadline is the 10th of the month preceding publication.

Inside This Issue

CALENDAR OF EVENTS

FEBRUARY
23-27
"Osteopathic Medicine: A Universal Approach"
Sponsored by the Osteopathic Physicians and Surgeons of California
Location: Sheraton Universal Hotel, Universal City, CA
CME: 40 hours category 1-A credits
Contact: 916-561-0224, FAX: 916-561-0728

FEBRUARY 27 – MARCH 3
"Ski & CME Midwinter Conference"
Sponsored by the Colorado Society of Osteopathic Medicine
Location: Keystone Lodge & Resort, Keystone Colorado
800-258-0437, Code CA2CCSO
CME: 40 hours category 1-A credits
Contact: Brooke Chynoweth
650 Cherry St., #440, Denver, CO 80246
303-322-1752 or 800-527-4578
FAX: 303-322-1956
E-mail: info@ColoradoDO.org
Web site: www.ColoradoDO.org

MARCH
3-7
"10th Annual Clinical Medicine Update for Primary Care Physicians"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Harvey's Hotel & Casino
South Lake Tahoe, Nevada
CME: 20 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
Web site: http://CME.cjb.net

APRIL
7-8
"Texas Osteopathic Medical Association House of Delegates Meeting"
Location: Austin, Texas
Contact: Paula Yeamans, 512-708-8662 or 800-444-8662

APRIL
15-16
"14th Annual Spring Update for Family Physicians"
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Dallas Southwest Medical Center
Dallas, Texas
CME: 12 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
Web site: http://CME.cjb.net

MAY
3-6
"92nd Annual Clinical Assembly & Scientific Seminar"
Sponsored by the Pennsylvania Osteopathic Medical Association
Location: Adam's Mark Hotel, Philadelphia, PA
CME: Over 40 hours category 1-A credits anticipated
Contact: Mario Lanni, POMA Executive Director
1330 Eisenhower Blvd., Harrisburg, PA 17111
717-939-9318; in PA 800-544-7662
FAX: 717-939-7225, E-mail: poma@poma.org

4-7
"103rd Annual Convention"
Sponsored by the Indiana Osteopathic Association
Location: Sheraton Hotel/Westin Suites, Indianapolis, IN
CME: 30 hours category 1-A credit anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

JUNE
8-11
"OMT With a View: Pain Management by the Sea"
Sponsored by the Osteopathic Physicians and Surgeons of California
Location: Marriott Laguna Cliffs Resort, Dana Point, CA
CME: 20 hours category 1-A credits
Contact: 916-561-0224, FAX: 916-561-0728

15-18
"TOMA's 101st Annual Convention & Scientific Seminar –The Century of Tomorrow Touching Our Communities Today"
Sponsored by the Texas Osteopathic Medical Association
Location: Bayfront Plaza Convention Center and
Bayfront Omni Hotel, Corpus Christi, Texas
Contact: Sherry Dalton, TOMA Conventions Coordinator
800-444-8662 or 512-708-8662
FAX: 512-708-1415
E-mail: sherry@txosteo.org

JULY
27-30
"TxACOFP Annual Clinical Seminar"
Sponsored by the Texas Society of the American College of Osteopathic Family Physicians
Location: Arlington Hilton Hotel, Arlington, Texas
Contact: Janet Dunkle, TxACOFP Executive Director
888-892-2637

www.txosteo.org

ON THE WEB in February

ON THE WEB is a new monthly feature of the *Texas D.O.* This page annouces headlines and trailers of timely osteopathic news articles, pertinent information on healthcare and education, legislative updates and much more; all of which can be found on our website <www.txosteo.org>.

FYI

- **Selected HealthFacts & Figures about Texas**
- **Texas HIV/STD Community Resource Directory Available**
- **Problem Nursing Homes to Face Immediate Sanctions**
- **Compliance Guidelines for Medicare+Choice Organizations**
- **Medicare Announces New Payment System for Home Health**

Washington Update

What's the latest D.C. decisions affecting osteopathic physicians?

American Forces Press Service

by Douglas J. Gilbert

Failure of a new anthrax vaccine production plant to pass FDA inspections has led DoD to postpone the second phase of vaccinations for at least six months.

In Brief

- **AMA Sues HHS**
- **Home Health Care Revives House Calls for Doctors**
- **Nurse Practitioners May Use More Health Care Resources than Physicians**
- **Arlington Memorial Hospital Begins $17 Million Renovation and Construction Project**
- **Health Faciluties Closings**
- **Disabled Persons to Retain Medicare/Medicaid Coverage After Return to Work**
- **FDA Announces New Internet Website for Consumers**
- **IOM Report Recommends Medicare Coverage for Nutritional Counseling**
- **Two Managed Care Companies Fined by ERST**
- **HCFA Says Medicaid Benefits are Being Illegally Denied**
- **Texas Cancer Care Restructures Relationship with OnCare**
- **Why Americans are Hospitalized and What it Costs**

Texas Stars

A Listing.

People who have made pledges or have contributed to TOMA's Building Fund Campaign are known to TOMA as "Texas Stars" due to their commitment to the osteopathic profession.

Thank You

A Listing.

Thank you to "Texas Stars" who have contributed above the $1,000 donation level to TOMA's Building Fund Campaign.

For Your Information

A Listing.

Phone numbers of Federal agencies, osteopathic agencies and state agencies useful to the osteopathic healthcare community.

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Medical Practice Issues
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American Heart Month

Saving Lives

A Focused Direction for the New Millennium

FEBRUARY

In its 50-year history, the American Heart Association has worked hard to accomplish much in its mission of reducing disability and death from cardiovascular diseases and stroke. Over time, there have been new educational programs developed to encourage reduced risk factors and healthy lifestyles for audiences of all ages and walks of life. Research has led to discoveries of new drugs, new surgical procedures, and even new ways of understanding the disease processes resulting in longer, healthier lives.

The fight is far from over, however. Cardiovascular diseases and stroke are still the number one and number three causes of death in the United States. And, unfortunately, stroke still continues to be the leading cause of serious, long-term disability in the U.S.

As an influential champion of public health, the AHA began discussion over four years ago about its direction for the 21st century. The outcome and ultimate goal were approved: to reduce coronary heart disease, stroke and risk by 25 percent by the year 2008.

Although the AHA will continue educational programs, the association intends to shift its focus from "wellness awareness" to "wellness practice." Numerous educational program activities and educational materials are offered to address key audiences such as women, Hispanics, African Americans, seniors (55+), school children, healthcare professionals and the public in general.

The association's strategic goal is to double the number of people who will reduce risk factors such as smoking, high blood pressure, cholesterol, and physical inactivity to goal levels as established by the AHA. The focus will be on reaching those who have had a previous heart attack or stroke, or have two or more risk factors.

Another strategic goal is for the association to work toward improving the chain of survival and acute care treatment. This means working to ensure that people suffering from cardiac emergencies and stroke receive treatment more quickly than ever before. Improving this access to care will happen through a campaign educating the public to recognize and respond to the early warning signs of heart attack and stroke by calling 9-1-1 first.

Why is this needed? Based on the results of a public awareness survey conducted by Gelb Consulting Group in October 1999, the findings show:

- Texans are only moderately aware of the signs and symptoms of heart attack.
- Texans are much less aware of the warning signs and symptoms of stroke.
- Texans do not seem to understand that there are emergency treatments for stroke and ways to reduce severe stroke and death if immediate action is taken at the onset of symptoms.

Heart Attack & Stroke "*Read the Signs. Raise a Flag.*"

This year's theme for American Heart Month is "Read the Signs. Raise a Flag." This is doubly important in that it is the launch of a public awareness campaign that will run for at least two years to enhance the impact of the message: knowing the warning signs, calling 9-1-1, and learning CPR.

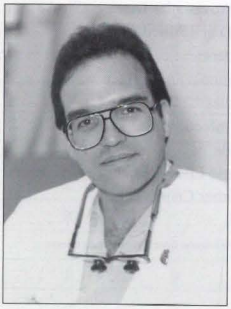
By the year 2008, the American Heart Association will reduce coronary heart disease, stroke, and risk by 25 percent according to its impact goal.

The AHA will accomplish this goal by:

- Improving access to emergency care by advocating for enhanced 9-1-1 systems.
- Advocating for placement of automated external defibrillators with first responders (police, fire and EMS) and in public gathering places.
- Advocating for comprehensive tobacco control legislation.
- Educating physicians and other healthcare professionals with the most current information regarding prevention and treatment of cardiovascular diseases and stroke.
- Reaching patients, healthcare providers, and healthcare organizations with the key messages.
- Encouraging patients on medication to adhere to the regimen prescribed by their physicians.
- Educating the public via a targeted media campaign on the Warning Signs of Heart Attack and Stroke, the need to call 9-1-1 at the onset of symptoms and the importance of learning CPR.

THE ARTIFICIAL HEART

A Reality in the 21st Century



By Albert H. O-Yurvati, D.O., F.I.C.S., F.A.C.O.S.
President
American Heart Association of Metropolitan Fort Worth

The advancement of cardiac surgery, starting in the late 1950s to the present, has shown and undergone a very rapid growth. Starting with the developments to treat extracardia and an intracardiac defects with the concomitant development of heart transplantation and mechanical heart assist, all are associated with developments in the last 50 years. Starting into the new millennium, the 21st century holds promise for the development of biomechanical artificial organs. On the forefront is the development of the artificial heart. The eventual end point goal of heart surgery will be a total mechanical replacement of the failing heart.

It is interesting to note that the development started in the late 1950s. The first artificial heart was made of polyvinyl chloride (PVC) in 1957, and this was implanted into an animal. However, part of the problem with the development of the artificial heart has been that of infection and thromboembolism. There has been rapid, renewed interest in the development of a total implantable heart with the development of new bio materials, as well as smaller motors and computers to drive the device. As we know, cardiac transplantation is limited by the availability of organs. This seems to be holding at a steady state and has not changed over the past few years. The other problem with cardiac transplantation is the trade-off of one disease state for another, being that of a reliant need for continued immunosuppression with all its concomitant complications. Therefore, the development of an implantable artificial heart is a goal that we will see obtained within this new millennium.

Currently, we have available an external artificial heart known as the Abiomed 5000, which is a device that can support the patient. However, it is an external device. Other external devices include the Thoratech Ventricular Assist Device (VAD) and the TCI Heartmate, which are both implantable devices, but require an external drive line in order to run the device. The problem with these devices is that they are externalized and, therefore, there is an increased risk of infection. Interestingly enough, the problem of thromboembolism has been addressed with the use of new bio materials which inhibit platelet activation and, therefore, reduce the problems with embolization. Also, a very novel approach has been done in that the bio surface in the Ventricular Assist Device has been made rough. This allows a monolayer of fibroblast to be laid down in order to prevent platelet adhesion. These patients are only on aspirin and do not need to be anticoagulated.

