

TEXAS D.C.C.

The Journal of the Texas Osteopathic Medical Association

See Cover Story
on Page 7

Volume IV, No. 9

October 1998

Osteopathic
Medicine

EARLY
VOTING
DAY

October 28



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TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

OCTOBER 1998

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CALENDAR OF EVENTS

OCTOBER

15

1998 Medical Ethics Conference: "Medicine in a Moral Fog - Are We Going Too Far?"

Sponsored by the Colorado Springs Osteopathic Foundation

Location: The Broadmoor International Center
Colorado Springs, CO

Contact: Colorado Springs Osteopathic Foundation
719-635-9057

NOVEMBER

12-15

1998 Primary Care Update

Sponsored by the West Virginia Society of Osteopathic Medicine

Location: Greenbrier Resort, White Sulphur Springs, WV
Contact: West Virginia Society of Osteopathic Medicine
304-345-9836

DECEMBER

4-6

"Annual Winter Update"

Sponsored by the Indiana Osteopathic Association

Location: University Place Conference
Center and Hotel, Indianapolis, IN
CME: 20 hours category 1-A anticipated
Contact: IOA, 3520 Guion Rd., Suite 202
Indianapolis, IN 46222
800-942-0501 or 317-926-3009

1999

FEBRUARY

5-9

Ninth Annual Update in Clinical Medicine for Primary Care Providers

Sponsored by the University of North Texas Health Science Center at Fort Worth

Location: Embassy Suites Resort
South Lake Tahoe, CA

CME: 20 CME hours

Contact: UNT Health Science Center Office of
Continuing Medical Education
817-735-2539 or 800-987-2CME

FEBRUARY continued

12-14

43rd MidWinter Conference/Legislative Symposium

Sponsored by the Texas Osteopathic Medical Association

Location: Fairmont Hotel, Dallas, TX
CME: Approx. 17 1-A CME hours
Contact: TOMA, 800-444-8662
512-708-TOMA (8662)
512-708-1415 Fax

25-28

Annual Convention

Sponsored by the Florida Osteopathic Medical Association

Location: Hyatt Regency Pier 66 Hotel
Ft. Lauderdale, FL
CME: Approx. 30 hours 1-A CME
Contact: Florida Osteopathic Medical Association
2007 Apalachee Parkway
Tallahassee, FL 32301
850-878-7364

APRIL

16-17

13th Annual Spring Update for Family Practitioners

Sponsored by the University of North Texas Health Science Center at Fort Worth

Location: Columbia Medical Center/Dallas Southwest
Dallas, TX
CME: 12 CME hours
Contact: UNT Health Science Center Office of
Continuing Medical Education
817-735-2539 or 800-987-2CME

JUNE

17-20

Annual Convention & Scientific Seminar

Location: Hotel Inter-Continental
Dallas, TX
CME: Approx. 26 1-A CME
Contact: TOMA, 800-444-8662
512-708-TOMA (8662)
512-708-1415 Fax

HEALTH RESOURCES ALONG THE TEXAS-MEXICO BORDER REGION



Health statistics reveal a substantial gap between the Border region and Nonborder Texas. (The Border is defined as covering the 43 counties south of Interstate 10 and west of Interstate 37.) For example, if the Border were a state, it would rank third after Louisiana and West Virginia in the rate of death from diabetes, and second only to New Mexico in the rate of death from hepatitis and chronic liver diseases. Nonborder Texas, in contrast, would rank 25th and 27th in those categories, respectively.

On the positive side, the Border region's infant mortality rate (6.3 infant deaths per 1,000 live births) is below that of Nonborder Texas, and only 11 states would have a lower rate. Also, the death rate from HIV infection in the Border is much lower than in the rest of Texas.

Relative to population, the Border counties have fewer hospitals, hospital beds and health care professionals than do Nonborder counties. Almost four-fifths of the Border counties are entirely or partially designated as "health professional shortage areas" by the federal government. About half of Texas' nonborder counties are so designated.

To increase the potential supply of physicians for the Rio Grande Valley, the 1997 Legislature approved the creation of a new regional academic health center and directed the University of Texas System to find a site for the center this year.

A 1989-1992 report by the U.S. Bureau of the Census revealed that about 44% of McAllen-Edinburg residents, 31% of Brownsville-Harlingen residents and 27% of El Pasoans had no medical insurance - not even Medicaid or Medicare. The statewide figure was 23%.

Border vs. Nonborder Texas Health Resources, 1995

	Border Counties	Nonborder Counties
General and Special Hospitals	2.0	2.7
Hospital Beds	338.0	403.6
Physicians	141.3	161.7
Registered Nurses*	579.0	699.8
Physician's Assistants	4.6	5.9

Note: All figures per 100,000 population.

*Data for 1994.

Sources: John Sharp, Texas Comptroller of Public Accounts, Texas Department of Health and Texas State Board of Medical Examiners.

OCTOBER 28

as

"OSTEOPATHIC MEDICINE EARLY VOTING DAY"

in Texas

Early voting is the law in Texas which means the frustration of waiting in long lines on election day is a thing of the past. Even with this convenience, however, an extremely low voter turnout has once again been predicted. Such rampant apathy will thus give each vote more impact in determining the outcome of elections. Furthermore, with government policies concerning health care issues boiling on the burners, physicians, in particular, should shed any reluctance they may have against political involvement. Your livelihood is too important to be left up to chance. Don't let the politicians shape the future of health care - do it yourself at the ballot box.

Mindful of these issues, TOMA has chosen October 28 as "Osteopathic Medicine Early Voting Day" in Texas for this election cycle and urges all osteopathic physicians and facilities to join us in our efforts to support this important concept. By allowing employees time off during working hours, there will be fewer excuses for not voting. If every osteopathic physician and health care facility in Texas followed through on this day, our political strength would be felt from Austin to Washington, D.C.

In establishing an early voting day in Texas through a resolution in 1994 (TOMA Supports Early Voting Day Policy - #94-03), the TOMA House of Delegates noted that Texas osteopathic physicians do not believe that a minority of the total electorate should be making government policies concerning issues such as health care and education. The House also indicated that if every health care provider and health care facility in Texas initiated a policy to allow their employees time off during working hours to participate in early voting, the political clout of organized medicine would be substantially enhanced in Austin and in Washington, D.C.

We encourage all Texas D.O.s and facilities to join us this year in promoting October 28 as Early Voting Day. This simple yet effective policy has the potential to create an impact that can and will make a beneficial difference.

Remember, if we don't make an effort to help shape the future of health care, someone else will. The possibilities are frightening.

Sue Bailey, D.O., Named U.S. Assistant Secretary of Defense

Sue Bailey, D.O., was sworn in as the U.S. assistant secretary of defense for health affairs on June 17. In her new position, she is responsible for all of the health care provided through the U.S. Department of Defense.

Dr. Bailey's duties include maintaining the medical readiness of all branches of the U.S. military, which requires ensuring that the military's medical and preventive health care services are prepared to support the rest of the U.S. armed forces during military operations.

In addition, she oversees the general health care services provided to current and retired members of the uniformed services, their family members and other people entitled to medical services through the Department of Defense.

Dr. Bailey served as the deputy assistant secretary of defense for health affairs since July, 1994. Besides her work at the

Department of Defense, she served as the president and medical director of Chevy Chase (Maryland) Associates; vice president for behavior sciences of Medlantic Healthcare Group in Washington, D.C.; and the medical director at Washington Hospital Center.

Other achievements include serving as the deputy co-chair for the 1996 re-election campaign of President Bill Clinton and Vice President Al Gore; a spokesperson for Clinton's health care reform campaign in 1993; and a medical delegate to the former Union of Soviet Socialist Republics for the American Center for International Leadership.

A 1977 graduate of the Philadelphia College of Osteopathic Medicine, she was one of three finalists President Clinton considered for surgeon general of the U.S. Public Health Service in early 1995.

Texas ACOFP Update

By Joseph Montgomery-Davis, D.O.
Texas ACOFP Editor

At the Annual Session of the Texas ACOFP on Saturday, August 8, the following Bylaws change pertaining to dues was passed. It is important to remember that the ACOFP dues were not increased; the money amounts were spelled out for clarification purposes, and some new membership categories were added.

Article IX - Dues

(Underline = new language or section.)

SECTION 1 The fiscal year of this society shall be January 1 - December 31.

SECTION 2 Annual dues will be established from time to time by the membership acting in annual session upon recommendation by the Board of Governors.

SECTION 3 The Board of Governors may establish an application fee if it feels that this is necessary. Such fees shall be estimated to be the approximate cost attendant to the processing of such application and therefore will not be refundable.

SECTION 4 Academic, Honorary, Honorary Life and Retired members shall not pay dues in these classes of membership.

SECTION 5 The Board of Governors may recommend assessments but these shall not become binding until approved by the general membership in annual session.

SECTION 6 All dues become delinquent at the close of the annual session. All assessments become delinquent ninety days after they are assessed.

SECTION 7

A. Active members shall pay \$175.00 per year.

B. Ad Interim members shall pay \$75.00 for the first year in practice; \$125.00 for the second year in practice; and \$175.00 for the third year in practice.

C. Associate members shall pay \$50.00 per year.

D. The Board of Governors will establish an appropriate fee for dues for Industry Associate members.

E. President Club members shall pay annual dues in the amount of \$50.00 more than otherwise applies to their class of membership. President Gold Club members shall pay annual dues in the amount of \$75.00 or more than otherwise applies to their class of membership. TxACOFP Patron members shall pay \$100.00 or more as determined by the Board of Governors as applies to their class of membership.

F. The annual dues for active members during the first three years following graduation or termination of an AOA or ACGME approved internship or family practice residency program shall be as follows:

- (1) First year = \$75.00
- (2) Second year = \$125.00
- (3) Third year and after = \$175.00

G. Active members who are serving in the uniformed service duty shall pay regular dues of \$75.00 until their tour of duty is completed.

Texas Worker's Compensation Commission

The TWCC Guideline Standardization Committee (GSS) is still working hard to develop standard definitions, standard durations for the treatment and standard criteria to determine what treatment interventions are included in treatment tables. Progress is being made by the GSS.

A very common problem with injured Texas workers is their inability to return for scheduled follow-up office visits once they feel better. This makes it impossible for physicians to determine whether or not maximum medical improvement (MMI) has taken place. Much to the irritation of physicians and their medical staffs, insurance carriers are constantly calling physicians to find out if the MMI has been reached.

At the last meeting of the TWCC MAC (Medical Advisory Committee), a solution to this problem was given. The health care provider should file a TWCC 64 form and state, "I have not seen this patient since _____. I am unable to certify MMI without seeing the patient." The insurance carrier can then refer to TLC §130.4 - Presumption that Maximum Medical Improvement has been reached and Resolution when MMI has not been certified.

Wednesday, October 28, 1998, has been designated as "Osteopathic Medicine Early Voting Day in Texas"

The era of standing in long lines on election day to cast ballots has come and gone in Texas. A very low voter turnout has been predicted this year. What this means is that each vote cast will have twice the impact on determining the outcome of local, state and national elections. Government policies concerning health care issues such as managed care are much too important to be left to chance. The future of osteopathic medicine in Texas is also much too important to be left to chance.

The Texas ACOFP and TOMA encourage all Texas osteopathic physicians, medical and health care organizations to adopt early voting policies in their work places that would allow employees time off during working hours to participate in early voting for local, state and national elections. By allowing employees time off during working hours and assisting with transportation to and

from voting places, there should be no excuse for not voting. We need to get our supporters to the polling places.

Don't forget that a new Texas Legislative session will begin in January, 1999; therefore, it is crucial that we elect people to political office who have a working knowledge of osteopathic medicine and support our profession. Our destiny is in our hands. Promote and participate in "Osteopathic Medicine Early Voting Day" in Texas on October 28.

OMT Follow Up

The following information is presented as a follow-up to the OMT coding lecture given by Don Self at the recent ACOFP Annual Seminar. Don did an excellent job of explaining Medicare OMT coding.

I would like to share with you a brief synopsis of OMT coding for Medicaid, Workers' Compensation and Medicare that I use in my office in Raymondville. Remember, OMT is a covered service and is reimbursable when the claim form is properly filled out (example below). If you follow my system of OMT coding and run into reimbursement problems, please call TOMA or the Texas ACOFP for assistance.

OMT Coding for TWCC

Texas Worker's Compensation Commission (TWCC) - Use the appropriate E&M code (new or established patient) depending on the amount of time you spend with the patient and add modifier -MP to the E&M code if OMT is provided. When manipulation is provided by an osteopathic physician, OMT codes 98925 through 98929 should be utilized and have the modifier -MP attached. Any follow-up office visits should include a separate and appropriate E&M service code, OMT code and/or any physical medicine procedures, if utilized.

If the patient returns for OMT only during the acute phase of illness for the same injury, the osteopathic physician may bill a 99212 E&M code for an established patient office visit in addition to the appropriate manipulation code and add modifier -MP to the E&M code. This rule is unique to osteopathic physicians.

Osteopathic physicians can bill their usual or customary charges for OMT or the TWCC maximum allowable reimbursement (MAR). Insurance carriers will reimburse the lesser of the bill charge or MAR amount.

OMT Coding for Medicaid

Texas Medicaid - Osteopathic manipulative treatment (OMT) performed by a provider licensed to perform OMT is covered for the acute phase of the acute musculoskeletal injury or the acute phase of an acute exacerbation of a chronic musculoskeletal injury.

The acute phase is defined as the period from the date of injury for a period not to exceed 180 days from the date of injury or the acute exacerbation of a chronic injury, or the date of plateauing.

Plateauing is defined as the point at which maximal improvement has been documented and further development ceases.

An initial or subsequent care visit or consultation may be paid in addition to OMT billed on the same day.

When billing for OMT services, the physician must document the diagnosis warranting the services and the date of onset/date of injury. In addition, modifier "AT" must be used when identifying an acute condition. Claims lacking the required information are denied.

Osteopathic manipulative treatment (OMT) codes 98925 through 98929

OMT Coding Synopsis

Dr. A. T. Still develops low back pain after lifting a heavy object on 2/14/98. Body areas involved - thoracic, lumbar and sacroiliac.

- A) Claim submitted to
Workers' Compensation
- B) Claim submitted to
Texas Medicaid
- C) Claim Submitted to
Texas Medicare

Diagnosis

- 1) 724.2 Low back pain
- 2) 846.0 Acute L-S strain
- 3) 739.4 Somatic dysfunction

Procedures, Services or Supplies

	CPT/HCPCS	Modifier	Diagnosis Code	Charges	Allowable Charges
A) Workers' Comp					
New E/M	99203	MP	1	\$74.00	\$74.00
OMT to 3 body areas	98926	Date Onset 2-14-98	3	\$80.00	\$45.00
B) Medicaid					
New E/M	99203	—	1	\$65.00	\$47.57
OMT to 3 body areas	98926	AT Date Onset 2-14-98	3	\$80.00	\$29.29
C) Medicare					
New E/M	99203	25	1	\$65.00	\$64.56
OMT to 3 body areas	98926	59	3	\$80.00	\$35.04

Note: The fees listed above are used to illustrate OMT coding procedures and should not be used for submission of actual health care claims. The procedure code (OMT) should be coded to the diagnostic code (Somatic dysfunction).

should be utilized. Medicaid will reimburse the lesser of the bill charge or the Texas Medicaid Fee Schedule amount.

OMT Coding for Medicare

Texas Medicare - Evaluation and management services are payable when performed by the same physician on the same day as OMT provided the E&M service is a significant, separately identifiable service and is appended with a "25" modifier.

Osteopathic manipulative treatment (OMT) codes 98925 through 98929 should be utilized.

If you perform OMT, or any other procedure on the same day as an E&M service, add the modifier "59" to each procedure (not E&M) code.

While Medicare presently says a different ICD-9 diagnostic code does not

have to be shown in order for the visit and the OMT to be paid on the same day, a different ICD-9 diagnostic code should be used for all carriers, if possible. The procedural code (OMT) should be coded to the diagnostic code (Somatic dysfunction).

The Medicare Physician Fee Schedule is based on the geographic area in which you are located (locality), whether you are a participating or non-participating physician, and the maximum limiting charge amount that can be charged for that service on a non-assigned claim.

Medicare will reimburse the lesser of the bill charge or the Medicare Physician Fee Schedule.

Medicare permits the physician to enter into private contracts with Medicare patients to provide covered services if specific requirements are met; however, the physician must "opt out" of Medicare for a two-year period.

Deadline for Submission of Health Care Claims

TWCC Rules

Time limit for claims - 365 days from the date of service, however, if the claim is denied and you want to get to dispute resolution, don't wait until the last minute.

Time limit for dispute resolution - 365 days from the date of service.

Texas Medicaid Rule

Time limit for claims - 90 days from the date of service.

Texas Medicare Rule

Time limit for claims - One year from the date of service with a 3-month grace period. After 15 months, there is a 10% reduction in reimbursement.

Neil "...keeps me apprised of the ever changing laws and rules for health insurance..."

Bill V. Way, D.O. President Elect for District V: TOMA

Neil H. Resnik, LUTCF

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Health Science Center Physician Elected to National Post

Alan Stockard, D.O., sports medicine physician with the Physicians & Surgeons Medical Group of the University of North Texas Health Science Center, was elected secretary/treasurer of the American Osteopathic Academy of Sports Medicine. Dr. Stockard will serve a one-year term in this position.

Fort Worth Scientist Tapped for FBI Post

The Federal Bureau of Investigation has appointed a Fort Worth molecular biologist as chairman of its DNA Advisory Board. He is Dr. Arthur Eisenberg, associate professor of pathology at the UNT Health Science Center.

Dr. Eisenberg, 42, has served as the board's molecular geneticist since 1995, a position to which he was reappointed in April, 1998. His appointment was announced in mid-August by FBI director, Louis Freeh. As chairman, Dr. Eisenberg succeeds Nobel Laureate Dr. Joshua Lederberg of The Rockefeller University, New York. He will serve as chairman through March, 2000.

The FBI's DNA Advisory Board's primary responsibility is to recommend standards to the bureau's director for DNA quality assurance and for proficiency testing at forensic laboratories throughout the United States. It also develops standards for forensic personnel who conduct DNA analyses in criminal cases.

As board chairman, Dr. Eisenberg will serve with 16 other scientists and crime laboratory specialists. All members are nominated by the National Academy of Sciences and other professional societies. The board holds meetings twice yearly in Washington, D.C., and other sessions as needed. The panel was established by the federal DNA Identification Act of 1994.

Dr. Eisenberg came to the UNT Health Science Center in 1989 as associate professor of pathology and director of the center's DNA Identity laboratory. He also

serves as an associate member on the graduate faculty of the biology department at the University of North Texas, Denton. Dr. Eisenberg earned his Ph.D. in molecular biology at the State University of New York in Albany.

"Art's international reputation for forensic expertise reflects, among many other cases, his identification activities in the aftermath of the Branch Davidian events of 1993," said David M. Richards, D.O., president of the UNT Health Science Center. "This is a prestigious national assignment that is well-earned and a new source of pride for this institution."

In addition to his work in forensics, Dr. Eisenberg has developed diagnostic assays for various genetic disorders, including widely-used DNA-based cancer diagnostic tests for leukemias and lymphomas. He also has improved paternity-related DNA testing methods.

Health Science Center Welcomes Future Health Professionals

The University of North Texas Health Science Center faculty welcomed and initiated the 28th class of osteopathic medical students and the 6th class of graduate school students at the UNT Health Science Center. The annual White Coat and Convocation Ceremony took place August 7 at the Will Rogers Auditorium at the Amon Carter Jr. Exhibit Hall in Fort Worth.

The White Coat Ceremony is a rite of passage for students entering the academic health community, and signifies their pending entry into professional ranks. The UNT Health Science Center's White Coat ritual included all 115 incoming students of the Texas College of Osteopathic Medicine, 87 students at the Graduate School of Biomedical Sciences and 16 new students in the Physician Assistant Studies Program.

Michael Clearfield, D.O., professor and chairman of internal medicine at the health science center, gave the keynote address on preparing for the academic

road ahead. Dr. Clearfield's work as primary investigator on a nationwide cholesterol research project was recently published in the *Journal of the American Medical Association*.

Supporters of the White Coat and Convocation ceremony included All Saints Health System, Harris Methodist Select, Plaza Medical Center of Fort Worth and the Robert Wood Johnson Foundation.

Federal Aviation Administration Considering Medical Certification for Users of Ritalin and Lithium

The Federal Aviation Administration (FAA) is currently reviewing data on the use of Ritalin for adult attention deficit disorder and medical certification. Under very strict criteria, a few pilots have been medically certified for third class operations. All of the subjects are on a low dose of the stimulant drug. Among other things, cognitive function tests have been performed both on and off the drug. The FAA will watch these few cases closely in anticipation of considering airmen on a case-by-case basis.

The FAA is also considering certification of airmen under Lithium treatment for mild bipolar disorders but only in cases where there is no history (not even a remote history) of a manic or depressive episode severe enough to be disqualifying. Since there are large variations in the dosage of Lithium compounds, the FAA requires strict serum Lithium monitoring with maintenance levels stable in the 0.6 mEq/L or below range. The reporting requirements will be rigorous. There are currently only a very few airmen that have qualified and the expectation is that a very small percentage of applicants on Lithium will ever do so.

Source: *Flight Physician*, Vol. 1, No. 3

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Why the Bull Market May Yet Have Legs

The Chicago Bulls, fresh off their sixth championship in the 1990s, are the most recent example of a natural law that is as true as they come: all good things must eventually end. (If you're not particularly fond of the Bulls, simply remove the word "good." The law stays the same.)

Defections and retirements will undoubtedly complete the run of professional basketball's "Team of the 90's."

In contrast to the public dismantling of the Bulls, most "eras" tend to end quietly, with no discernible distinction between the beginning of the end and the end itself.

We use the Chicago Bulls to analogize another great run – the historic bull market of the 1990s. Questions about its longevity are now being raised in virtually all circles, from locker rooms to cocktail parties to financial talk shows.

A brief glance back shows the Dow* standing at 2,810 at the conclusion of this decade's first day of trading. That number looks awfully insignificant when posted against 8,952 – where the Dow stood at the end of the first half of 1998.

So the \$64,000 question – and we've asked this one before – is whether this is the beginning of the end or the end of the beginning.

Arguments can be made on both sides. Bears tell us that we are only now starting to feel the full impact of the single-biggest factor that can put an end to this bull market: the crisis in Asian financial markets. Bulls on the other hand point out that Asian economic woes are a far less important indicator of continued vitality in our own equity markets than U.S. corporate earnings – which they expect to be strong.

Suffice to say that, as usual, there are no shortages of opinions on either side. There are in addition a few signs positive enough to be noted here.

Take the case of Al Dunlap, until recently CEO of Sunbeam Corp. During his tenure at Sunbeam and in previous stints at Scott Paper and Crown Zellerbach, Al earned himself the nickname "Chainsaw" due to his draconian methods of turning companies into profit machines. These methods, boiled down, amounted to laying off employees by the thousands and shutting down plants by the dozens, all in the name of cutting costs at the troubled companies he was brought in to help turn around. The Chainsaw was a pioneer in the revolution that took place in corporate America in the '80s and '90s, creating companies that have delivered tremendous shareholder value during the entire decade.