Therefore, the goal of the implantable device would be one that is totally implanted, a very low thrombogenicity, and would be able to have long term results as far as wear and tear of components.

The development of this type of artificial heart is quite interesting in that some of the first interests were started in Japan and in the Soviet Union in the late 1950s, and then at multiple centers in the United States in the 60s and 70s. At the present time, there is no FDA approved total mechanical artificial heart on the market. However, multiple centers are developing, with private biomechanical companies, artificial replacements. Of note are the Jarvic-type devices and most recently, the Abiomed total artificial heart. This device has been called the Abiocor. This artificial heart will be totally implanted. The driving lines and internal battery source will be internalized.

As President of the American Heart Association for Metropolitan Fort Worth, I am quite excited by the future in the treatment of cardiovascular diseases. I believe that February, being "heart month," leads us to reflect upon what we have accomplished in the past and what the future holds for us in the treatment of cardiovascular diseases. A major goal of the American Heart Association is the reduction of cardiac and stroke risk by about 25% by the year 2008. This is a major goal and can only be accomplished with the participation of everyone in the state of Texas, not only to include patients, but also the providers of health care.

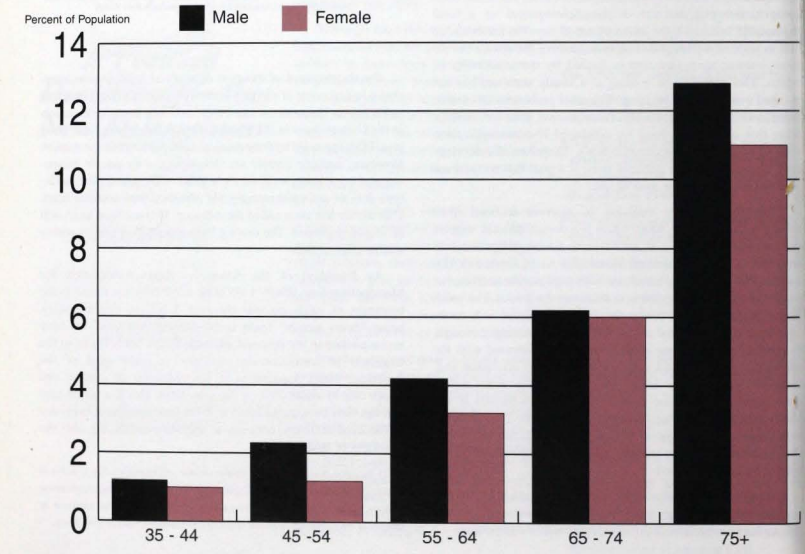
Dr. O-Yurvati is board certified in cardiovascular and thoracic surgery, and is in private practice in Fort Worth. He is president of the American Heart Association of Metropolitan Fort Worth. He also serves as clinical associate professor of surgery at the University of North Texas Health Science Center at Fort Worth.

1996 Leading Causes of Death in the U.S.

Cause of Death	Number
1. **Heart Disease***	**733,834**
2. Cancer	254,278
3. Cerebrovascular Disease (Stroke)	160,431
4. COPD and Allied Conditions	106,146
5. Accidents	93,874
6. Pneumonia and Influenza	82,579
7. Diabetes	61,559
8. HIV Infection	32,655
9. Suicide	30,862
10. Chronic Liver Disease	25,135
All Other Causes	451,168
TOTAL	**2,322,421**

* Includes 476,818 deaths from coronary heart disease.

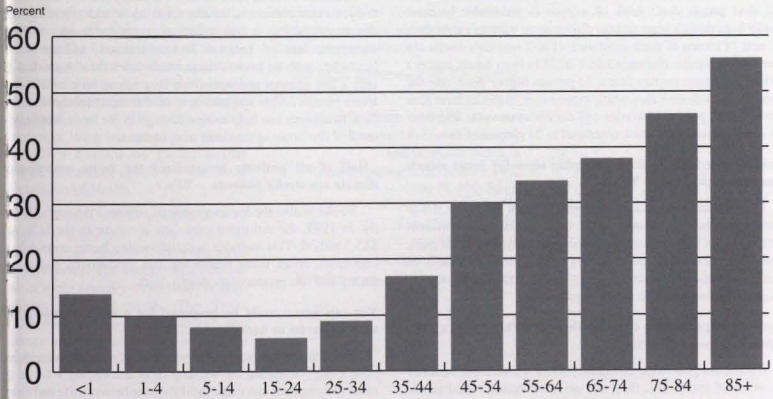
1988 - 1996
Prevalence of Stroke by Age and Sex in the U.S.



Leading Causes of Death in the U.S. by Age and Rank in 1996

Cause of Death	1-24	25-44	45-64	65-84	85+
Heart Disease	**5**	**4**	**2**	**1**	**1**
Cancer	4	3	1	2	2
Cerebrovascular Disease	9	8	4	3	3
Accidents	1	1	3	7	7
COPD	8	–	5	4	5
Pneumonia and Influenza	7	10	10	5	4
Diabetes Mellitus	–	9	6	6	6
Suicide	3	5	9	–	–
Chronic Liver Disease	–	7	7	10	–
Atherosclerosis	–	–	–	–	
Nephritis and Nephrosis	–	–	–	8	9
Homicide	2	6	–	–	–
Septicemia	10	–	–	9	10
HIV Infection	6	2	8	–	–

1996
Percent of All Deaths in the U.S. Due to Cardiovascular Diseases by Age



American Heart Association Quiz

FACT or Fiction

Most cardiac emergencies happen outside the home. – ♥*Fiction*

In fact, most happen at home. About 80 percent of all cardiac emergencies happen at home. This is the key reason to know the signs of heart attack, call 9-1-1, and if necessary, give CPR.

Pain that spreads to the shoulders, neck or arms is a warning sign of a heart attack. – ♥*Fact*

This type of pain is one of the common warning signs for a heart attack. The "classic" warnings signs are: uncomfortable pressure, fullness, squeezing or pain in the center of the chest that lasts more than a few minutes, or goes away and comes back; pain that spreads to the shoulders, neck or arms; and chest discomfort with light headedness, fainting, sweating, nausea or shortness of breath.

If someone experiences sudden and severe heartburn, they should not be concerned. – ♥*Fiction*

They should be very concerned because they are experiencing a symptom of a heart attack. Many people try to rationalize and think that if they take an antacid the pain will go away in 15 minutes when, in fact, they've mistaken severe heartburn for a serious heart attack. Sometimes the signs for heart attack last several minutes and sometimes they go away and come back. Most people don't know that most heart attacks occur slowly and more gradually than the stereotypical "Hollywood heart attack" as shown in the movies where people clutch their chests in sudden pain and collapse.

It is not common for a woman to have a heart attack. Breast cancer is a greater threat. – ♥*Fiction*

Women are at substantial risk for heart attack. Studies show that most people don't think of women as vulnerable to heart attacks even though heart disease claims more women's lives than the next 14 causes of death combined. (1 in 2 women's deaths are from cardiovascular disease while 1 in 27 is from breast cancer.) African American women face a 72 percent higher death rate for coronary heart disease than white women face. Statistics have also shown that 42 percent of women will die within one year after having a recognized heart attack compared to 24 percent of men.

Women experience different warning signs for heart attack than men experience. – ♥*Fact*

The warning signs for women are different and the AHA is working to increase awareness of these signs. Less common warning signs that women may experience: atypical chest pain, stomach or abdominal pain; nausea or dizziness; shortness of breath and difficulty breathing; unexplained anxiety, weakness or fatigue; palpitations, cold sweat or paleness.

If you are experiencing a stroke, there is nothing you can do. It just happens. – ♥*Fiction*

If someone gets to the emergency room within three hours of the onset of symptoms, they can get a treatment called tissue plasminogen activator (TPA), which can help reverse the effe of a stroke. The sooner TPA or other appropriate treatment begun, the better the chances for recovery. There are four milli stroke survivors alive today – 31 percent of survivors need h caring for themselves and 16 percent have to be institutionaliz

Strokes only happen to the elderly. – ♥*Fiction*

They affect the young and old alike. Hispanics, Afric Americans, people with high blood pressure and people w have already had a heart attack or stroke are all at higher risk.

- Seniors: for people over age 55, the incidence of stroke mo than doubles with each successive decade.
- Under age 65: 28 percent of people who suffer a stroke in a given year are under age 65.
- Baby boomers in particular are entering an age range whe they'll be at higher risk for stroke.
- African Americans: Compared with whites, Africa Americans have a two- to three-fold greater risk of stroke, an African American men and women are 2.5 times more likel to die of stroke.

Sudden weakness on one side of the body is a warning sig for stroke. – ♥*Fact*

This is a real "red flag" for stroke and a signal to call 9-1- immediately. More than 70 percent of adults in the U.S. don know the symptoms of a stroke. As a result, many people wait to long before seeking medical attention – and either die or suffe severe disability. Warning signs are as follows: sudden numbnes or weakness of face, arm, or leg, especially on one side of th body; sudden confusion, trouble speaking or understanding; sud den trouble seeing in one or both eyes; sudden trouble walking dizziness, loss of balance or coordination; sudden severe headaches with no known cause. Sometimes these signs last fo only a few minutes and sometimes they last as long as 24 hours Every minute counts and getting to the ER immediately is critical New treatments can help reduce damage to the brain, but only i the first few hours of the onset of symptoms.

Half of all patients hospitalized for acute neurological disease are stroke patients. – ♥*Fact*

Stroke is also the leading cause of serious long-term disabil- ity. In 1999, the estimated total cost of stroke in the U.S. was $45.3 billion. This includes hospital/nursing home costs, physician costs, drugs, home healthcare, lost productivity due to disability and lost productivity due to death.

You can never really be prepared for a medical emergency such as stroke or heart attack. – ♥*Fiction*

You can prepare yourself if you learn to "read the signs and raise a flag." Knowing the warning signs and calling 9-1-1 at the onset of symptoms can make the difference between life and death.

Cardiovascular Disease & Stroke in Texas

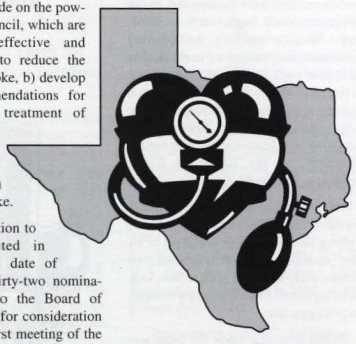
By Jennifer Smith, M.S.H.P., Director
Chronic Disease Community and Worksite Wellness
Texas Department of Health

In the recently released report by the Texas Department of Health, *Chronic Disease in Texas: A Surveillance Report of Disease Indicators*, it was noted that chronic disease conditions are the major cause of illness, disability and death in Texas as well as in the United States today. Despite broad public awareness of specific life-threatening diseases such as cancer and heart disease, most people are still not aware that collectively, chronic disease conditions account for three out of every four deaths in Texas and the United States. Today heart disease, cancer and stroke are the three leading causes of death, accounting for almost two-thirds of all deaths.

Though many organizations are attempting to reduce the burden of heart disease and stroke in Texas, there was a sporadic collaboration of efforts. In April 1998, a group of over 50 organizations was formed to look at heart disease and stroke. That group, called the Texas Coalition on Cardiovascular Disease and Stroke, attempts to coordinate and promote effective statewide and local initiatives and garner support for prevention initiatives. The Coalition worked tirelessly with members of the 76th Legislature, and particularly the House Public Health Committee, to study the effects of cardiovascular disease (CVD) and to develop legislation. What transpired was the creation of a Council on Cardiovascular Disease and Stroke attached to the Texas Department of Health.

The council will be composed of 12 members appointed by the Board of Health. The members will serve staggered six-year terms. The council may appoint one or more advisory committees or consultants to assist them. The Texas Department of Health can accept and allocate appropriated funds, however, no funds were allocated this year.

The council will be reporting each year to the Board of Health and each odd numbered year to the lieutenant governor and speaker of the house. The report will include progress made on the powers and duties of the council, which are to: a) develop an effective and resource-efficient plan to reduce the burden of CVD and Stroke, b) develop a database of recommendations for appropriate care and treatment of patients with CVD and stroke, c) collect, analyze and maintain a database of information related to CVD and stroke.



Nomination information to the council was posted in September with a due date of November 1, 1999. Thirty-two nominations were presented to the Board of Health in January, 2000 for consideration and appointment. The first meeting of the council is tentatively scheduled for February, 2000. Though the act gave no specifics on the makeup of the council, nominees will be considered based on geographic location, sex, race, and professional or lay experience.

For more information on the council, you may contact:

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Chronic Disease Community
and Worksite Wellness
Texas Department of Health - T402
1100 W. 49th Street
Austin, Texas 78756
512-458-7111 x2209
512-458-7618
jennifer.smith@tdh.state.tx.us
Website: www.tdh.state.tx.us/wellness

LOOKING AT THE HEART OF THE PROBLEM

Recent Reports and Studies

Heart Disease Begins at a Young Age

Although symptoms of heart disease may not show up until a person is middle-aged or older, a new study presented November 9, 1999 at the American Heart Association Scientific Sessions found that heart disease actually begins developing in childhood. The study of transplant hearts from teenage donors found that one in six of them had significant blockages, or plaque, in at least one coronary artery.

These findings support AHA recommendations that heart disease and stroke prevention should begin early in childhood – before smoking, bad dietary habits, and other causes of heart disease and stroke, such as high blood pressure, physical inactivity, obesity or diabetes, become established, said the senior author of the study, E. Murat Tuzcu, M.D., director of the Intravascular Ultrasound Laboratory, at the Cleveland Clinic Foundation, Cleveland, Ohio.

Although evidence of early atherosclerosis has been seen in autopsy studies of young people killed in accidents or by other non-disease related causes, no previous study ever took such a close look into living hearts from apparently disease-free young people.

"In this particular study, the focus was not the factors that lead to disease in children," said Tuzcu. "However, these findings should raise the public's awareness that heart disease is not just a disease of the elderly. It is a disease of both young and old. Aggressive heart disease prevention should begin in childhood, when it's easier to establish healthy habits and correct harmful ones, before the damage begins."

The unique study used ultrasound to look at the arteries of recently-transplanted hearts. By placing a miniature ultrasound device on a tube and guiding it to the heart via an artery in the transplant patient's leg, the researchers were able to use sound waves to image the heart arteries.

The study examined the heart arteries of 181 heart transplant recipients two to six weeks following transplantation. The donor hearts were from people who were free of known heart disease. Nevertheless, the researchers saw well-developed atherosclerosis in the arteries of hearts from donors in all age groups – including teenagers. While 26 of the 36 heart donors between 41 and 50 years of age had heart disease, five of 32 donors under age 20 also showed signs of atherosclerosis, the researchers reported. An analysis of risk factors – such as age, gender, high blood pressure, smoking, and body weight index - showed that age was associated with the degree of atherosclerosis independently of the other risk factors.

"This study of individuals with no known heart disease demonstrates that heart disease begins at a very young age and well-developed plaque deposits are present in one in six teenagers," said the researcher.

AHA news release, 11-9-99

Stroke Burden – Especially in Elderly – Much Higher than Previously Estimated

The number of individuals in the U who have strokes each year is higher th the half million previously estimate according to a study in the Decem issue of Stroke: Journal of the Americ Heart Association.

Researchers compared their data to 19 statistics gathered from the Framingha Heart Study, which showed that appro mately 500,000 individuals suffer strok each year in the U.S. However, t American Heart Association's "1999 He and Stroke Statistical Update," uses mo current data to put the number of strokes 600,000 per year.

"Our study confirmed a recent o which found that the number of first-tim and recurrent strokes in the U.S. each ye is actually closer to 750,000," says th study's lead author G. Rhys William M.S., director of the Department Health Outcomes Management ar Research of Knoll Pharmaceutical Co Mount Olive, New Jersey.

Williams and his team found that tot stroke incidence was 1.5 times higher tha first-ever stroke incidence among indivi uals aged 65 to 74; twice as high as earli estimates for those in the 75 to 84 ag group; and three times higher for those ag 85 and over. Williams says this sugges that for individuals over 75, 50 percent t 70 percent of strokes are recurren compared to 25 percent to 35 percent fo all age groups in the general population.

"As the elderly population continue to grow, the stroke burden in this countr will also grow unless something is done t prevent strokes and to find better ways t treat and reduce the effects of stroke," sai Williams.

He noted that future studies on strok rates should look more closely at strok incidence in non-Caucasian population "Previous research indicates that Africa Americans are at higher risk for strok than Caucasians. However, stroke inci dence research on Hispanics and Asian is limited."

While previous studies on stroke occu rence in this country have focused o smaller patient registries, mainl

Caucasians, this one used a large administrative database. For statistics on individuals who were hospitalized for stroke, Williams and his colleagues looked at a representative 20 percent sample of all inpatient hospital discharges for 1995 – a total of more than 6 million discharges from 938 hospitals in 19 states. Researchers used a literature review to estimate stroke rates in individuals who were not hospitalized.

Source: American Heart Association news release, 12-2-99

Growing New Blood Vessels – Promising Treatment for Heart Bypass Patients

Heart bypass patients treated with a timed-release capsule of a substance that promotes the growth of new blood vessels showed evidence of improved blood supply and heart function, according to a study supported by the NHLBI of the National Institutes of Health.

"Growing" blood vessels, a strategy called angiogenesis, is a promising experimental treatment for blocked arteries in bypass surgery patients for whom surgery alone would not adequately restore blood flow to the heart.

Dr. Michael Simons and colleagues at Harvard Medical School inserted timed-release capsules of basic fibroblast growth factor (bfGF) into the heart muscle of patients scheduled for bypass surgery. Patients received either a 10 microgram (mcg) or 100 mcg dose of the substance. Other patients received a harmless placebo capsule at the time of surgery. The relatively small study (24 patients total) was designed to test the safety and effectiveness of the procedure.

The study, published in the November 2 issue of *Circulation*, found that there were no serious adverse effects of the treatment. Both magnetic resonance imaging and nuclear stress testing were used to evaluate changes in blood flow. Stress tests showed a worsening of blood flow in the placebo group, no change in the 10 mcg group and significant improvement in patients receiving 100 mcg. MRI results showed clear improvement in blood flow in patients given 100 mcg. Patients in the highest dose group were free of angina but some patients in the placebo and low-dose group experienced chest pain.

Source: NIH release, 11-1-99

NHLBI-VA Study Finds No Heart Failure Survival Increase with Beta-Blocker

A study sponsored by the NHLBI and the Department of Veterans Affairs found that the beta-blocker bucindolol did not reduce death from heart failure. This finding contrasts with results from other trials of beta-blockers.

The reasons for the unexpected results of the Beta-Blocker Evaluation of Survival Trial (BEST) are not yet clear. However, they may be due to BEST's use of a different beta-blocker and to its greater number of African Americans and persons with severe heart failure.

The study, which began enrollment in 1995, examined whether bucindolol, a beta-blocker drug, improved survival in patients with moderate to severe heart failure. BEST was conducted at 90 clinical sites in the U.S. and Canada. The study enrolled 2,708 participants. About 33 percent of the participants were U.S. veterans; 22 percent were women; and 30 percent were from minority groups. The average age of the participants was 60 years. BEST is the first heart failure study to include substantial numbers of African Americans and patients with advanced heart failure.

Patients were randomized to receive either the beta-blocker bucindolol or a placebo. All patients also received standard heart failure therapy. Thus, almost all patients (more than 90 percent) were on an ACE inhibitor, a diuretic, and digitalis. Nine-two percent of the BEST participants had moderately severe heart failure (Class III) at the time of their enrollment in the study, and 8 percent had severe heart failure (Class IV). The average left ventricular ejection fraction was 23 percent. The most common cause of the heart failure was coronary artery disease.

The study, which had been scheduled to end in June 2000, was stopped in July 1999, at the recommendation of its Data and Safety Monitoring Board (DSMB). The DSMB based its recommendation upon the totality of evidence available in BEST, as well as on recent findings from other studies, specifically the Cardiac Insufficiency Bisoprolol Study II (CIBIS II) and the Metroprolol CR/XL Randomized Intervention Trial in Heart Failure (MERIT-HF).

Researchers are still examining the reasons for the difference in overall results between BEST and those studies. One factor may be the type of beta-blocker used: BEST patients were treated with bucindolol, while those in studies finding improved survival used metoprolol and bisoprolol. Another possible factor is that BEST participants had more advanced heart failure than those in other studies.

"BEST found somewhat different results for various subgroups of participants," said Dr. Michael Domanski, leader of NHLBI's Clinical Trials Scientific Research Group. "Those with moderate heart failure and those not African American appeared to gain a benefit from the drug, but African Americans and those with the most severe heart failure did not."

The differences by subgroup and between the results of BEST and other large trials raises the possibility that some heart failure patients may not derive a benefit from, or could even be harmed by, the use of beta-blockers, Domanski said.

Source: NIH, 11-10-99

Heart Disease and Stroke
Recent Drug & Device Approvals & Studies

FDA Approves New Drug to Reduce Risk of Stroke

In late November, the Food and Drug Administration approved a new drug that combines two active ingredients – aspirin and dipyridamole – into one pill to reduce the risk of stroke for patients who have already had transient ischemic attacks or completed ischemic strokes due to blood clots in the brain.