This revolution however – like all revolutions – did not come without costs. For the thousands of workers in companies Chainsaw and others like him were responsible for downsizing, the price was high indeed. This is a sometimes painful reality of a system which otherwise serves us so well.

In Wall Street parlance, to have been a victim of the Chainsaw was to have been "Dunlapped." The man's name had become a verb, synonymous with, "out of a job."

What happened at Sunbeam mostly had to do with a second revolution Chainsaw had begun. In addition to being recognized for turning companies around, Chainsaw was an agent for change in corporate governance.

He insisted that members of the controlling board not only pay themselves exclusively in company shares, but also that they think like owners – meaning they buy shares of the companies they govern on their own dime.

Dunlap was quoted in Investment News as saying of the policy, "If you're a good board member, you can really help influence the company. If you don't want to take the risk, God help the shareholders."

The company lost \$44.6 million in the first quarter. It may post yet another loss this quarter. Earnings expectations for 1999 have been lowered from \$2 a share to just over \$1. There is an inventory glut from

somewhat dubious sales practices that will take time to correct. Most ominously,

Sunbeam's share price has fallen from a high of \$52 to somewhere around \$11, depending on what day you look.

In short, Chainsaw had made many promises that the numbers would simply not substantiate. The board, in-turn, took the only owner-driven, short-term, profit-motivated, still-hungry action it could have and unceremoniously showed Chainsaw the door.

The revolution, as well as the bull market, marches on.

*The Dow Jones Industrial Average is an unmanaged index reflecting the overall return attained by a diversified group of 30 stocks of major industry blue-chip companies based in the United States. All returns are calculated with reinvested dividends and expressed in US dollar terms. Past performance does not guarantee future performance and your actual results will vary.

This article is not intended to provide specific advice or recommendations for any individual. Consult us, your LPL financial advisors, or your attorney, accountant or tax advisor with questions.

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Texas Hospitals Introduce New Interns and Residents

Recently graduated osteopathic physicians from osteopathic colleges across the United States have begun their training programs at Texas hospitals and medical centers. Among the interns and residents training for the 1998-99 year are the following.

THE CORPUS CHRISTI MEDICAL CENTER



Michael Bratsch, D.O.
Family Practice Resident
UNTHSC/TCOM



Ramon Cantu, D.O.
Family Practice Resident
MSU-COM



Isidro deLeon, D.O.
Family Practice Resident
UNTHSC/TCOM



Nancy Eisen, D.O.
Family Practice Resident
UNTHSC/TCOM



Derek Farley, D.O.
Family Practice Resident
UNTHSC/TCOM



Jason Groomer, D.O.
Family Practice Resident
COMP



Ron Guevara, D.O.
Family Practice Resident
UNTHSC/TCOM



John Herrick, D.O.
Family Practice Resident
UNTHSC/TCOM



Keith Hurst, D.O.
Family Practice Resident
UNTHSC/TCOM



Will Jeffers, D.O.
Family Practice Resident
COMP



John Ledbetter, D.O.
Family Practice Resident
UNTHSC/TCOM



Steven Nowotny, D.O.
Family Practice Resident
UMDNJ/SOM



Ehrin Parker, D.O.
Family Practice Resident
UNTHSC/TCOM



Paresh Patel, D.O.
Family Practice Resident
UNTHSC/TCOM



Mario Perez, D.O.
Family Practice Resident
UNTHSC/TCOM



Clay Pickering, D.O.
Family Practice Resident
UNTHSC/TCOM



Maria Ponce, D.O.
Family Practice Resident
UNTHSC/TCOM



Christopher Pudol, D.O.
Family Practice Resident
COMP



Cynthia Rutledge, D.O.
Family Practice Resident
UNTHSC/TCOM



Nolan Ulrich, D.O.
Family Practice Resident
UNTHSC/TCOM



Roxanne Woods, D.O.
Family Practice Resident
OSUCOM

DALLAS/FORT WORTH MEDICAL CENTER (GRAND PRAIRIE)



Barry Clark, D.O.
Intern
UOMHS/COMS



Chris Gayden, D.O.
Intern
UNTHSC/TCOM



Donald Lamoureux, D.O.
Intern
UHS-COM



Michael Rimlawi, D.O.
Intern
NYCOM



Stephen Seale, D.O.
Intern
UNTHSC/TCOM



Cobra Shanley, D.O.
Intern
UNTHSC/TCOM

OSTEOPATHIC MEDICAL CENTER OF TEXAS (FORT WORTH)



Kimberly D. Barbolla, D.O.
Internal Medicine Intern
UNTHSC/TCOM



Michael Y. Chang, D.O.
Intern
UNTHSC/TCOM



R. John Charboneau, D.O.
Intern
OSU-COM



Yung S. Chen, D.O.
Family Practice Intern
UNTHSC/TCOM



Robert D. Clark, D.O.
Internal Medicine Intern
UNTHSC/TCOM



Bart W. Crosby, D.O.
Family Practice Intern
UNTHSC/TCOM



Rob D. Dickerman, D.O.
Intern
UNTHSC/TCOM



Martha A. Dodson, D.O.
Family Practice Resident
UNTHSC/TCOM



John W. East, D.O.
Intern
UNTHSC/TCOM



William K. Garretson, D.O.
Vascular Surgery Resident
UNTHSC/TCOM



John W. Goulart, D.O.
Intern
UOMHS/COMS



Kelly D. Grimes, D.O.
Family Practice Intern
UHS-COM



Jeffrey M. Hantes, D.O.
OB/GYN Intern
UNTHSC/TCOM



Vincent J. Lewis, D.O.
Internal Medicine Intern
UNTHSC/TCOM



David W. Longley, D.O.
Family Practice Intern
UNTHSC/TCOM



Carolyn B. McDougald, D.O.
Family Practice Intern
UNTHSC/TCOM



Michael J. Methner, D.O.
Internal Medicine Intern
UHS-COM



M. Kathleen Querry, D.O.
General Surgery Resident
UNTHSC/TCOM



Mark A. Sanders, D.O.
Family Practice Intern
UNTHSC/TCOM



Damon A. Schranz, D.O.
Family Practice Intern
UNTHSC/TCOM



Ana Shah, D.O.
Intern
UNTHSC/TCOM



James L. Slayton, D.O.
Internal Medicine Intern
UNTHSC/TCOM



Lynn M. Speaks, D.O.
OB/GYN Intern
UNTHSC/TCOM



Gina R. Stubbs, D.O.
Internal Medicine Intern
NYCOM



J. Keith Thompson, D.O.
Intern
UHS-COM



The Q. Truong, D.O.
Internal Medicine Intern
UHS-COM



Kris H. Wusterhausen, D.O.
Family Practice Intern
UNTHSC/TCOM

Photo Unavailable

Chau N. Pham, D.O.
Geriatric Medical Fellowship
OUCOM

David E. Tanner, D.O.
Manipulative Medicine
Resident
UNECOM

METHODIST HOSPITALS OF DALLAS - CHARLTON METHODIST HOSPITAL (DALLAS)



John E. Denning, D.O.
Primary Care/Sports Medicine
Fellowship - CCOM



Katie Mastrogiovanni, D.O.
Family Practice Resident
UNTHSC/TCOM



Cathy D. Robbins, D.O.
Family Practice Resident
UNTHSC/TCOM



Brian T. Spore, D.O.
Family Practice Resident
UNTHSC/TCOM



Anjali Varde, D.O.
Family Practice Resident
UNTHSC/TCOM



Stephanie R. Waterman, D.O.
Family Practice Resident
UNTHSC/TCOM



J. Steve Welch, D.O.
Family Practice Resident
UNTHSC/TCOM

TEXAS TECH UNIVERSITY HEALTH SCIENCES CENTER AT AMARILLO



Dale Hollis, D.O.
Resident
UHS-COM



Deborah Minnick, D.O.
Resident
UNTHSC/TCOM



Bart Robbins, D.O.
Resident
UNTHSC/TCOM



Ava Swayze, D.O.
Resident
UHS-COM

Texas College of Osteopathic Medicine Incoming Class

Zabair Hae Abdul - Plano
Michael Charles Ampelas - Seguin
Paul Aoun - Fort Worth
Annee Aquino-White - San Antonio
Ronald Christopher Auvenshine - Lubbock
Manjia Polachirackal Babu - Houston
Bruce Alan Barker - Brazoria
Shreyas Pushpavan Bhavsar - Houston
Mohamad Reza Bidgoli - Plano
Victor Manuel Burgos - Fort Worth
Saparna Chakraborty - Lewisville
Jyeshth Chasmawala - Fort Worth
Khem Chu - Houston
John Franklin Cole - Abilene
Jonathan Costa - Dartmouth, Massachusetts
Michael James Cutler - Bountiful, Utah
Amy Elizabeth Dadura - Houston
Matthew James Darling - Spring
Charlie Frank Dendy - Monahans
Jacquelin Dewbre - Fort Worth
Raymond Gene Duggan - Abilene
Jill Elaine Evans - Fort Worth
Melissa Fortner - Abilene
Clayton Frenzel - Arlington
Michelle C. Friedeck - San Antonio
Mark Andrew Gamber - Arlington
Sonia Radhika Garadi - Bedford
Hans K. Ghayee - Houston
Denise Goksel - Fort Sam Houston
Astrid Gutschmann - San Antonio
David Eugene Haacke - Sugar City, Idaho
Leslie Christine Hardick - Watauga
Lori Gaye Harvey - Decatur
Nadyabanu Hasham - Houston
Michael Robert Hohnadel - Arlington
Bradley Shane Holland - Watauga
Ching-Wei Hsu - Webster
Christopher Patrick Hummel - Lewisville
Adriana Maria Hwa - Houston
Gregory Dennis Iverson - Salt Lake City, Utah
Gene David Joe - Houston
Azah Keyhani - Houston
Kouroush Keyhani - Houston
Jagjit Singh Khairah - Sugarland
Patti Rebecca King - Devers
Mark Malouf Kuper - Hereford
Lien Bich Lam - Rowlett
Cynthia Elaine Larson - Houston
Arthur Joseph Lee - Plano
Tayson Lengocky - Houston
Brandon Joseph Lewis - New Braunfels
Piper Prescott Lillard - Jacksboro
Vernaine G. Limbo - Kingwood
Frank L. Loyd - Chandler
Vibhal Rick Luthra - Norwalk, California
Ramandip Kaur Mangat - Houston
Courtney Renee Marburger - San Antonio
Andrew Steven McAdoo - Flower Mound

Sharla Marie McCone - Crowley
Jennifer Theresa McGaughy - Boyd
Tamara Merritt - Richmond
Brent David Michener - Plano
Elaine Kay Miller - Amarillo
Amber Mae Moreno - San Antonio
Farhad Keikhosrow Mosallaie - Houston
Farah Munir - San Antonio
Gregory Allen Newman - San Antonio
Hoang Huy Nguyen - Houston
Lily Thi Nguyen - Fort Worth
Phuong Thi Doan Nguyen - Houston
Christian Michael Niedzwecki - College Station
Petua Okolo - Grand Prairie
Urmila Parthasarathy - Sugarland
Chirag Raman Patel - Bedford
Manish Prahlad Patel - Carrollton
Khuong Dinh Phan - Fort Worth
Christy Erin Pinkham - Amarillo
Gretchen Jane Pollom - Houston
Minh Tan Quach - Fort Worth
Bibas Reddy - Weslaco
Alisha Kristine Riggs - Plano
Andrew Loyd Roberts - Canyon
Tina Kim Schuster - San Antonio
Sachin Shrenik Shah - Missouri City
Deepshikha Sharda - Austin
Sheree T-Hsuan Shen - Cerritos, California
Kimberly Ann Shields - Plano
John Patrick Simons - Austin
Sony Sinha - Avenel, New Jersey
Lynda Brady Stafford - Pasadena
Justin Joseph Stewart - Abilene
Robyn Dana Stewart - Dublin
Cynthia Rogers Stuart - Carrollton
Bernard Anthony Stupski - Austin
James Tai - Deerfield Beach, Florida
Eden Temko - Austin
Anita Tharian - Uvalde
Nguyen Xuan Tran - Dallas
Hilda Horng-Chyi Tso - Houston
Andrey Tsyss - Milwaukee, Wisconsin
Beth Ann Valashinas - Austin
Avinash Vallurupalli - Plano
Shelly Rene VanScoyk - Grand Prairie
Nancy Ann Varghes - Grand Prairie
Jose Santiago Villarreal - Odessa
Adam David Weglein - Plano
Erin Carpenter Westerholm - Bastrop
Kenneth Raymond Wilks - College Station
Dennis Avery Williams - Fort Worth
Jacob Carmen Yannetta - Orange
Won Yi - Katy
Gina Marie Zanchelli - Houston

Physician Assistant Studies Program Incoming Class

Linda L. Armstrong - Granbury
Maria C. Calzada - Spring

Bic G. Chau - Carrollton
Kim M. Cottle - Lewisville
Jeffrey D. Curtis - Fort Worth
Kelly A. Fenimore - Houston
David T. Gonzales - Bryan
Farivash Hamraie - Grapevine
Darren P. Hughes - Dallas
Sheryl A. Lucier - Wichita Falls
Meredith C. Peaslee - Watauga
Traci D. Phelps - Fort Worth
Tiffani J. Shoemaker - Bryan
Barbara A. Slusher - Kenah
Christie D. Troyer - San Antonio
Dianne Urey - Fort Worth

Graduate School of Biomedical Sciences Incoming Class

Donald Anderson - Fort Worth
Wagma Atiqzoy - Kabul, Afghanistan
Kerri Avedon - Watauga
Jinhui Bai - Manassas, Virginia
Melissa Barnes - Brazoria
Amy Bateman - Alamosa, Colorado
Sejal Bhagia - Irving
Quinn Biggs - Sandy, Utah
Lynn Breaux - New Orleans, Louisiana
Edward Chambers - Irving
Ben Compton - Meridian, Mississippi
Patrick A. Cooke - Denton
Ginelle Courchaine - Fort Worth
Alberto Coustasse-Hencke - Santiago, Chile
Paromita Das - Ahmedabad, India
Magali DeLassen - Fort Worth
Martin Farias - Brownsville
Rosemary Galdiano - Fort Worth
Robert Galvan - Fort Worth
Anna Garcia - Corpus Christi
Peter Gargalovic - Presov, Slovakia
Jennifer Griffith - College Station
Lori Harker - Garland
Stephanie Harnden - Cleburne
Bradley Hart - Detroit
Mark Holton - Bedford
Kelly Houchin - Claremont, California
Allen Johnson - Fort Worth
Daryhl Johnson - Jackson, Mississippi
Percival Kane - Lake Charles, Louisiana
Dorothy Katarikawe - Dallas
Cheryl Kelley - Fort Worth
Bridget Lane - Peoria, Illinois
Linda Leaville - Texarkana
Lara Lippolis - Milano, Italy
Min Lu - Zheijiang, China
Tammy Macdonald - Fort Worth
Heidi Magnuson - Fort Worth
Pamela Marshall - Gainesville, Florida

continued on next page

Amy McArthur - Fulshear
 Ryan McCorkle - Mineola
 Millicent McDonald - Dallas
 Donald Michael - Harlingen
 Matthew Milholland - Fort Worth
 Heather Miller - Sherman
 Michelle Moerbe - Irving
 Joel Montgomery - Hurst
 Chris Morgan - McKinney
 Samer Nachawati - Grand Prairie
 Santosh Narayan - Mumbai, India
 Kavita Niranjan - Fort Worth
 Eric Nolen - LaGrange
 Katie Overheim - Gallup, New Mexico
 Chong Pak - Columbia, Maryland
 Vinay Parameswara - Bangalore, India

Eric Pearlman - Dallas
 Christopher Perkins - Dallas
 Chau Pham - Columbus, Ohio
 José Pina - Kingsville
 Sangeetha Prasanna - Fort Worth
 Ronald Pugh - Dallas
 Marla Ratliff - Fort Worth
 Cynthia Rashid - Vinita, Oklahoma
 Matt Richardson - Fort Worth
 Leslie Don Roberts - Longview
 Anna Rodriguez - Dallas
 Randy Sanders - Weatherford
 Huong "Crystal" Saunders - Garland
 James Saunders - Garland
 Ritu Shetty - Mumbai, India
 Mark Shepherd - Bedford

Debleena Sinha - Denton
 Vigiang Song - Shanghai, China
 Jack Sosebee - Weatherford
 Vicky Sprinkle - Arlington
 Gayathri Sridhar - Mishawaka, Indiana
 Rebecca Sykes - Bloomington, Indiana
 Kimberli Taylor - Jackson, Mississippi
 Sara Taylor - Mansfield
 Thomas Taylor - Dallas
 Viji Thomas - Irving
 Pamela Verrett - Thibodaux, Louisiana
 Kelly Vopat - Austin
 Suzanne Whizin - San Angelo
 Vanessa Williams - Mound Bayou, Mississippi
 Mehmed Younouzov - Kardjali, Bulgaria
 Du Yu - Beijing, China

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Expert IRS Audit Defense for TOMA Members

Statistics are very clear that physicians are one of the primary targets of the IRS! To protect our members in the times of audit crisis, TOMA has contracted for the audit defense services of TaxResources, Inc., the oldest, largest and consistently successful prepaid audit defense firm in the United States.

By successfully defending hundreds of audits each year, they have the reputation of being the most knowledgeable group of professionals in the country dealing with agencies responsible for the collection of income tax. They have successfully defended a range of cases from those requiring mere explanatory correspondence to those requiring specialized knowledge of complicated issues unique to the medical profession.

Income tax audit defense is the only thing they do. For over 10 years they have dedicated themselves exclusively to the defense of U.S. taxpayers and are endorsed and recommended by over 50 of the most prestigious and respected medical associations in the U.S.

They do not take the place of your CPA or accountant. However, in order to bring about a winning conclusion to an IRS problem, their specialized expertise and knowledge is invaluable for you and your accountant during an audit crisis. Not having prepared your return gives them the benefit of not having to justify any possible fiduciary responsibilities incurred by the tax preparer. They are free to concentrate their efforts only on defending you.

Through experience, they know there is much more to defending an audit than just facts and figures. Consequently the majority of tax specialists associated with their company are former IRS auditors and are completely knowledgeable of the organization's inner workings and subtle tricks and traps.

Membership in their audit defense program gives you the highest professional defense of your rights and assets in any IRS or state income tax audit. This covers the current year as well as all prior years. They will defend you through the entire audit process including, if necessary, the highest level of appeals and the mandatory pretrial conference before going to tax court.

They handle the defense of an audit from the time of first notice to its completion, handling all appointments, all correspondence and all contact with the IRS. This assures you of no hassles, no intimidation and no lost time away from your practice.

In addition, membership in TaxResources gives you unrestricted use of their toll free "hotline" for advice and consultation or to answer questions concerning any areas of income tax or the IRS. They can also provide you with the necessary information to restructure your practice to protect your independent contractor status. These services are like having your own tax specialist on retainer without paying the retainer. You will receive a quarterly "Tax Tip" Bulletin, written in a down-to-earth, understandable style designed to give you the knowledge to minimize your tax liability and help avoid tax audits.

We have negotiated a discounted personal annual membership fee for TOMA members of \$175 - \$40 below the usual price. This is the entire cost of their complete membership service and there are no circumstances by which the defense of an audit can cost you an additional penny.

You have recently received information on this program in the mail. Should you like additional information or easy access to enrollment, call TaxResources at 800-922-8348.

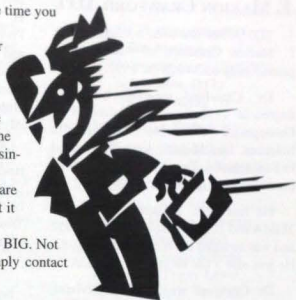
MEMBERSHIP ON THE MOVE

October is the beginning of the TOMA Membership Drive for 1999. By the time you read this article, you should have received a dues statement.

This year we are doing something different. In addition to your regular membership dues, your statement will include an opportunity for you to become a Sustaining Member and pay your TOMA District dues. You will also have the opportunity to make your contribution to TOMA PAC (TOMA'S Political Action Committee) and become a Texas Star by contributing to the Building Fund. In addition, spouses will be encouraged to join ATOMA, the association's auxiliary organization. All of this can be accomplished with one single payment.

We hope that this "all purpose" billing will make it easier for you to take care of all of your financial responsibilities at one time and not have to think about it again for a whole year.

We know there is a down side to this arrangement - your bill is going to be BIG. Not to worry! TOMA will be delighted to help you set up a payment plan. Simply contact Membership Coordinator, Lucy Gibbs, to work out the details.



When it comes to wound healing, we're the experts.

Maybe you've seen it in your practice. A patient's wound resists treatment and complications begin to set in. It's time you called in a specialist who knows how to speed the healing process. At the Wound Healing and Hyperbaric Medicine Center, our many years of experience in diagnosing and treating non-healing wounds have earned us a following with doctors and patients throughout Tarrant County. Our advanced wound-healing technology includes a multi-chamber hyperbaric unit as well as nutritional counseling, wound care education and home health guidance.

On referral or as a consultant, our skilled team of physicians, nurses and hyperbaric technicians work directly with you to develop a patient-specific protocol. If your patients and your practice suffer from a wound that won't heal, it's time you made the call. We'll help you close the files on chronic open wounds.



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AND
HYPERBARIC MEDICINE
CENTER**

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In Memoriam

F. MARION CRAWFORD, D.O.

TOMA has just been notified that Dr. F. Marion Crawford of San Antonio, passed away on March 26, 1997.

Dr. Crawford received his D.O. degree in 1932 from the University of Osteopathic Medicine and Health Sciences, Des Moines, Iowa. He moved to San Antonio, Texas, in 1951, where he practiced until his retirement.

He had been an active member of TOMA and TOMA District VII since 1952 and was awarded life membership in 1982. He was also a life member of the AOA.

Dr. Crawford was the last surviving member of the John Philip Sousa Marching Band.

JAMES HENRY KRITZLER, D.O.

Dr. James H. Kritzler of Houston, passed away on February 28, 1998. He was 78.

Services were held March 3 at Holy Trinity Methodist Church in Houston

Dr. Kritzler was a 1944 graduate of the University of Health Sciences College of Osteopathic Medicine, Kansas City, Missouri. He began his medical career in family practice in McLean, Texas, where he practiced for nine years. In 1955, Dr. Kritzler entered a radiology residency at Grandview Hospital, Dayton, Ohio.

Following his residency, Dr. Kritzler practiced radiology at Amarillo Osteopathic Hospital from 1958-59; Doctors Hospital in Houston from 1959-67; Community Hospital, Houston, from 1967-68; and at Eastway General Hospital, Houston, from 1968-83. He retired in 1983.

Dr. Kritzler was a member of the Lion's Club in McLean; member of the Masonic Lodge as a 32nd degree Mason in McLean; and member of the Community Hospital Foundation Board, of which he served as president from 1996-98.