The pivotal clinical trial of the new drug, which will be marketed as Aggrenox by Boehringer Ingelheim Pharmaceuticals, Inc., of Ridgefield, Connecticut, was a double-blinded, placebo controlled, 24-month study, referred to as European Stroke Prevention Study 2 (ESPS2). The study included 6,602 patients who had an ischemic stroke (76%) or transient ischemic attack (TIA, 24%) within three months prior to entry. The results showed the combination reduced the risk of stroke by 36.8% and the cumulative risk of stroke and death by 24.2% compared to placebo.

The study also compared the use of the combination to the single use of each active ingredient and results showed the combination was more favorable for reducing risk of stroke than each active ingredient alone. The new drug is contraindicated for patients with hypersensitivity to dipyridamole, aspirin or any of the product's other components. Adverse events associated with the use of the drug include headache, abdominal pain, dizziness and nausea.

FDA Talk Paper – 11-23-99

FDA Approves New Device to Remove Blood Clots from Coronary Arteries

On March 15, the FDA approved a new medical device for removing blood clots from blocked heart arteries or bypass grafts prior to angioplasty. The device will provide an alternative treatment to so-called clot-busting drugs, and will be particularly useful for patients in whom these drugs cannot be used. The product, the AngioJet System, received expedited review by the FDA. It was approved less than six months after receipt of a marketing application from the manufacturer, Possis Medical, of Minneapolis, Minnesota.

The device is a coronary catheter system that shoots a jet of saline solution back into the tip of the catheter to suck out blood clots. Treatment with this device takes about one minute. Once the blood clot is removed, the patient can then undergo angioplasty.

Blockages in heart arteries are sometimes complicated by blood clots, resulting in heart attack or death. Currently these clots are treated with clot-busting drugs. However, for various medical reasons, many people cannot take such drugs. The new device will provide an alternative method to treat these patients. Approval of the AngioJet System was based on review of clinical studies of safety and effectiveness conducted by the manufacturer.

The company studied 731 people at 41 medical centers in the U.S. and Canada who had come to the hospital with symptoms of a heart artery blockage. In one study, 180 were treated wi AngioJet, and 169 were treated with urokinase, a clot-bustir drug. The study showed that AngioJet was similar in effectivene to urokinase.

In another study, 105 patients who could not be treated wit cot-busting drugs were treated with AngioJet. The study showe the device to be similarly effective in these patients. Anothe study showed that AngioJet could be effectively used along wit other treatments to remove blood clots during a heart attack.

FDA Talk Paper, 3-15-99

New Drug Shows Promise for Saving Lives from Heart Failure

A new drug for heart failure saves lives and reduces symp toms, according to a study presented November 10 at th American Heart Association Scientific Sessions. The new drug called omapatrilat, is a member of a new class of compounds called vasopeptidase inhibitors.

The results of this study, combined with others, suggest that the use of omapatrilat may reduce deaths and hospitalizations from congestive heart failure by as much as 30 percent, said Jean-Lucien Rouleau, M.D., director of cardiology, Mount Sinai Hospital Association at the University Health Network of Toronto, Canada. "It's a potential breakthrough in the treatment of congestive heart failure."

The new drug works in two ways. Like conventional ACE inhibitors, it blocks the action of angiotensin, inhibiting the constrictive action of this substance. But omapatrilat also neutralizes a substance called neutral endopeptidase, resulting in blood vessels relaxing.

"Omapatrilat is the first drug in this class and it may be better than the ACE-inhibitor class," said Rouleau. "It may end up replacing ACE inhibitors because it's an ACE inhibitor plus."

In the study, 289 patients received 40 mg of omapatrilat daily and 284 received 20 mg of lisinopril, an ACE inhibitor, for 24 weeks. The patients' average age was 64 years and 79 percent were male. All had mild to moderate congestive heart failure.

After 12 weeks of therapy, the patients' performance on treadmill tests improved similarly in both treatment groups. Measurements of cardiovascular and overall clinical function also improved. Side effects were minimal and included diarrhea and mild dizziness. But improvements were also seen in death rates and hospitalization for worsening heart failure. Only 16 patients in the omapatrilat group experienced any of these adverse events, while 29 did in the lisinopril group.

A new study of omapatrilat, OVERTURE (Omapatrilat versus enalapril randomized trial of utility in reducing event), has already started. Coordinated at the Columbia College of Physicians and Surgeons in New York, it will enroll 4,420 patients.

Source: American Heart Association news release, 11-10-99

News

from the University of North Texas Health Science Center at Fort Worth

Health Science Center Physician Completes Advanced Training in Pediatric Care

J. Roy Lowry, D.O., a surgeon at the University of North Texas Health Science Center at Fort Worth, completed a fellowship training program in pediatric otolaryngology at LeBonheur Children's Medical Center in Memphis, Tennessee.

By completing the training, Dr. Lowry will provide Fort Worth patients with the treatment of advanced sinus diseases, airway problems and other ear/nose/throat complications for children. Approximately 50 percent of Dr. Lowry's current patients include children.

Dr. Lowry has been with the UNT Health Science Center since 1986. Within the Department of Surgery at the health science center, Dr. Lowry is an ENT specialist and associate professor of surgery.

UNT Health Science Center Names Interim Positions for TCOM

Benjamin L. Cohen, D.O., interim president of the University of North Texas Health Science Center, announced Deborah L. Blackwell, D.O., as interim dean of the health science center's Texas College of Osteopathic Medicine, and Mitchell D. Forman, D.O., as interim associate dean for student affairs.

Dr. Blackwell is currently the associate dean for clinical and health affairs at the health science center. She will continue her current responsibilities in that role in addition to the educational responsibilities as interim dean of TCOM.

Dr. Forman, an associate professor in the Department of Medicine, will administer all aspects of student life at the health science center including admissions, financial aid, student counseling, student development, student services, and the registrar and will facilitate the integration of these various student support activities with the activities of other divisions and units in the institution. Dr. Forman is a rheumatologist in the Department of Medicine and will continue to serve in that clinical role part-time.

The interim announcements are made in response to the naming of Dr. Cohen as interim president of Fort Worth's only academic medical center following the retirement of former president, David M. Richards, D.O. Dr. Cohen served as vice president for health affairs for the health science center and executive dean of TCOM. Dr. Cohen serves in the presidency role until mid-August of 2000 when the new president Dr. Ronald R. Blanck, currently U.S. Army Surgeon General, reports for duty.

44th MidWinter Conference Sponsors and Exhibitors

Listings of Sponsors and Exhibitors were current at the time this issue went to press.

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FROM THE TEXAS MEDICAL FOUNDATION

Improving the Quality of Life for Medicare Beneficiaries

According to Medicare claims data, only 37.1 percent of Texas Medicare beneficiaries who have diabetes are getting yearly hemoglobin A1C (HbA1C) tests. Only 41.3 percent had a mammogram in 1997 or 1998, and only 23 percent had a pneumococcal vaccination paid by Medicare between 1991 and 1997. These rates are very low, considering the fact that these preventive services are covered by Medicare with little or no cost to Medicare beneficiaries. Underutilization of these services translates to costly diseases and complications that claim the lives of many Medicare patients: diabetes, breast cancer, flu, and pneumonia.

As part of the Health Care Financing Administration's (HCFA) national effort to reduce the morbidity and mortality rates associated with these diseases, the Texas Medical Foundation (TMF) has embarked on a statewide campaign to educate and encourage Texas physicians and beneficiaries to utilize Medicare's preventive benefits.

Through a contract with HCFA as the peer review organization (PRO) for Texas, TMF is committed to educating physicians and Medicare beneficiaries about preventive services available to prevent or offset the incidence and rate of complications associated with diabetes, pneumonia/influenza, and breast cancer. This can be accomplished through early detection and/or intervention by increasing the utilization rates of mammography, influenza and pneumococcal vaccinations, and diabetes testing and services. TMF hopes to achieve this through community outreach efforts and working directly with physician offices to encourage a systems approach to providing comprehensive preventive and diabetes care.

Much of the difficulty in providing consistent, comprehensive care is due to a "system issue," not a "professional issue." Physicians do not intentionally provide less than optimal care; however, the care process within their clinic may not support optimal care. TMF can help in the implementation of a systematic approach to providing care which can translate into a time-efficient practice.

TMF is offering "tool kits" to health care providers which include preventive care flow sheets, patient education materials, and information about Medicare's coverage of flu and pneumococcal vaccinations, mammography, and diabetes testing and services.

Beneficiaries can receive the influenza or pneumococcal vaccinations free of charge, with no coinsurance or Part B deductible. Medicare pays for one flu vaccination per year (shots are given right before flu season in the fall). For pneumococcal vaccinations, one may be all a beneficiary needs. Vaccination against influenza and pneumonia prevents illness and complications that can be fatal to the Medicare population.

Medicare also helps pay for one screening mammogram per year for female beneficiaries aged 65 or older (or age 40 or older in women with disabilities who quality for Medicare). Becau mammograms can spot cancerous tumors in the breast that a too small to feel, they are crucial in the early detection of bre cancer. Beneficiaries pay only 20 percent of the cost of t mammogram with no Part B deductible.

For patients with diabetes, Medicare provides coverage f glucose monitors, test strips, lancets, routine foot care, dilate eye exams for diabetics with retinopathy, laser treatment f diabetic retinopathy and cataract surgery, insulin pumps, an outpatient diabetic education. Beneficiaries pay for 20 percent these services after the annual Part B deductible.

HCFA and TMF strive to improve the quality of health car for Medicare beneficiaries in this state in not only these thre areas, but for acute myocardial infarction, congestive hea failure, and stroke patients as well. For more information o these projects, or to order TMF's tool kits, call Bob Abel Projects Coordinator, at 1-800-725-9216.

From Dr. Fred Sutton, TMF Physician Reviewer, to the Physicians of Texas

As physicians with admitting privileges at inpatient prospective payment system (PPS) facilities, our ability to influence the success of the Payment Error Prevention Program (PEPP) is substantial. PEPP is a program designed by the Health Care Financing Administration to reduce the payment error rate by monitoring inpatient PPS hospital claims and educating providers regarding payment errors. Beginning February 1, 2000, TMF will work with providers to reduce billing errors in targeted areas.

PEPP efforts are directed at inpatient PPS providers, and physicians can assist these facilities in reducing the overall payment error rate through proper documentation. Targeted areas for analysis under PEPP include errors in DRG coding, whether or not Medicare patients received the correct type of care in the most appropriate setting, and whether or not physician documentation supports the use of billed codes. This last targeted area is one that HCFA really wants to stress to physicians.

As we care for patients, we have a responsibility to properly document their diagnosis and treatment. Incomplete or unsupported documentation can subsequently increase the number of incorrect payments made by Medicare.