Survivors include his wife of 54 years, Eleanor Kritzler of Houston; two sons,

Eric Nelson Kritzler of Houston and James H. Kritzler and his wife, Susan, of Pearlband; one daughter, Ellen Kay Hines and her husband, Gary, of Houston; one brother, Nelson Kritzler and his wife, Doris, of Kenton, Ohio; and four grandchildren, Kristi and Justin Hines and Alyssa and Michael Kritzler.

In lieu of flowers, memorials may be made to the University of Health Sciences College of Osteopathic Medicine; Ohio Northern University in Ada, Ohio; Holy Trinity Methodist Church; or any charity of your choice.

MARJORIE C. LUKE

Mrs. Marjorie C. Luke of Fort Worth, passed away August 31.

Services took place September 4 at St. Luke's in the Meadow Episcopal Church in Fort Worth.

Mrs. Luke was secretary to the Rear Admiral of Galveston during World War II. She and Dr. Luke married in 1945 and celebrated 51 years together before his death in 1997. She had worked with him in his office until 1994.

Survivors include her sons, Edward A. Luke, Jr., D.O., of Fort Worth, Charles Luke and wife, Lory Garrett, of Gilbert, Arizona, and Robert Luke and wife, Elaine, of Arlington; daughters, Marjorie "Suggie" and husband, San Dick, of Fort Worth, and Lezlie and husband, James Peterson, of Castaic, California; sisters, Mary B. Garrard of Fort Worth and Margaret Ann Swearingon of Austin; niece, DeLee and husband, Joe Walker, of Fort Worth; six grandchildren; and numerous great-nieces and great-nephews.

Mrs. Luke volunteered her time to many causes, especially St. Luke's in the Meadow Episcopal Church. She was a Cub Scout Den Mother for many years.

Memorials may be made to the Boy Scouts of America, Longhorn Council; or the TCOM Foundation at the University of North Texas Health Science Center.

Ten Years Ago in the Texas D.O.

♦ **M. E. "Bo" Kirkwood, D.O.**, was elected chief-of-staff, by unanimous vote, of Pasadena General Hospital, Pasadena, Texas. He became the first D.O. to hold the position and was the only D.O. on staff at the time.

♦ **Wayne R. English, Jr., D.O.**, was selected to deliver the 1988 Scott Memorial Lecture at the Kirksville Founder's Day.

♦ **Earl C. Kinzie, D.O.**, was lauded by the Lindale School District with receipt of a plaque. The inscription read, "Number One Lindale Eagle Physician 1940-1986, Dr. E. C. Kinzie, in honor and deep appreciation of the faithful, devoted and valuable service given to the athletes of the Lindale School System."

♦ **A controversial policy** was approved by the Board of Cook County Hospital, Chicago, Illinois, whereby patients could refuse to be treated by physicians and nurses afflicted with AIDS. The policy created an uproar of opposition from the state hospital association and other groups.

♦ **President Ronald Reagan** signed into law legislation expanding Medicare to include coverage of acute care catastrophic illnesses. Except for provisions aimed specifically at the poorest beneficiaries, the new benefits would be financed through increases in the monthly premium for optional Part B coverage (currently \$24.80 per month), and imposition of a new "supplemental" premium that would be assessed on a sliding scale for the 40 percent of Medicare beneficiaries with incomes high enough to owe \$150 or more per year in Federal income taxes.

ATOMA News

By Lewis Isenberg
ATOMA President-Elect

Membership: Some disjointed and convoluted thoughts about recruitment...

I am a "joiner." Not necessarily a "worker" or a "loyal, dependable member," but a joiner. Not so much now as in a "younger, adventurous" time in my life. In some organizations to which I belong or have belonged, I merely pay or paid my monetary dues. Some I participate in when it suits my purpose and some I make a very conscious effort to assure that the goals of the collective membership are met. Guess which ones I get the most satisfaction from?

I am always impressed by that person in most organizations, whether social, professional or religious, who has recruited lots and lots of members over the years. One civic organization to which I belong has a member who has recruited several hundreds of members over the years. He is in his 90's, deaf and relies on a mechanical aid to get around. Some member is designated each week to pick him up at the "assisted living" center where he resides and bring him to the weekly luncheons. Guess what? Every so often he shows up with a potential new member, along with whichever regular member has been designated to provide weekly transportation. It is usually someone young enough to be his great-great-grandchild, or it may be someone from the center, i.e., a nurse, doctor, administrator or someone from practically anywhere with whom he has been in contact. Of course it is helpful that the organization is a very old international organization and he has been selling it longer than most of us have been alive. I think we all know or have known this person who targets a potential member and makes the effort to get them to join.

Okay, what's my point? Two points, actually. 1) This person believes in what they are selling! And 2) They rarely miss an opportunity to talk about what they believe. This belief is demonstrated by the sincerity conveyed and is recognized and accepted by those individuals with whom they contact. No great secret, no elaborate practiced spiel, no give-away

programs, just honesty, sincerity and making the effort to speak with those people who they feel will make a good member.

No pep talks, no chiding or other negative or positive motivation. Remember, I said that I am a "joiner" - what I didn't say is that I am the "world's worst recruiter." But I will make you all a deal - I will get a new member if you will!

Fund-raiser Report 99th Annual Convention in Austin By Peggy Rodgers, ATOMA Treasurer

ATOMA thanks each and every one of you for your support during our convention in Austin. During the convention, ATOMA tackled a new project - the Golf Tournament, headed by Mrs. Rita Baker and co-chaired by Mr. Lewis Isenberg. Dean, Jacobson Financial Services and Healthcare Insurance Services sponsored the tournament and the proceeds were donated to ATOMA projects.

ATOMA also raffled a laptop computer and grandfather clock, plus we sold our T-shirts. We had tremendous support from you and extend our thanks for all your help, whether it was financial or your physical presence.

A special thanks go to these major contributors to our raffle:

TOMA District II	\$3,000.00
TOMA District III	\$ 400.00
ATOMA District V	\$ 500.00
TOMA District V	\$3,000.00

Door prize donors should have a special place in heaven!

The Golf Tournament Tee Sponsors also deserve a major round of applause:

CORPORATE SPONSORS

Intermedical of Texas, Inc.
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Texas Osteopathic Medical Association
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Terry and Cindy Boucher
George and Linda Cole
Bill and Darlene Way
Randy and Peggy Rodgers
Jerry and Joan Smola
Elaine Rahm Tyler
Martha Coy

After the dust has settled from the convention, you are probably wondering where the proceeds from these efforts are going. Therefore, ATOMA would like to show you the results of our efforts with the following list of contributions from the proceeds of this convention.

AAOA Special Projects	\$574.00
National Ad Campaign	\$1,723.00
TCOM Student Emergency Fund	\$2,872.00
ATOMA Contingency Fund	\$1,149.00
TOMA Building Fund	\$1,149.00
Impaired Physicians Fund	\$2,298.00
SAA Travel Fund	\$574.00
AAOA Golf Tournament	\$300.00
AAOA Convention Expense	\$175.00
OHST Foundation	\$200.00
1999 AAOA Convention Expense	\$474.00
(Rita Baker's Installation)	
TOTAL	\$11,488.00

ATOMA plans to continue to sell T-shirts, which funds our Endowment (Scholarship) Fund, raffle off items during President's Night and use the proceeds from the Golf Tournament to donate to various osteopathic organizations and areas of need during the convention in Dallas.

Thanks again for all your help!

Texas D.O. October 1998 **21**

OUR THANKS TO THE SPARKS FOUNDATION

TOMA and the TxACOPF wish to thank the Sparks Foundation for their generosity and support with grants this past year.

Their support has made possible the purchase of a new conference table for the T. R. Sharp Education Center, located in the TOMA headquarters, as well as a tape duplicating machine, a table-top paper folding machine, a lap top computer and the management of the TxACOPF website.

Many of these items, shared by both TOMA and the TxACOPF, further provide assistance in the servicing of all osteopathic physicians in Texas.

Once again, our sincere thanks to the Sparks Foundation.



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Congress Considering Fees for Home-Health Consumers

A controversial issue is surfacing as pressure mounts in Congress to increase payments to home health care agencies that receive Medicare funds. The new issue is copayments, whereby Medicare beneficiaries would pay a fee each time they use a home health service. Money collected by the program would be used to finance higher Medicare payments to providers of home health care.

Last year, Congress placed limits on Medicare home health expenditures to hold down the program's costs as well as to reduce fraud and abuse. However, complaints about the new payment schedule have been heavy, with home health agencies maintaining that money-saving efforts were forcing them to curtail important services to homebound patients. Since that time, hearings have been held and bills introduced in both the House and Senate. House Ways and Means Committee Chairman Bill Archer (R-TX), calls home health "a top priority" during the rest of this year's congressional session.

Several barriers may well forestall any congressional action this year, though. Opponents argue that the copayment would be unfair to Medicare beneficiaries living on fixed incomes. Additionally, there is disagreement within the home health industry on how the current payment system should be changed.

Tax Credits Possible for Clinical Trials

A Texas congressman has introduced a bill that would provide an incentive for private companies to conduct clinical trials at medical schools and teaching hospitals.

Representative Sam Johnson of Richardson, Texas, has introduced the Medical Innovation Tax Credit to provide a 20 percent tax credit for clinical trials conducted at academic health centers. The bill, H.R. 3815, is intended to boost private sector support for medical research as federal support continues to dwindle. Experts say government funding has decreased due to sharp changes in the health care market.

Similar legislation has recently been filed in the Senate by Sen. Alfonse D'Amato (R-NY), with Sen. Kay Bailey Hutchison (R-TX), as a co-sponsor.

Source: The TSBR Reporter, Vol. 9, No. 3

Texas Medical Foundation Board of Trustees

On July 11, 1998, six physicians were elected to the Texas Medical Foundation (TMF) Board of Trustees for a three-year term. These physicians are:

Mark L. Bing, M.D., Katy
John E. Eisenlohr, M.D., Dallas
William R. Jones, D.O., Georgetown
Hugh Lamensdorf, M.D., Fort Worth
Fred Merian, M.D., Victoria
Monte E. Troutman, D.O., Fort Worth

The election of TMF officers will occur again in 1999.

The TMF's current officers are:

John W. Meyer, M.D., President
D. Clifford Burross, M.D., President-elect
Donald M. Peterson, D.O., Secretary
Frank Bryant, Jr., M.D., Treasurer



AOA EYE ON FEDERAL AGENCIES

Y2K = Pay Update Delay?

In order to focus its resources on getting the Year 2000 (Y2K) computer problems solved, the Health Care Financing Administration (HCFA) will most likely delay implementation of the annual physician payment update (usually made on January 1 each year) and several provisions of the Balanced Budget Act of 1997. HCFA was told by an independent contractor that "making changes of any type to computer systems between October of 1999 and April of 2000 is a stupid thing to do because of the unstable environment in which they'll be operating." Administrator Nancy-Ann Min DeParle told representatives of physician groups at a July 16 meeting on the topic that the agency wants to work with physicians "to figure out an alternative if normal updates can't be made." Hitting literally closer to home, however, are points you will need to address in your own practice:

- * Will your vendors be there in the Year 2000? The Gartner Group, a statistical polling company, predicts that 40 percent of billing software vendors will abandon the marketplace rather than become Year-2000 compliant. Keep your eye on them - check their websites to see if the product you use to process claims will be Y2K compliant. If

your system is not Y2K ready, you may have to file paper claims in 2000 until you get the glitches worked out.

- * Data exchanges: Are you linked to other computers in a multi-site practice, or to a hospital? If so, you must coordinate with them to make sure you will be able to exchange data after 12-31-99.