Thorough documentation is beneficial for numerous reasons. First, it aids physicians in organizing thoughts and consistently documenting details concerning the patient's condition, treatment, and response to care. This, in turn, enhances the quality of patient care by providing a record for care givers from which to evaluate, plan, and monitor the patient's treatment. Additionally, adequate documentation mitigates the effects of litigation and provides diagnosis and procedure information needed to bill and receive reimbursement.

In order to support PEPP, there are some important steps you can take in your documentation. You should:

continued on next page

News from the Texas State Board of Medical Examiners

Executive Director to Leave Board

At the December 9-11, 1999 meeting of the Texas State Board of Medical xaminers, during a state-of-the-agency report, TSBME Executive Director Bruce A. evy, M.D., J.D., asked the Board to initiate a search for his successor. In his statement, r. Levy reminded the Board that when he became executive director in November 1993, had a reputation for not effectively protecting the public. In his more than six years ith the Board, Dr. Levy has guided the agency to a position of respect from the public, e Legislature, medical schools and the medical community. Dr. Levy's direction has abled the Texas State Board of Medical Examiners to earn a national reputation as a odel for state medical boards across the country. Board members represent Texas on e Federation of State Medical Boards, and Dr. Levy has served on the Federation's oard, as well as on numerous Federation committees. He serves on committees of the ational Board of Medical Examiners and sits on panels to evaluate other state medical oards and provided recommendations for improvement to those state legislatures.

Since 1995, Dr. Levy has served as the elected chair of the Texas Health Professions ouncil and as the chair of the Graduate Medical Advisory Committee of the Texas igher Education Coordinating Board. In Dr. Levy's tenure as executive director, the oard has issued new licenses to 17,438 physicians, which represents more than one-ird of all licensed Texas physicians and more than half of all physicians practicing ithin Texas. The board has taken 1,032 disciplinary actions against physicians in the me period. In addition, it has developed guidelines or rules for proper prescribing for ain management, integrative and complementary medicine and resident permitting; it is eveloping rules for office-based anesthesia and will soon implement physician profiles. 1998, Dr. Levy requested an outside audit by consultants KPMG, which resulted in a organization of the agency that has enhanced efficiency and made it possible for the gency to carry out its mandates within budgetary constraints.

Dr. Levy, 52, received his medical degree from Hahnemann Medical College and ospital in Philadelphia in 1971. He received a law degree from the University of ouston, Bates School of Law, in 1992. He is board certified by the American Board of nesthesiologists and has served as Assistant Professor, Department of Anesthesiology, niversity of Washington, Seattle, and as Clinical Assistant Professor, Department of nesthesiology, Baylor College of Medicine, Houston. He lives in Austin with his wife, arcia, and their children.

A national search for an executive director will be undertaken. Dr. Levy will serve as n ex-officio member of the Board's search committee and will continue to direct the oard through the transition to the appointment of a new executive director.

Board Sets Internet Prescribing Policy

At the December 9-11, 1999 Board meeting, the Board established the following poly regarding Internet prescribing:

ction 3.08(4) [of the Medical Practice Act] authorizes the Board to discipline a licensed xas physician for unprofessional conduct that is likely to deceive or defraud the public injure the public. Section 3.08(4)(E) defines unprofessional or dishonorable conduct to clude "prescribing or administering a drug or treatment that is nontherapeutic in nature nontherapeutic in the manner the drug or treatment is administered or prescribed."

ction 3.08(4)(E) defines unprofessional or dishonorable conduct to include escribing, administering or dispensing in a manner not consistent with public health d welfare dangerous drugs as defined by Chapter 483, Health & Safety Code.

ction 3.08(18) authorizes the board to discipline a licensed Texas physician for profesonal failure to practice medicine in an acceptable manner consistent with public health d welfare. It is unprofessional conduct for a physician to initially prescribe any dangerous drugs or controlled substances without first establishing a proper physician-patient relationship. A proper relationship, at a minimum, requires:

(1) verifying that the person requesting the medication is in fact who they claim to be;

(2) establishing a diagnosis through the use of accepted medical practices such as a patient history, mental status exam, physical examination and appropriate diagnostic and laboratory testing;

(3) discussing with the patient the diagnosis and the evidence for it, the risks and benefits of various treatment options; and

(4) insuring availability of the physician or coverage for the patient for appropriate follow-up care.

"From TMF"...continued from previous page

- Document medical necessity of admissions and procedures as if you expected questions from your peer review organization, insurance companies, or the utilization staff at your own hospital.
- Document all diagnoses and procedures and state them as specifically as possible.
- Once you have developed a history and physical (H&P), ensure that future documentation addresses the problems identified in the H&P, treatment initiated, and the patient's response.
- In addition to noting the status of unresolved problems, be sure to document in the progress notes major changes in the patient's condition and action taken.
- Always document discharge planning and plans for follow-up.

For more information about PEPP or TMF's current review activities, call the health services assessment department at 1-800-725-9216.

TMF documentation prompter cards and posters are available to Texas physicians to assist them in their medical record documentation. Cards are 25¢ each, and posters are $2 each. Call the communications department at the number listed above to order cards and/or posters, or order at <www.tmf.org>.

Cancer Clinical Trials Claims Mailing Addresses for Participants

TRICARE-eligible persons who participate in the National Cancer Institute's (NCI) cancer-prevention and treatment clinical trials should send their claims for care received during the trials to one of two addresses, depending on the TRICARE region in which they live.

The NCI's cancer prevention and treatment clinical trials allow TRICARE-eligible patients access to the latest cancer therapies. Under the demonstration projects, which began in 1996, patients can have their treatment covered while they participate in research studies designed to find better ways to prevent, diagnose and treat cancer.

The following are addresses to which the claims should be sent:

TRICARE Regions 1, 2, 3, 4 and 5
Palmetto GBA
DOD Cancer Prevention and Treatment Clinical Trials Demonstration
P.O. Box 100514, Florence, SC 29501-0514
Toll-free telephone: 1-800-779-3060

TRICARE Regions 6, 9, 10, 11, 12 and the Central Region (formerly Regions 7/8)
Palmetto GBA
DOD Cancer Prevention and Treatment Clinical Trials Demonstration
P.O. Box 870060, Surfside Beach, SC 29587
Toll-free telephone: 1-800-395-7821

- TRICARE Region 1 consists of the District of Columbia, Connecticut, Delaware, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, New York, Pennsylvania, Rhode Island, Vermont, certain northern Virginia zip codes located near the Washington, D.C., area, and a few zip code in the northeastern part of West Virginia.
- TRICARE Region 2 is made up of North Carolina and mo of Virginia, except for the small part of northern Virgini that's part of Region 1.
- Included in Region 4 are the Florida Panhandle, Alabam Mississippi, Tennessee, and the eastern third of Louisian generally including Baton Rouge and points east.
- Region 5 is made up of Wisconsin, Michigan, Illinois Indiana, Ohio, Kentucky, the St. Louis area in Missouri, an most of West Virginia, except for a small part of the north eastern corner of the state that's part of Region 1.
- Region 6 includes Oklahoma, Arkansas (except for a smal part of northeastern Arkansas that's in Region 5), the western two-thirds of Louisiana generally west of Baton Rouge, an all of Texas except for part of the southwestern corner of the state that includes El Paso.
- The Central Region consists of Arizona (except for the Yum area), Nevada, New Mexico, Colorado, Wyoming, Utah, most of Idaho (except for six counties in northern Idaho), Montana, North and South Dakota, Kansas, Nebraska, Minnesota, Iowa, Missouri (except for the St. Louis area), and that piece of southwestern Texas which includes El Paso.
- Regions 9 and 10 consist of southern and northern California, respectively. Region 9 also includes the Yuma, Arizona, area.
- Region 11 is made up of Washington, Oregon, and six counties in northern Idaho.
- Region 12 includes Alaska and Hawaii.

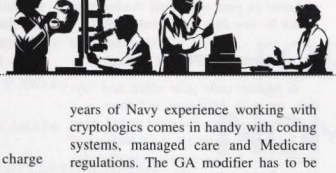
In Memoriam

Beth Esselman

Mrs. Beth Esselman of Fort Worth passed away on January 2, 2000. She was 83. Services were held January 5 at Greenwood Garden Chapel, with burial in Greenwood Mausoleum. Mrs. Esselman was born October 22, 1916, in La Plata, Missouri. She was a member of Ridglea Presbyterian Church.

Survivors include her husband, George Esselman, D.O., of Fort Worth; sons, Doug Esselman and his wife, Debbie of Colleyville, and Gregory Esselman and his wife, Elaine, of Springfield, Missouri; daughter, Karen Martin of Benbrook; and grandchildren, Angela Martin, Summer Martin and Andrew Esselman. Memorials may be made in Mrs. Esselman's name to the American Red Cross.

Self's Tips & Tidings



By Don Self

Is it Time to Revise Your Superbills?

Superbills (also known as charge tickets, communications forms or computer input slips) should be updated least annually to reflect the changes in e codes and the changes in the physician's coding habits. Here are a few oints you may wish to consider when viewing your present superbill:

Do you have all five new patient, all ve established patient and all three ospital admit codes on the slip? The niversity of Chicago Medical Center was ned extremely heavily by the OIG for not ving their doctors a chance to check off e lower level codes on their superbill. on't be guilty of the same thing.

Do you have a place immediately llowing the code for someone to indite a modifier? Modifiers make a differnce as to not only whether you get paid, t also how much you get paid.

If you're in a Health Professional ortage Area (HPSA), have you split your ding on diagnostic tests so that you get id the HPSA 10% bonus from Medicare the professional component? You nnot use the QB modifier on total mponent codes such as EKG anymore. ou must split the service into the technical and professional components (93005 d 93010) and then use the QB modifier the professional component code. This applicable for X-rays, EKGs, Holters, ress Tests, Dopplers, etc.

Along the same lines, if you're oking for the very best prices on superlls we have ever seen offered by anyone, ve Jeff or Rosemary at PME a call. heir number is 800-541-2618. They also n save you money on any charting pplies (charts, labels, dividers, etc.).

on't Confuse the GA Modifier with the GX Modifier

No, I'm not talking in code although it ems like it. Quite often I find that my 10 years of Navy experience working with cryptologics comes in handy with coding systems, managed care and Medicare regulations. The GA modifier has to be used when the physician believes the service being rendered to the patient is likely to be denied payment by Medicare. The GX modifier denotes the service being rendered to the patient is never paid by Medicare for any reason. Here are a couple of examples:

GA - The patient requests a B-12 shot for fatigue. Medicare does not pay for B-12 for this diagnosis, but does pay for B-12 for other diagnoses. You would use the GA modifier on the claim and, even though you have the patient sign the waiver acknowledging that Medicare will not pay for the service, you still have to file the claim with Medicare.

GX - The patient requests acupuncture. Acupuncture is never paid by Medicare, so if the patient asks you to file the claim anyway (they may be hoping their secondary insurance pays for it), you would use the GX modifier.

Medical Necessity Gets in the Way of Billing

Unless you've spent the last year sitting at home watching reruns of the O. J. trial, you know that you can bill for a 99211 when a patient with hypertension come into your office on a regular basis for blood pressure checks, even if the nurse provides the service. But, what about the patient who walks in and requests a blood pressure check because they saw a television show recommending one every quarter? There is no medical necessity for that blood pressure check, in the eyes of Medicare, and it should be considered to be a screening service. Since 99211 is sometimes paid by Medicare but should not be this time, you will want to make sure you have the patient sign a waiver acknowledging they will pay for it out of their own pocket without any reimbursement by Medicare. You then (as we said before) have to go ahead and file the claim with Medicare using the GA modifier).

Don's New Seminar Policy for 2000

In years past, we held the majority of our seminars in larger cities. This year, we may show up in your town as we are scheduling seminars for Odessa, Laredo, Waco, Amarillo, Del Rio, Texarkana, etc., as well as the larger cities. Another change is that we're holding the seminars in conference rooms around a conference table with open discussions encouraged, limiting the attendance to no more than 15 people. In fact, due to the fact most conference tables only seat 10-12, that will be our limit. Consequently, if you receive a seminar notice from us and wish to attend, it would be in your best interest to get your registration in quickly before it is sold out.

March 11 – San Francisco
American Dermatology Management

March 22 – Kerrville
March 23 – Harlingen
March 30 – Galveston
April 5 – Amarillo
April 6 – Lubbock

If you want us to come to your town, give us a call at 800-256-7045 and we'll do the best we can to get it set up. If you want a registration form for one of the above seminars, call us or fax us at 903-839-7069 and we'll fax you a form.

Doctors Not Reporting Which Level in SNF

In more than three-fourths of the consultations we perform on a practice where we examine all of the fees, codes, charging practices and collections of the medical office, we discover the same thing occurring over and over. That is where the doctor is handed a list of nursing home patients to see, takes the list with him/her and, at the nursing home, just check off that they've seen the patient, without individu-

ally listing the level of service provided to each patient. On top of that error, we believe that more than half of the doctors do not itemize the services they provided at the SNF to the billing personnel. For instance, if you do a joint injection on a Medicare patient, are you informing your staff of this? How about the trigger point, osteopathic manipulation, ear irrigation, removal of lesion, etc?

It is amazing how much money is being lost in this area. Along the same lines we see this happen constantly when the place of service is not the office. Many years ago, I shadowed a physician through his office visits and hospital rounds for one day, while he introduced me as an intern. (We had a deal that he would pay me three times whatever I found that he missed). At the end of the day, we compared our notes. He was good at documenting and knowing the codes. In fact, he was probably one of the very best physicians we have ever seen in that department. However, I discovered more than $508 that one day that he did not report to the staff and didn't know he could bill for. That was a family physician and just one day. It may pay you to have someone on your office staff shadow your doctor for one day.

Beware of Phone Scams

If anyone calls your office and says they are with Medicare and there is a mandatory seminar you must attend, hang up. Some companies are in the business of doing this. I also received another fax from a Texas doctor asking if I endorse or recommend US Seminars. I told her that I would rather have root canal surgery before I would attend any seminar taught by those folks. You get the message.

Collecting Co-Pay Prior to Service

For those offices that are seeing managed care patients who have to pay a set amount ($10 or $15) co-pay for each visit, why not collect it up front? You can put up a sign in the office stating that as of March 1st, patients on managed care w have to pay the co-pay at the initiation the visit. This is not only allowed, it recommended by several managed c companies. You can't do this w Medicare, however, since you do know, prior to the service, what servic will be rendered.

Don Self, CSS, BFM
Don Self & Associates, In
P.O. Box 15
Whitehouse, TX 75791-15
903-839-70
FAX: 903-839-70
E-mail: donself@donself.co
Web: http://www.donself.co

OSHA Revises Compliance Directive for Bloodborne Pathogens

OSHA has issued a new directive revising its 1992 compliance directive for enforcing the standards that cover occupational exposure to bloodborne pathogens and for ensuring consistent inspection procedures. The new directive reflects the availability of advances made in medical technology and improved treatment following exposure.

The new directive emphasizes the importance of an annual review of the employer's bloodborne pathogens programs and the use of safer medical devices, without advocating the use of one device over another. It also highlights basic work practices, personal protective equipment, and administrative controls. The agency will review the 1991 standard on occupational exposure to bloodborne pathogens with regard to possible revision. The directive can be found at: http://www.osha.gov.

CALL FOR AWARDS NOMINATIONS

The TOMA Awards and Scholaship Committee is currently accepting nominations for four awards:

- **Distinguished Service Award**
- **Meritorious Service Award**
- **Outstanding Community Service Award**
- **Public Service Award**

These awards represent the highest honor that TOMA can bestow in recognition of outstanding service and contributions to the osteopathic profession in Texas.

The Distinguished Service Award is presented to an osteopathic physician in recognition of outstanding accomplishments in scientific, professional, osteopathic education, or service to the osteopathic profession in Texas or at the national level. The candidate must be a member of the Texas Osteopathic Medical Association; a longtime member of their district society; and a member of the American Osteopathic Association. Those holding an elective office in TOMA are ineligible to receive the award during their term of office.

The Meritorious Service Award is presented to an individual in recognition of outstanding accomplishments in scientific, philanthropic, or other fields of public service to the osteopathic profession in Texas. The candidate does not have to be an osteopathic physician.

The Community Service Award is presented to an osteopathic physician in recognition of outstanding service to their community through the promotion of and dedication to osteopathic medicine in their practice. The candidate must be a member in good standing of the Texas Osteopathic Medical Association, have provided excellent service to their local, regional, or state community, exceptional care to their patients, and demonstrated a commitment to the principles and philosophy of osteopathic medicine. The candidate should exemplify what the profession perceives to be the "typical" osteopathic physician who cares for patients and is an unsung, local hero. Those holding an elective office in TOMA are ineligible to receive the award during their term of office.

The Public Service Award, TOMA's newest award, may be presented to a maximum of two governmental officials whose works and accomplishments are outstanding in promoting the health care needs of the state of Texas, while recognizing the unique value of the osteopathic philosophy.

The Nomination Process

TOMA districts that wish to nominate persons for these awards should complete a nomination form, available from Paula Yeamans at the TOMA State Office, and include pertinent biographical data about the individual as well as information about the person's accomplishments that make them deserving of the award. The nomination form must have at least five signatures of TOMA members in good standing; however, no member holding an elective office in TOMA is eligible to sign the nomination. **The nomination form should then be sent to the TOMA Executive Director, no later than March 1, 2000**, who will forward it to the TOMA Awards and Scholarship Committee for consideration.

Upon receipt of the nomination form, the TOMA Awards and Scholarship Committee will conduct a discreet but thorough investigation as to the accuracy of the information. After careful review, the committee chairman may nominate a candidate, as recommended by the committee, presenting necessary information to the Board of Trustees. An affirmative vote by three-fourths of the members of the Board of Trustees will be required to grant any award.

Award recipients will be notified by the Board of Trustees and will be requested to attend TOMA's annual convention, at which time the award will be presented by the TOMA President or Master of Ceremonies during the President's Banquet on Saturday night.

Please note that not more than one of each award will be granted in any one year, except for the Public Service Award. Additionally, these awards are not necessarily annual awards.

THE INDEPENDENT

INVESTOR

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1999 Reinforced the Need for a Long-term Approach to Investing

Perhaps no year in recent memory did as much as 1999 to remind us that patience and a long-term approach to investing are two of the most important attributes to possess when painting a financial future.

The casual observer might look at the individual events of the past year and guess that the performance of the U.S. financial markets was harshly affected. Who could fault such an assumption? The list of happenings that would seemingly have an adverse effect on the market is daunting indeed, yet the market has survived the year's activities:

- Continuing speculation, ranging from skepticism to, in some cases, muted hysteria over the Year 2000 computer bug - Companies spent billions of dollars making the necessary revisions for the date change. While the economic effects may take months to sort themselves out, the doomsday scenario of mass stock and fund distributions has not taken shape.

- The federal government's antitrust trial and early victory against Microsoft - The technology giant, a component of the NASDAQ, Standard & Poor's 500 and Dow Jones Industrial Average, has long been a bellweather of the technology industry. Despite legal setbacks and widespread speculation about its future, Microsoft's stock price has remained strong.

- The conflict of Kosovo, and its potential to harm world financial markets - While the conflict noticeably affected certain markets, the U.S. was able to avoid lasting financial effects from the bombing campaign in the Balkans.

- The impeachment proceedings against President Clinton - Not since Andrew Johnson in 1868 has a U.S. president been impeached. Financial experts wondered about the possible effects a distracted president and federal government might have on the stock market.

- Three interest rate increases by the Federal Reserve - Pundits spent a good deal of time in 1999 predicting the next course of action by the Fed, and whether another rate hike would prompt a market freefall.

As a whole, the markets shrugged off what might have been valid reasons to fall into a slump. The Dow, after skyrocketing 1,000 points within a month in February and March, did spend a good portion of 1000 off its year high. However, by the middle of December, the Dow and NASDAQ were again at record high levels.

Even as the markets again hit record levels, investors should proceed with caution. A well-diversified portfolio can offer the best defense against fluctuations in the economy. This does not simply mean different types of stocks, but also different types of investment vehicles. Combining different asset classes, such as stocks and bonds, which behave differently in response to changing market conditions, can lessen a portfolio's risk.

With the prevalence of today's media, it's easy to get caught up in the conjecture that often accompanies news events. It's important to remember that in the long run, the markets have historically bounced back from the Great Depression, world wars and much more. It helps to look at investing as a journey. A diversified, long-term investment strategy will go a long way in helping you look past the potholes and keep your eyes on the road ahead.

If you would like to review your existing investment or savings vehicles, or if you'd like to discuss how to properly diversify your portfolio to achieve your goals given the current economic environment, give us a call. We'll be glad to help you implement a proper long-term approach to investing.

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TOLL FREE 800-321-0246

TOMA Welcomes New Members

The Board of Trustees of the Texas Osteopathic Medical Association are pleased to introduce the following new members who were formally accepted at the September 25, 1999 Board meeting.

Richard L. Becker, D.O.
130 Beltline #150
Garland, TX 75040
Dr. Becker is a member of District V. He graduated from the University of Health Sciences College of Osteopathic Medicine in Kansas City in 1984, and is Certified in Family Practice

Wayne L. Brown, D.O.
13 South Royall
Palestine, TX 75801
Dr. Brown is a member of District III. He graduated from the Texas College of Osteopathic Medicine in 1984 and is Certified in Family Practice.

Sullivan R. Bryant, D.O.
554 S. Hampton Rd.
Dallas, TX 75232
Dr. Bryant is a member of District V. He graduated from the Kirksville College of Osteopathic Medicine in 1973 and specializes in Family Practice.