- * Biomedical equipment: Much of this equipment is run by internal computers, which also need to be able to accept an eight-digit date format. This is a critical problem, as patients' lives could be at stake if a vital piece of medical equipment malfunctioned during a procedure. Check with your supplier or manufacturer on the status of any devices you use in your practice. The website the Food and Drug Administration has set up to track progress of devices is:
<http://www.fda.gov/cdrh/yr2000/year2000.html>.

For more information on Y2K status, check the following websites: www.itpol-icy.gov for status of government systems; www.year2000.com for private sector information.

Teleconsultations in Rural Health Professional Shortage Areas (HPSAs)

As of January 1, 1999, Medicare will pay specialists who provide consults via video communication systems to patients in rural health professional shortage areas, the HCFA wrote in a proposed rule published June 22 in the Federal Register. The proposal would implement a provision in the Balanced Budget Act of 1997 (BBA).

- * What's covered? A teleconsult for a Medicare-covered service that meets all the following criteria: 1) it involves an interactive patient encounter (including clinical assessment) in which a medical exam is directed by the consultant; 2) it utilizes multimedia communications equipment that includes at least two-way real-time audio and video; 3) the referring physician (or other practitioner) must participate under the consultant's direction at the level dictated by the patient's medical needs, and by the information needs of the consultant; and 4) the consultant must provide feedback to the referring practitioner.

Continued on next page

* Who can perform this service? Both the referring practitioner and the consultant may be either physicians, physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists or anesthesiologist assistants, certified nurse midwives, clinical social workers or clinical psychologists.

* How will it be reimbursed? The consultant will receive the full fee schedule amount he/she would otherwise receive for a consultation (minus the patient copay and deductible) but must pay 25 percent of that amount to the referring/referring physician. Site of service is considered the consultant's office - not where the patient is treated. HCFA plans to develop modifiers to use in teleconsults, but covered codes include 99241-99245, 99251-99255, 99261-99263 and 99271-99275.

To access the Federal Register online for complete copies of any of these regulations, go to:
http://www.access.gpo.gov/su_docs/aces/aces140.html.

Medicare+Choice Private Fee-for-Service Option

HCFA defines a private fee-for-service (PFFS) plan as a Medicare+Choice (M+C) plan that pays providers of services at a rate determined by the plan on a fee-for-service basis without placing the provider at financial risk; does not vary the rates for a provider based on utilization of that provider's services; and, does not restrict enrollees' choice among providers who are lawfully authorized to provide the services and agree to accept the plan's terms." Watch out for this odd hybrid of fee-for-service and managed care, part of the M+C interim rule published June 26 in the Federal Register. Even if you have not made a move to sign up with one of these plans, you will be treated as having a contract if you meet the following conditions:

1. You are aware that the patient receiving the services is enrolled in the plan. This can be through presentation of an enrollment card or other documenta-

tion by the patient, or through notice of the patient's enrollment by HCFA, a Medicare intermediary or carrier, or the plan itself. To know this, you cannot count on information you received during the patient's last visit. Check with the patient during each visit because until Year 2002, patients can join and quit M+C plans at any time. "If the provider fails to acquire current information from the enrollee or the plan at the time of each service, we do not see how he or she can be held to have met" this criterion, HCFA wrote. After 2002, this will tighten up a bit.

2. The services you provide to the enrollee are covered by the plan.

3. Before furnishing the services, you have a "reasonable opportunity" to learn about the terms and conditions of payment and coverage under the plan. After getting this information, "treating the patient implies consent" to these terms and conditions. HCFA has several requirements for this criterion, but physicians still must keep on top of the matter.

WHAT: The plan must "communicate" the following information: billing procedures, the amount the plan will pay for the service, the amount the physician is allowed to collect from the enrollee.

TO WHOM: The information above does not necessarily have to get right to the physician. HCFA will consider you to have been provided the information if the plan sends it to either the provider of the services, the provider's employee or billing agent, a partnership "of which the provider is a member," or "any party to which the provider makes assignment or reassigns benefits."

HOW: The information must be transmitted by mail, FAX, e-mail or telephone, OR the plan provides a toll-free number or e-mail address on the enrollment card where you can get the information. Announcements in newspapers, journals, magazines, TV or radio are not sufficient.

Standard National Coverage for Bone Mass Measurements

As of July 1, Medicare put a national coverage policy on bone density into place. Here are the key points, published an interim final rule June 24 in the Federal Register.

* HCFA's standard definition: Bone mass measurement means a radiologic, radioisotopic, or other procedure that is performed for the purpose of identifying bone mass, detecting bone loss, or determining bone quality. It is performed with either a bone densitometer (other than dual-photon absorptiometry) or with a bone sonometer system that has been FDA-approved for this use, and includes a physician's interpretation of the results.

* **Conditions of coverage:** Medicare will pay for medically necessary bone mass measurement if it is determined to be appropriate (this includes choice of the appropriate method) and ordered by a physician or a qualified non-physician practitioner. To be covered, the test must be performed under the appropriate level of physician supervision and be reasonable and necessary to diagnose, treat or monitor an eligible patient (see below).

* **Frequency:** Medicare will cover a bone mass measurement for a patient if "at least 23 months have passed" since the last one. However, it may be covered more frequently if medically necessary.

* **Patients eligible for coverage:** Women determined by a physician or a qualified non-physician practitioner to be estrogen-deficient and at clinical risk for osteoporosis based on her medical history and other findings; patients with vertebral abnormalities (shown in an X-ray) indicative of osteoporosis, osteopenia or vertebral fracture; patients receiving (or expecting to receive) glucocorticoid therapy equivalent to 7.5 mg of prednisone or greater per day for over three months; patients with primary hyperparathyroidism; patients being monitored to assess an FDA-approved osteoporosis drug therapy.

New System for Medicare Coverage Decisions in Early Stages

Two HCFA officials met with members of national specialty societies on July 8 to discuss development of a new process for determining what will and

will not be covered by Medicare. The agency issued a Notice of Proposed Rulemaking on the topic in 1997, but due to its controversial nature - specifically its mention of cost-effectiveness as a criterion for coverage - HCFA did not issue a final rule.

Instead, HCFA hopes to publish a final notice with comment period on the steps and process it uses to make coverage decisions by the end of the year. Specific decision-making criteria will not be in the notice. HCFA will get together with the "stakeholders" in each particular decision and get input, then publish guidance documents on coverage as needed.

When coverage decisions prove difficult or controversial, HCFA will refer matters to a Federal Advisory Committee, modeled on FDA advisory panels. This would have five or six subspecialty panels, and these would act as technical advisors on the state of science and state of knowledge pursuant to the topic at hand. The meetings of the advisory committee would be public and specialty societies would be able to provide expertise and testimony. Decisions that would have a significant impact on the Medicare program (cost) or Medicare population (quality of life) would most likely go to this committee. Members of the committee should not represent particular points of view, HCFA says. The agency wants

people on the committee who can make unbiased, scientific decisions, not advocates for certain causes. Requests for committee nominees will be published in the forthcoming notice.

Diabetes Self-Management Coverage Guidelines Released

As of July 1, Medicare covers training for diabetes outpatient self-management, but the National Diabetes Advisory Board (NDAB) standards you will have to meet in order to bill are arduous. HCFA spelled out coverage rules, along with the new HCPCS codes for the service, in a Program Memorandum to carriers. Your Medicare allowable rate (unadjusted for geographic locality) will be \$55.41 per hour for an individual session and \$32.62 per beneficiary per hour in a group session. To bill, use the following codes:

G0108: Diabetes outpatient self-management training services, individual session, per 60 minutes of training.

G0109: Diabetes outpatient self-management training services, group session, per individual, per 60 minutes of training.

Medicare deductibles and coinsurance apply. On the first claim for this service, you must include a "Certificate of Recognition" from the American Diabetes Association that affirms you are a recognized provider. Note: for the initial office

visit, HCFA says you should bill the appropriate E&M code; thereafter, use one of the codes above.

To access the Program Memorandum, which includes the NDAB standards, go to: <http://www.hcfa.gov/pubforms/transmit/ab983660.htm>.

Practice Expense Fairness Coalition (PEFC) Sees Problems with "Top-Down" Methodology

The PEFC, which consists of members of primary care-focused specialty societies including the AOA, has some key problems with HCFA's proposed change to practice expense methodology. Notably, it maintains the bias toward surgical specialties by starting with a set payment amount for each specialty; it uses data (from the American Medical Association Socioeconomic Monitoring System Survey) which has a number of drawbacks, including lack of information about D.O.s, low response rates and cross-walks for under-sampled specialties. Also, the Relative Value Update Committee (RUC) has never validated the time element of work RVUs, a key component in the new methodology. AOA is in the process of developing comments on the proposal.

TOMA HEALTH & REHABILITATION HOT-LINE

(800) 896-0680

Assistance - in complete confidence - is only a telephone call away.

The above telephone number is dedicated exclusively to osteopathic physicians seeking help for alcohol or chemical dependency or for friends/relatives who are concerned about a colleague with a possible problem.

The hot line insures immediate access to help and advice in strict confidentiality. A TOMA Field Representative, who works in conjunction with the TOMA Physician Health and Rehabilitation Committee, will answer the telephone. The hot line is staffed during regular weekday business hours.

The TOMA Physician Health and Rehabilitation Committee serves as an advocate for Texas osteopathic physicians with dependency problems.



Self's Tips & Tidings



By Don Self

Medicare+Choice

The most far reaching and radical change to hit the medical profession since the inception of Medicare and Medicaid will take place within the next 14 months. The Balanced Budget Act of 1997 requires the Health Care Financing Administration to offer a multitude of choices to Medicare beneficiaries, effective January 1, 1999. In October/November of 1998, HCFA will be mailing booklets/flyers to explain the different health plans to more than 39 million Medicare beneficiaries. In the opinion of this writer, less than one percent of those patients will understand what choices, options or plans will be best for them. For the vast majority of geriatric patients, the decision as to which health care plan to choose won't be a choice - it will be a gamble.

In November of this year, Medicare will offer open enrollment to patients in all of the Medicare + Choice plans, which include:

- * **HMOs (Health Maintenance Organization)**- The patient must obtain services from a designated network of providers with little or no out-of-pocket payments. The beneficiary may not have the choice of his/her own physician. As usual, clerks in the HMO will decide whether the patient needs the service or not, instead of the patient and the physician.

- * **HMO with a Point of Service (POS) Option** - This option permits the Medicare HMO patient to go outside of the network with a higher out-of-pocket expense. The beneficiary may choose his/her own doctor but, by doing so, has to pay more.

- * **PPO (Preferred Provider Organization)** - Similar to the HMO

option, the patient chooses which provider in the designated network, set up by their plan, to receive services from. Unlike the basic HMO plan, the patient may choose to go outside of the network and the plan will pay some of the costs based on a percentage, while the patient assumes the responsibility for the rest of the payment.

- * **PSO (Provider Sponsored Organization)** - Similar to HMOs, but the PSOs are formed, managed and directed by physicians and hospitals. This seems to be the plan that will try to incorporate the majority of physicians into "groups," so as to not lose the entire Medicare market share. Surprisingly, only a couple of these plans met the August 1st deadline to register so we can expect a large number to be trying to join the system in 1999.

- * **PFFS (Private Fee-For-Service Plans)** - The patient chooses a private indemnity type insurance plan, similar to purchasing private insurance today. The difference is that Medicare will pay the plan for covered Medicare services (with restrictions) and the patient is responsible for whatever the plan doesn't cover, as well as possible additional premiums. While patients do have their choice of physicians with this plan, their out-of-pocket expenses may be greater with this plan than with the other choices. Providers, on the other hand, will have an equal number of restrictions in reimbursement with this plan, just as they do with traditional Medicare.

- * **MSAs (Medical Savings Accounts)** - This is similar to a private insurance plan and a pay-as-

you-go plan. This is the most complicated of the choices and under the pilot program, only one percent (390,000) of the Medicare beneficiaries may participate. The patient chooses an MSA plan, which is a health insurance policy, and Medicare pays the premium to the plan. The patient uses the funds in the MSA to pay for services provided on a pay-as-you-go basis. There are no limits on what providers may charge the patient and, unlike all of the other Choice plans, the patient may not withdraw from the plan except during the withdrawal period of December 15 to December 31 of each year.

It is my view that Congress is doing Medicare what they have done to the Internal Revenue Service - complicating matters beyond repair. HCFA reports that currently, 19 percent of Medicare beneficiaries are enrolled in HMO Medicare. They anticipate that by the year 2005, more than 30 percent of the patients will be enrolled in one of the Medicare+Choice plans. This means that, by their estimates, approximately 70 percent of the patients will remain in the traditional Medicare program. I am not that optimistic, though. Based on past instances of confusion with Medigap, Medicare-Select plans, etc., I anticipate the number of patients enrolling in different Choice plans will be greater - with or without the beneficiary's knowledge. In this age where consumers are switched (without their permission) from one long-distance phone carrier to another, it is my belief that the geriatric patient will become a greater target than ever before.

It is also my prediction that patients, physicians and providers will remain confused and lost in this quagmire for years to come, as I will discuss in future

Washington Update

Organ Donation

New rules regarding organ donation took effect August 21 that may require significant changes in hospital procedures. Hospitals will be required to have an agreement with an organ procurement organization (OPO) under which the hospital will contact the OPO in a timely manner about all individuals who die or whose death is imminent in the hospital. The OPO will determine medical suitability for organ donation. The hospital is required to ensure, in collaboration with the designated OPO, that the family of each potential donor is informed of its options to donate organs, tissues, or eyes or to decline to donate. The individual designated by the hospital to initiate the request to the family must be an organ procurement representative or a designated requester who has completed a course offered or approved by the OPO in the methodology for approaching potential donor families and requesting organ or tissue donation.

Year 2000 Computer Problem

Medicare's year 2000 computer problem has delayed work by the Health Care Financing Administration (HCFA) on preparation of a new prospective payment system for home health services. Inequities in the interim payment system now in use will therefore remain in effect for longer than Congress anticipated when it provided for use of an interim payment system until a new prospective payment system went into effect on October 1, 1999. After recent subcommittee hearings on the problem, Rep. Bill Thomas (R-CA), chair of the House Ways and Means Health Subcommittee, said that Congress is likely to pass a minimal fix that will keep some home health agencies in business that might otherwise close. But Congressional leaders more recently have said that the Administration should take the lead in proposing what that fix should be.

Requirement for Surety Bonds for Home Health Agencies Will Not Be Enforced

Separately, HCFA has announced that it will not enforce a requirement that home health agencies (HHAs) obtain surety bonds, even though it has just published a regulation describing the surety bond requirement. In the preamble to the regulation, HCFA says "Because of significant concerns expressed by the United States Congress and HHAs, and notification that the General Accounting Office (GAO) is investigating issues surrounding the surety bond requirement we will suspend the compliance date until we evaluate the GAO report. Although the surety bond requirements remain in effect, the practical effect of this document is to absolve participating HHAs from having to show compliance with the requirements until 60 days following publication of a new final rule but no earlier than February 15, 1999."

Security Standards for Electronic Health Data Proposed

The Clinton Administration has proposed security standards for electronic health data. When finalized, the standards will apply to all health plans, health care providers and others that maintain or transmit health information electronically.

Further Delay in D.O. Appointment to MedPAC

On July 28, the GAO announced that the 1998 appointment of members to the Medicare Payment Advisory Commission (MedPAC) will be postponed for seven months. Therefore, those members of the Commission, whose appointments were to expire in September, automatically received a seven-month extension to their current terms. According to MedPAC and GAO officials, this extension will better accommodate the Commission's work schedule, so that now all of the 15 appointments end on April 30, 1998, 1999 and 2000. For the osteopathic medical profession, this decision means that the GAO will not have the opportunity to place an osteopathic physician on the panel until next Spring.

Sources: AOAHA Washington Update, AOA Washington Update

articles. For now, let's see if HCFA meets the deadline for mailing out notices, booklets and pamphlets on the new choices in October of this year. One report stated that HCFA doesn't have the funds to spend on this massive education campaign, which is being called the largest peacetime educational campaign in history. If they fail to meet the deadline, what will that do to the January 1, 1999 enrollment period?

In our monthly newsletter (to subscribe, call 1-888-DONSELF), we are going to cover each plan affecting our clients, as well as list those plans in which we would definitely not participate. (Visit: www.donself.com for more information.)

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F Y I

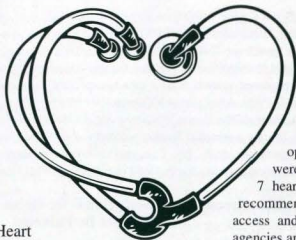
A website containing a free Year 2000 computer hardware test program, which can be run to check that your computer will be year 2000 compliant, was incorrect, as listed in this column in the September issue.

The correct website is as follows:
<http://v11.zdnet.com/scripts/y2k.pl>.

Special attention should be given when keying v11: (v as the letter v); (l as the letter l); and (1 as the number 1).

THE TEXAS COALITION ON CARDIOVASCULAR DISEASE AND STROKE

FACT: Heart disease and stroke are the *number one and number three killers* in the nation, but together they are the *number one drain* on health care resources.



FACT: The American Heart Association has estimated that *CVD will cost Americans \$274 billion* in medical expenses and lost productivity in 1998.

FACT: In Texas, heart disease claimed 42,330 lives (30.3% of all deaths) in 1996, up from 41,630 the previous year and *continues to be the leading cause of death*.

FACT: Stroke ranked third with *9,845 deaths* (7.0%), compared to 9,788 in 1995.

FACT: In 1995, there were approximately 185,000 Medicare hospitalizations in Texas for which CVD was listed as a principal cause for admission. *Medicare charges from CVD procedures alone in Texas were over \$500 million.*

FACT: The *highest mortality* is found among the *black population*, both in Texas and the U.S.

The health and economic burden of cardiovascular disease (CVD) and stroke is tremendous. As the number one and number three causes of death for all Texans, CVD and stroke are also the biggest drain on our health care resources with an annual estimated cost of over \$9 billion in direct health care costs alone. Together, CVD and stroke claimed the lives of over 52,000 Texans in 1996. Risk factors such as tobacco use, high cholesterol, high blood pressure, obesity, and physical inactivity can be controlled through lifestyle modification and appropriate use of medications.

Last spring, in response to these sobering statistics, the Texas Coalition on Cardiovascular Disease and Stroke was formed to explore ways to reduce the effect of heart disease and stroke on the state.

Coalition members include the American Heart Association, Texas Osteopathic Medical Association, Texas Medical Association, some of the state's major health plans and other representatives of the health care industry. Co-chairs are George Rodgers, M.D., and Clyde Yancy, M.D.

Following a July 8 meeting, recommendations and input from coalition members were drafted through the work of the primary prevention, secondary prevention and legislative/resource development committees. The report and recommendations were presented on behalf of the coalition during a August 7 hearing of the House Subcommittee on CVD. Initial recommendations include enhancing education, improving access and treatment, improving coordination of health care agencies and enhancing data collection.

The report noted that currently, there is no targeted state funding to evaluate and address the burden of CVD in Texas. In addition, surveillance information to evaluate the effectiveness and health outcomes of different programs is lacking. Public and private sectors must work together in a partnership if Texas is to achieve meaningful reductions in CVD and stroke.

The coalition concluded that while primary and secondary prevention can effectively reduce the rate of CVD and stroke, resources for research, education, prevention and treatment are insufficient and uncoordinated. Coordination at the statewide level is needed to ensure that all communities in Texas have access to effective primary and secondary prevention programs, such as the ones currently offered by various public, private and voluntary organizations.

Specifically, the report recommendations are as follows:

- 1) A panel of the state's leading experts in the prevention, treatment, research and education of CVD and stroke should be appointed and charged with the responsibility of developing an effective and resource-efficient plan to reduce the morbidity, mortality, and economic burden of CVD and stroke in Texas. Panel members would include providers, researchers, representatives from public health, third party payers, large employers, and patients and families whose lives have been affected by CVD or stroke.

- 2) Enhance, coordinate, and promote health education, public awareness and community outreach efforts through the Texas Department of Health and other public and private organizations.
- 3) Coordinate activities with groups that are addressing similar disease conditions and risk factors, such as the Texas Diabetes Council.
- 4) Identify and create incentives, not mandates, for providers and employers to encourage efforts in prevention, public awareness and treatment.
- 5) Evaluate the appropriate role and provide guidance for the following three areas of responsibility in prevention, public awareness and treatment:

Government

Health care system (providers, managed care organizations)
Patient and family

- 6) Improve access to appropriate prevention, public awareness and treatment strategies for all Texans, including the uninsured and those living in rural or underserved areas.
- 7) Enhance data collection and analysis related to CVD and stroke at the state and regional levels. Data is crucial for directing the activities of the panel in the most cost efficient manner. Data can be collected through existing avenues such as the Texas Department of Health, the Texas Health Care Information Council, hospital discharge data, insurance claims and other potential sources such as the Texas Medical Foundation and pharmaceutical companies. This data would be kept in the public domain for all interested parties to access and use. Data is needed for the following purposes:

- * To identify risk factor prevalence among youth and adults, with emphasis on special populations;
 - * To evaluate the morbidity, mortality and economic cost of CVD and stroke;
 - * To identify existing gaps between scientific knowledge and treatment and identify opportunities to improve quality of care; and
 - * To examine community data related to environmental influences affecting risk factors for CVD and stroke such as school, worksite and community policies and activities.
- 8) Emphasize to employers the importance of early identification and modification of risk factors and suggest methods by which they can assist their employees.
 - 9) Educate the Texas Education Agency and local school districts about the positive, long-term benefits of a public school curriculum that includes physical education, nutrition, and health education and their relationship to CVD and stroke prevention.
 - 10) Enhance systems of care by evaluating available clinical guidelines and developing uniform recommendation, not mandates, for acute and long-term treatment of patients with CVD or stroke. This cooperative process would involve health care professionals and managed care organizations from multiple entities in both the public and private sectors.

- 11) Communities should be given assistance and incentives in developing comprehensive prevention efforts at the local level.

- 12) A mechanism should be provided to evaluate the implementation and effectiveness of the above recommendations and ensure accountability.

Response to the coalition's recommendations was positive. William R. Archer, III, M.D., Texas Commissioner of Health, has expressed an interest in developing support structure within the Texas Department of Health to address CVD. In addition, Representative Dianne White Delisi, chair of the House Subcommittee on CVD, has lent her support and has suggested that the coalition further consolidate the presented recommendations.

Representative Delisi has agreed to present a summary of the subcommittee's report and recommendations to the House Public Health Committee on October 1. Upon approval of the recommendations, they will be submitted to the Speaker of the House as part of the House Public Health Committee's full report by October 16. Once the report is submitted to the Speaker's office, a bill may be filed for legislative action at any time during the upcoming legislative session. The coalition plans to work closely with Representative Delisi and Dr. Archer throughout the entire process.