Jeanie T. Huynh, D.O.
2121 Richmond Avenue #414
Houston, TX 77082
Dr. Huynh is a member of District VI and is in her first year of practice. She graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1994 and specializes in Obstetrics and Gynecology.

Stephen Krzeminski, D.O.
105 W. Pearl
Granbury, TX 76048
Dr. Krzeminski is a member of District II. He graduated from the Texas College of Osteopathic Medicine in 1987 and is Certified in both Opthalmology and Otorhinolaryngology.

Staju Z. Kurunthottical, D.O.
1111 Call Field Road
Wichita Falls, TX 76308
Dr. Kurunthottical is a member of District VI and is in her first year of practice. She graduated from the University of Osteopathic Medicine and Health Science, College of Osteopathic Medicine and Surgery in Des Moines, Iowa, in 1996, and specializes in Family Practice.

Rhodesia N. LaStrap, D.O.
1305 Airport Freeway #202
Bedford, TX 76021
Dr. LaStrap is a member of District XV. She graduated from the Texas College of Osteopathic Medicine in 1987 and specializes in Obstetrics and Gynecology.

Robert E. Lyon, D.O.
6117 Woodrow Road
Lubbock, TX 79424
Dr. Lyon joined as a Non-Resident Associate Member and is now practicing in Lubbock where he is a member of District X. He graduated from the University of Health Sciences College of Osteopathic Medicine in Kansas City in 1990 and is Certified in Anatomic Pathology and Laboratory Medicine.

Mohammed Mahmood, D.O.
4114 Baynard
Houston, TX 77072
Dr. Mahmood is a member of District VI and is in his first year of practice. He graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery in Des Moines, Iowa, and specializes in Internal Medicine.

Mark E. Morris, D.O.
6440 Brentwood Stair Road
Fort Worth, TX 76112
Dr. Morris is a member of District II. He graduated from the Texas College of Osteopathic Medicine in 1989 and specializes in Family Practice.

Michael W. Walker, D.O.
3070 College #300
Beaumont, TX 77701
Dr. Walker is a member of District XII. He graduated from the University of Health Sciences College of Osteopathic Medicine in Kansas City in 1996 and specializes in Family Practice.

TOMA Welcomes Associate Members

Ruth Martinez-Holliday, D.O.
415 Tomahawk Drive
Harker Heights, TX 76548
Dr. Martinez-Holliday is a member of District XVIII. She graduated from Nova Southeastern University of Health Science, College of Osteopathic Medicine in 1996. She joins as an Associate Military Member stationed at Fort Hood and specializing in Radiology.

William R. Barkman, D.O.
102 Llano
Aztec, NM 87410
Dr. Barkman graduated from Nova Southeastern University of Health Sciences, College of Osteopathic Medicine in 1975 and specializes in Orthopedics.

Alexander M. Tucker, D.O.
120 McMillen Dr.
Newark, OH 43055
Dr. Tucker graduated from the University of North Texas Health Science Center, Texas College of Osteopathic Medicine in 1995 and specializes in Internal Medicine.

Thomas D. Edwards
Instructor, Dept of Family Medicine
UNTHSC/TCOM
1305 E. Seminary Dr.
Fort Worth, TX 76115

Henry R. Lemke, Program Director
Linda E. Reed, PA, Faculty
Physician Assistant Program
UNTHSC/TCOM
3500 Camp Bowie Blvd.
Fort Worth, TX 76107

Individuals Joining TOMA as Intern or Resident Members

Michael P. Abdelsayed, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is serving an Internship at Bi-County Community Hospital in Warren, Michigan.

Eduardo Aguirre, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is serving an Internship at Dallas Southwest Medical Center.

Anaisys M. Ballesteros, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is serving an Internship at Palmetto General Hospital in Miami.

George R. Collins, D.O., graduated from the West Virginia School of Osteopathic Medicine in Lewisburg, West Virginia, and is serving a Residency at Brooke Army Medical Center, Fort Sam Houston, Texas.

continued on next page

Jonathan S. Coolidge, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is serving an Internship at Doctor's Hospital in Groves, Texas.

Tri D. Dang, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is serving an Internship at Scott & White Medical Center in Temple, Texas.

Jennifer L. DeVoke, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is serving an Internship at Bay Area Medical Center in Corpus Christi, Texas.

Patrick B. Gaylor, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is serving an Internship at Mesa General Hospital in Mesa, Arizona.

Mark R. Happe, D.O., graduated from Lake Erie College of Osteopathic Medicine in East Lansing, Michigan, in 1998, and is serving a Residency at Brooke Army Medical Center, Fort Sam Houston, Texas.

Matthew J. Isom, D.O., graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery in Des Moines, Iowa, in 1999 and is serving an Internship at Brooke Army Medical Center, Fort Sam Houston, Texas.

Sarah A. Jabbar, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1997 and is serving a Residency at Dallas/Fort Worth Medical Center in Grand Prairie.

Daniel J. Ladd, Jr., D.O., graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery in Des Moines, Iowa, in 1999 and is serving an Internship at Tri-City Hospital in Dallas.

Sophia Lal, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999. She is doing an Internship at Shriner's Burn Hospital in Galveston.

Paul J. Lee, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is doing an Internship at Kaiser-Oakland Hospital in Oakland, California.

John H. Leigh, D.O., graduated from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery in Des Moines, Iowa, in 1999 and is serving an Internship at Bay Area Medical Center in Corpus Christi.

Donald P. Lesslie, III, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is doing an Internship at Doctor's Hospital in Columbus, Ohio.

Shirat Ling, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is doing an Internship at Bay Area Medical Center in Corpus Christi.

Rowena J. Maclin, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is doing an Internship at John Peter Smith Hospital in Fort Worth.

Waleed Mahmoud, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is doing an Internship at John Peter Smith Hospital in Fort Worth.

Cheri L. Mann, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is doing an Internship at St. Paul Medical Center in Dallas.

Angela D. May, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is doing an Internship at Bay Area Medical Center in Corpus Christi.

Gregory N. Messner, D.O., Graduated from the Kirksville College of Osteopathic Medicine in Kirksville, Missouri, in 1995, and is serving a Residency at Dallas/Fort Worth Medical Center in Grand Prairie.

John S. Peters, D.O., graduated from the West Virginia School of Osteopathic Medicine in Lewisburg, West Virginia, and is serving a Residency at Brooke Ar Medical Center, Fort Sam Houston, Tex

Kyle D. Phillips, D.O., graduated fr the University of North Texas Heal Science Center/Texas College Osteopathic Medicine in 1999 and doing an Internship at Scott & Wh Memorial Hospital in Belton, Texas.

Marcia E. Rannefeld, D.O., graduat from the University of North Texas Heal Science Center/Texas College Osteopathic Medicine in 1999 and is doi an Internship at Texas Tech Universi Health Science Center in Lubbock.

Thu P. Vo, D.O., graduated from th University of North Texas Health Scienc Center/Texas College of Osteopathi Medicine in 1999 and is doing an Internshi at Hillcrest Providence Hospital in Waco.

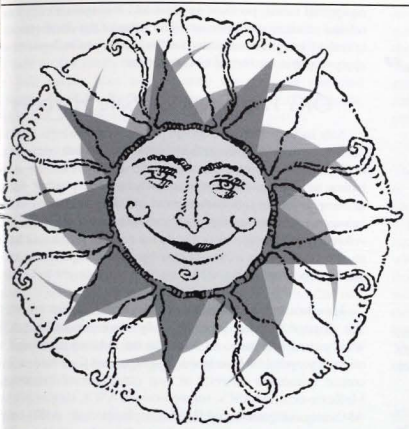
Jeff J. Wang, D.O., graduated from th University of North Texas Health Scienc Center/Texas College of Osteopathi Medicine in 1999 and is doing a Internship at Bay Area Medical Center i Corpus Christi.

Robert C. Williams, D.O., graduated fro the University of North Texas Healt Science Center/Texas College o Osteopathic Medicine in 1999 and is doing an Internship at the University of Arkansas for Medical Sciences in Little Rock.

Aimee L. Wright, D.O., graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and is doing an Internship at St. Paul Medical Center in Dallas.

The following doctors graduated from the University of North Texas Health Science Center/Texas College of Osteopathic Medicine in 1999 and are doing Internships at the Osteopathic Medical Center of Texas in Fort Worth:

Karen L. Benz, D.O.
Niska A. Blevins, D.O.
Patrick A. Conway, D.O.
Ryan S. Farrer, D.O.
Craig A. Ferrara, D.O.
Lisa L. Gardner, D.O.
William T. Gray, D.O.
Jessica Hals, D.O.
Bryan P. Hoffman, D.O.
Shane P. Kimball, D.O.
Esquiel P. Olivarez, Jr., D.O.
Robert G. Parrott, D.O.
C. Brien Wofford, D.O.



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8 New "Safe Harbor" Provisions Announced by OIG

Effective November 19, 1999, the Department of Health and Human Services' Office of Inspector General announced eight new final regulatory safe harbors to the federal anti-kickback statute (FR 11/19/99).

The new safe harbors, which protect certain arrangements from prosecution under the anti-kickback statute, address the following payment or business practices:

- Investments in underserved areas
- Practitioner recruitment in underserved areas
- Obstetrical malpractice insurance subsidies for underserved areas
- Sales of physician practices to hospitals in underserved areas
- Investments in ambulatory surgical centers
- Investments in group practices
- Referral arrangements for specialty services
- Cooperative hospital service organizations

The Office of Inspector General has previously published 13 regulatory safe harbors, 11 in 1991 and two in 1992. The November 19 final rule establishes eight new safe harbor provisions and clarifies six of the original 11 safe harbors published in 1991.

The 1991 safe harbors addressed the following types of business or payment practices: investments in large publicly held health care companies; investments in small health care joint ventures; space rental; equipment rental; personal services and management contracts; sales of retiring physicians' practices to other physicians; referral services; warranties; discounts; employee compensation; group purchasing organizations; and waivers of Medicare Part A inpatient cost-sharing amounts.

The 1992 interim final safe harbors, which were issued in final form in 1996, addressed the following practices in managed care settings: increased coverage, reduced cost-sharing amounts, or reduced premium amounts offered by health plans to beneficiaries; and price reductions offered to health plans by providers.

The November 19 final rule clarifies aspects of the original safe harbors for large and small entity investments; space rental, equipment rental; personal services and management contra referral services; and discounts. The intent of the clarification to make the regulations easier for the industry to understand a apply to particular factual circumstances.

OIG Fact Sheet on Safe Harbors

Safe harbors immunize certain payment and business practic that are implicated by the anti-kickback statute from criminal a civil prosecution under the statute. To be protected by a sa harbor, an arrangement must fit squarely in the safe harbor. Faili to comply with a safe harbor provision does not mean that arrangement is per se illegal. Compliance with safe harbors voluntary, and arrangements that do not comply with a safe harb must be analyzed on a case-by-case basis for compliance with t anti-kickback statute.

Investments in Ambulatory Surgical Centers (ASCs) The original proposal protected only Medicare-certified ASC wholly owned by surgeons. Many in the industry urged that t original proposal be broadened. The expanded final rule protec certain investment interests in four categories of freestandin Medicare-certified ASCs: surgeon-owned ASCs; single-specialt ASCs (e.g., all gastroenterologists); multi-specialty ASCs (e.g., mix of surgeons and gastroenterologists); and hospital/physician owned ASCs. In general, to be protected, physician investor must be physicians for whom the ASC is an extension of the office practice pursuant to conditions set forth in the safe harbo Hospital investors must not be in a position to make or influenc referrals. Certain investors who are not existing or potentia referral sources are permitted. The ASC safe harbor does no apply to other physician-owned clinical joint ventures, such a cardiac catheterization labs, end-stage renal dialysis facilities o radiation oncology facilities.

Joint Ventures in Underserved Areas – Often health care ventures in medically underserved areas have difficulty attracting needed capital, and, often, the best available sources of capita are local physicians. Many underserved area ventures cannot fi in the existing safe harbor for small entity joint ventures because that safe harbor limits physician ownership and the revenues that can be derived from referrals from physician investors. The underserved area joint venture safe harbor relaxes several of the conditions of the existing joint venture safe harbor. The new safe harbor permits a higher percentage of physician investors – up to 50 percent – and unlimited revenues from referral source investors. The new safe harbor expands on the 1993 proposal by including joint ventures in underserved urban, as well as rural, areas. To qualify, a venture must be located in a medically underserved area, as defined by Department regulation, and serve 75 percent medically underserved patients.

Practitioner Recruitment in Underserved Areas – This safe harbor protects recruitment payments made by entities to attract needed physicians and other health care professionals to rural and urban health professional shortage areas (HPSAs), as designated by the Health Resources and Services Administration. The safe harbor requires that at least 75 percent of the recruited

actitioner's revenue be from patients who reside in HPSAs or edically underserved areas or are members of medically under-rved populations, such as the homeless or migrant workers. ie safe harbor limits the duration of payments to three years. ie safe harbor does not prescribe the types of protected yments, such as income guarantees or moving expenses, iving that determination to negotiation by the parties.

Because of the risk of disguised payments for referrals, the fe harbor does not protect payments made by hospitals to isting group practices to recruit physicians to join the group, r does it protect payments to retain existing practitioners. Such rangements remain subject to case-by-case review under the ti-kickback statute.

Sales of Physician Practices to Hospitals in Underserved reas – This safe harbor protects hospitals in HPSAs that buy d "hold" the practice of a retiring physician until a new physi-n can be recruited to replace the retiring one. To qualify for fe harbor protection, the sale must be completed within three ars, and the hospital must engage in good faith efforts to recruit iew practitioner.

Subsidies for Obstetrical Malpractice Insurance in nderserved Areas – This safe harbor protects a hospital or ner entity that pays all or part of the malpractice insurance emiums for practitioners engaging in obstetrical practice in PSAs. To qualify for protection, at least 75 percent of the subsi-zed practitioners' patients must be medically underserved tients.

Investments in Group Practices – This safe harbor protects vestments by physicians in their own group practices, if the oup practice meets the physician self-referral (Stark) law defi-nition of a group practice. The safe harbor also protects invest-ments in solo practices where the practice is conducted through the solo practitioner's professional corporation or other separate legal entity. The safe harbor does not protect investments by group practices or members of group practices in ancillary serv-ices' joint ventures, although such joint ventures may qualify for protection under other safe harbors.

Specialty Referral Arrangements Between Providers – The safe harbor protects certain arrangements when an individual or entity agrees to refer a patient to another individual or entity for specialty services in return for the party receiving the referral to refer the patient back at a certain time or under certain circum-stances. For example, a primary care physician and a specialist to whom the primary care physician has made a referral may agree that, when the referred patient reaches a particular stage of recovery, the primary care physician should resume treatment of the patient. The safe harbor does not protect arrangements involving parties that split a global fee from a federal program. The safe harbor requires that referrals be clinically appropriate, rather than based on arbitrary dates or time frames.

Cooperative Hospital Services Organizations – This safe harbor protects cooperative hospital service organizations (CHSOs) that qualify under section 501(e) of the Internal Revenue Code. CHSOs are organizations formed by two or more tax-exempt hospitals, known as "patron hospitals," to provide specifically enumerated services, such as purchasing, billing, and clinical services solely for the benefit of patron hospitals. The safe harbor will protect payments from a patron hospital to a CHSO to support the CHSO's operational costs and payments from a CHSO to a patron hospital that are required by IRS rules.

Source: American Osteopathic Association Department of Government Relations

ATTENTION TOMA MEMBERS

This serves as a reminder that any member or district planning to present resolutions to the TOMA House of Delegates' meeting, April 7-8, 2000, in Austin, must submit such resolution(s) to the TOMA office prior to **March 1, 2000**.

No resolution will be voted on in the House of Delegates' meeting unless it have been received in the TOMA office prior to the above deadline .

If you have any questions regarding resolutions, please call Paula Yeamans at the TOMA office at 800-444-8662.

HEALTH NOTES

Texas Records Dengue Fever Death

The Texas Department of Health (TDH) has confirmed that a South Texas girl has died from dengue fever. The girl's death in late 1999 was the first caused by dengue fever in Texas in several decades. Health officials believe she contracted the viral mosquito-borne illness during a visit to Mexico. TDH officials said the girl died from dengue hemorrhagic fever, a variation of dengue fever marked by internal bleeding. They said medical confidentiality requirements prevented the release of more specific information about the girl. TDH confirmed 51 cases of dengue fever in 1999. Health officials have determined that 16 of the cases were contracted in South Texas. The other 35 cases are believed to have been contracted in Mexico or Brazil. The South Texas girl who died is the only confirmed case of hemorrhagic dengue fever in the state last year.

The 16 Texas-acquired cases of dengue fever last year were contracted in Cameron, Hidalgo, Starr, Webb and Willacy counties. Dengue fever is prevalent in many South and Central American countries and in Asia. Texas is the only state in the United States that has recorded locally-acquired cases of dengue fever in recent years.Dengue fever season in Texas typically runs from August through December. The dengue virus is carried primarily by the Aedes aegypti mosquito, a species common throughout Texas. Cooler weather either kills the mosquitoes that carry the dengue virus or causes them to become less active. Local, state, federal and Mexican health officials have worked throughout the last several months to address the dengue fever threat along the state's border with Mexico. They say the best way to reduce the risk of dengue fever is to eliminate mosquito hatching grounds by emptying sources of standing water such as old tires, tin cans, barrels, jars, birdbaths and flower pot bases. Dengue fever symptoms include sudden onset of high fever, severe headaches, joint and muscle pain, nausea, vomiting and a rash which can appear three to four days after onset of fever. The last outbreak of dengue fever in Texas was in 1995 when 29 cases were recorded, including seven contracted within the state. For more information contact Doug McBride, TDH Public Information Officer, Austin, at 512-458-7524.

First Drug for Post-Traumatic Stress Approved

The FDA has approved Zoloft (sertraline hydrochloride) as the first drug treatment for post-traumatic stress disorder (PTSD). This disorder has long been recognized as an important clinical problem.

Zoloft was approved in 1992 for treating depression, and was subsequently approved to treat obsessive compulsive disorder and panic disorder. According to the American Psychiatric Association Diagnostic and Statistical Manual (DSM-IV), a diagnosis of post-traumatic stress disorder requires exposure to a traumatic event that involved actual or threatened death or serious injury, or threat to the physical integrity of self or others, and a response that involves intense fear, helplessness, or horror.

The types of symptoms that occur as a result of exposure to the traumatic event include re-experiencing the event, in the form of flashbacks or dreams, and avoidance of situations reminiscent of the traumatic event. Patients also suffer from numbing of general responsiveness as manifested by diminished interest in significant activities. And patients also experience symptoms of irritability, sleep disturbance, impaired concentration, and outbursts of anger.

A PTSD diagnosis requires the sy toms be present for at least a month they cause clinically significant dist or impairment in social, occupational other important areas of functioning.

Zoloft's effectiveness for treat symptoms of PTSD is based on two mu center placebo-controlled, 12-week t in adults who were diagnosed with PT The overall positive outcome in th trials appeared to derive from the fem patients, with little effect seen in the m subgroup. The importance of this appar gender difference is unknown.

On October 8, 1999, FD Psychopharmacological Drugs Advis Committee recommended approvi Zoloft for the treatment of PTSD. Zol is marketed by Pfizer, Inc., New York, N

FDA Talk Paper, 12-7-99

FDA Approves New Indicatio for Taxotere

On December 23, 1999, the FD approved Taxotere for treating non-sm cell lung cancer that does not respond cisplatin-based chemotherapy.

Taxotere was approved for treatme of patients with locally advanced metastatic non-small cell lung cancer aft failure of prior cisplatin-bas chemotherapy. Most patients with no small cell lung cancer are found to hav metastatic disease when diagnosed, ar curative treatment is not possible. Tw randomized controlled clinical tria demonstrated that patients treated wi Taxotere had increased survival compar to patients receiving supportive care cancer therapy consisting of eith vinorelbine or ifosfamide. Taxoter which is manufactured by Avent Pharmaceuticals, was initially approve on May 14, 1996, for treating patient with advanced breast cancer. In it meeting on December 13 and 14, 199 FDA's Oncology Drugs Advisor Committee recommended approval o the drug for this new indication.

FDA Talk Paper, 12-23-99

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Schools Complete Diabetes Study

A wide-ranging study on diabetes in Bexar County shows a whopping one-fifth of the population has the disease, and sheds light on how best to educate a community on awareness and treatment.

Researchers with the University of Texas Health Science Center at San Antonio's School of Nursing, along with the University of Texas Houston Health Science Center School of Public Health, San Antonio campus, collaborated on the study. It was conducted within the boundaries of the San Antonio Independent School District and presented to the Texas Diabetes Institute (TDI).

The figures are startling. In the last 20 years, diabetes has increased three-fold in San Antonio, with one in every four or five people with the disease. Investigators also found great public ignorance in knowledge about diabetes. Interviews with community members showed the disease is known as "sugar in the blood" or "high blood sugar." Insulin was widely thought to cause blindness or kidney damage.

Investigators found that information must be highly visible and accessible. Focus groups favored pictorial and spoken information over printed materials. Most importantly, the study concluded, education efforts must be personalized and in a family setting, preferably with home visits."

TSBR Reporter, Vol. 10, No. 4

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