TOMA will keep its members informed as to the work and progress of the coalition. In addition, a series of excerpts from the report will be printed in the next several issues of the *Texas D.O.*

The following are excerpts from the introduction of the report of the Texas Coalition on Cardiovascular Disease and Stroke, which was presented at the August 7 hearing of the House Subcommittee on CVD:

Report Introduction

Cardiovascular disease (CVD) refers to a group of diseases that target the heart and blood vessels and is the result of complex interactions between multiple inherited traits and environmental issues including diet, body weight, blood pressure and lifestyle habits. Common forms include heart disease, stroke and congestive heart failure.

A major cause of CVD is atherosclerosis, a general term for the thickening and hardening of the arteries. It is characterized by deposits of fatty substances, cholesterol and cellular debris in the inner lining of an artery. The resulting buildup is called a plaque. These plaques can partially or completely occlude a vessel and may lead to heart attack or stroke. Three of the major causes of atherosclerosis are 1) elevated levels of cholesterol and triglycerides, 2) high blood pressure, and 3) cigarette smoke.

Heart disease and stroke are not only the number one and number three killers in the nation (respectively), but together they are the number one drain on health care resources. According to the American Heart Association, 58,200,000 Americans are estimated to have one or more types of cardiovascular disease; these diseases claim more lives than the next seven leading causes of death combined. Additionally, about 4.9

million Americans live with the debilitating effects of congestive heart failure, which is the single most frequent cause of hospitalization of Americans age 65 or older. The American Heart Association has estimated that CVD will cost Americans \$274 billion in medical expenses and lost productivity in 1998.

In Texas, heart disease claimed 42,330 lives (30.3% of all deaths) in 1996, up from 41,630 the previous year, and continues to be the leading cause of death. Stroke ranked third with 9,845 deaths (7.1%), compared to 9,788 in 1995. Together these two diseases

rank 1 and 3 respectively as killers both nationally and in Texas. It is estimated that they cost the state more than \$9 billion dollars a year which totals over \$500 per Texan.

One quarter of the Texas population is enrolled in Medicaid and/or Medicare (4.6 million in Texas). In 1995, there were approximately 185,000 Medicare hospitalizations in Texas for which CVD was listed as a principal cause for admission. Medicare paid over \$1 billion dollars for these stays. Medicare charges from CVD procedures alone in Texas were over \$500 million.

Known as the silent killer, the first appearance of heart disease is all too often sudden and devastating. At least 250,000 Americans die each year from heart attacks within one hour of experiencing symptoms and before reaching a hospital. CVD is the number one cause of emergency room visits, and more money is spent on treating heart disease and stroke than any other cause of hospitalization. The average cost of coronary artery bypass totals \$44,200 per patient, not including rehabilitation and lost productivity. Approximately 10 to 20% of bypass surgeries are repeat surgeries, and after 10 years, up to 50% of bypass grafts will become occluded. The average cost of stroke is \$15,000 per patient not including rehabilitation and lost productivity. Of note, 10% of strokes exceed \$35,000.

In Texas, as well as nationally, mortality from CVD has been steadily declining over the past 17 years. Evidence from heart attack registers tells us that much of the fall in mortality is attributable to changes in risk factors, rather than advances in medical care. Nonetheless, CVD continues to be the major cause of death, particularly among Texas' minority populations. The highest mortality is found among the black population, both in Texas and in the U.S. Mortality for blacks from heart disease is almost 150% that for whites and almost twice that for Hispanics. Additionally, the mortality rate for stroke among blacks is about twice that for both whites and Hispanics.

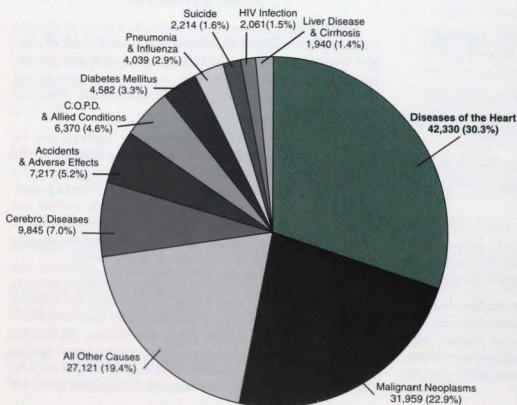
NEXT MONTH: "Risk Factors Driving Heart Disease and Stroke" and "Prevention Initiatives" excerpted from the report of the Texas Coalition on Cardiovascular Disease and Stroke.

Disease	*Rate
All Causes	736.4
Diseases of the Heart	223.2
Malignant Neoplasms	168.5
Cerebro. Diseases	51.9
Accidents and Adverse Effects	38.0
C.O.P.D. and Allied Conditions	33.6
Diabetes Mellitus	24.2
Pneumonia & Influenza	21.3
Suicide	11.7
HIV Infection	10.9
Liver Disease & Cirrhosis	10.2
All Other Causes	143.0

*Rate per 100,000 population

Sources: Statistical Services Division, Bureau of Vital Statistics, Texas Department of Health. Prepared by Health Information Research Team, Bureau of State Health Data and Policy Analysis, Texas Department of Health, May 1998.

Leading Causes of Death - Texas Residents, 1996 (Number and Percent of Deaths by Disease Category)



Osteopathic Medical Center First in Texas to Use New Heart Stabilizer

Cardiac surgeons at Osteopathic Medical Center of Texas have performed the first minimally invasive heart surgery in Texas using a Cohn Cardiac Stabilizer, a device just approved by the Food and Drug Administration.

The new device holds the heart in place during a surgery called a minimally invasive direct coronary artery bypass, or "mid-cab."

Albert Yurvati, D.O., a cardiovascular and thoracic surgeon at Osteopathic Medical Center of Texas, says the stabilizer makes the mid-cab surgery much easier to perform.

"Before, it was very difficult to get the heart still," Dr. Yurvati said. "With the new equipment, the heart is much more stable than it was using other devices."

Delbert Mully, the first patient to undergo a mid-cab at OMCT, is pleased with the results. Mully had undergone traditional open-heart surgery in April, 1997. A blockage recurred, and Dr. Yurvati recommended the mid-cab. The surgery took place on a Tuesday. He was out of the intensive care unit by Wednesday night.

"Last year, after the surgery, I was more tired and the breathing exercises I had to do were more difficult," Mully recalled. It took a month after the operation last spring before Mully could enter cardiac rehabilitation and resume driving. This time, the recovery would be shortened to about two weeks.

"I'm tickled to death," said the former high school athletic coach. "I feel like I'm free."

Dr. Yurvati and William Wallace, D.O., performed the surgery with the stabilizer for the first time July 7. Each physician has attended a specialized training course at the Advanced Laparoscopic Training Center in Marietta, Georgia, under the direction of

Dr. William Mayfield, a pioneer in minimally invasive heart surgery.

In a mid-cab operation, the patient does not have to be placed on a heart-lung machine. Because the surgery is performed by making a four-inch incision in the chest, the breast bone does not have to be opened as it is in conventional open-heart surgery.

Other advantages are shorter recovery times and a shorter hospital stay (typically three days for a mid-cab and about five to seven days for conventional open-heart surgery).

Mully was able to sit up in a chair the day of surgery. His time in the intensive care unit was an overnight stay, compared with the usual two to three days required for normal open-heart surgery.

Because the incision is smaller in a mid-cab, the danger of infection is also reduced. The incision for open heart surgery is usually 12 to 14 inches long.

"Not every patient is a candidate for the mid-cab," Dr. Yurvati said. "it's only for people who have blockages on the front side of the heart. But for those who are candidates, the benefits are enormous."

GERIATRIC MEDICAL FELLOWSHIPS

University of North Texas Health Science Center of Fort Worth

The University of North Texas Health Science Center at Fort Worth (UNTHSC) is located in the cultural district of Fort Worth, Texas. UNTHSC, in partnership with the Baylor College of Dentistry in Dallas and the University of North Texas in Denton, offers two-year fellowships to osteopathic physicians in internal medicine and family medicine. Experiences include:

- ☐ *Clinical Rotations* through hospital service, ambulatory clinics, long term care facilities, and home-visits.
- ☐ *Research Opportunities* incorporating the interests of fellows in specialty areas of geriatric medicine and dentistry.
- ☐ *Administrative Training* that includes a junior medical directorship.
- ☐ *Curriculum Development and Instructional Strategies* for a variety of audiences.

Integrated didactics, formal course work, and clinical opportunities provide the foundation of the fellowship experience. Fellows have an opportunity to enroll in the MPH or DPH degree programs during fellowship.

Funded by the Bureau of Health Professions of the Department of Health and Human Services, stipends are determined by the number of years in post-graduate training and professional work history. Applicants must be U.S. citizens or permanent residents, be osteopathic physicians, and have at least three years of post graduate training or work-related experience.

For further information contact Janice A. Knebl, D.O., F.A.C.P., Department of Medicine, Division of Geriatrics, 817/735-2108.

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Managed Care Reform Passes House of Representatives

On Friday, July 24, the House of Representatives passed the Republican-sponsored Patient Protection Act of 1998 (H.R. 4250) by a vote of 216-210. This managed care reform legislation was created by the House Republican Health Care Task Force, chaired by Representative Dennis Hastert (R-IL). The Democrats offered their own managed care reform proposal, the Patient Bill of Rights, introduced by Representative John Dingell (D-MI) and supported by Representative Greg Ganske, M.D. (R-IA).

Provisions in the Patient Protection Act of 1998 include a ban on "gag rules," and direct access to OB/GYNs and pediatricians. It also extends the "prudent lay person" standard of accessing emergency medical services to all managed care enrollees. The

difference between this protection and the protection in the Balanced Budget Act of 1997 that applied to Medicare and Medicaid beneficiaries is that "severe pain" is not a condition that would allow for mandatory emergency coverage. There are also restrictions on the use of out-of-network hospitals for emergency care.

Also included in the Patient Protection Act of 1998 is a provision requiring health plans to offer both an internal and an external appeals process to enrollees. In contrast to the Patient Bill of Rights, the Patient Protection Act would require enrollees to pay up to \$100 for the external appeal. In addition, the Patient Protection Act of 1998 includes medical malpractice reforms, which are supported by the AOA. However, the

legislation does not give enrollees the right to sue their HMOs, when insurer's actions negatively affect patient care. The AOA firmly believes that HMO liability is a fundamental element of managed care reform, and will continue to advocate for this protection in the Senate.

The Senate is expected to address the issue of managed care reform after their summer recess. During the recess, the AOA will continue advocating for the inclusion of osteopathic anti-discrimination language in the legislation. At that time, debate will again center on the Democrats' Patient Bill of Rights and the Senate Republican Patient Bill of Rights (similar to the House Republican package). The President has threatened to veto the Republican proposal.

HCFA Publishes Proposed Medicare Payment Scale

On June 5, the Health Care Financing Administration (HCFA) published the proposed Medicare physician fee schedule for 1999. Family practice physicians would get more and specialists will get less, however, the new rules close the gaps somewhat among specialties.

Among other things, the rules develop a resource-based system for determining practice expense relative value units (RVUs), as required by Congress in legislation enacted in 1993. The new method considers the cost of staff, equipment, certain items and services, overhead, supplies and rent in providing medical and surgical services in various settings.

Under HCFA's new "top-down" approach, code-specific values for 1999 would start with total specialty costs gathered from the American Medical Association Socioeconomic Monitoring System. The data would be used to calculate expenses generated for

each hour of a physician's work. The expense would then be multiplied by the total number of hours worked for each specialty as determined by Medicare claims data. The proposal would generate six "cost pools" from the actual practice expense data for each specialty: administrative labor, clinical labor, medical supplies, medical equipment, office supplies, and all other. The cost pools would then be allocated to individual procedure codes by HCFA.

The rules also offer a second option, a version of HCFA's June 1997 practice expense methodology proposal. This option proposed a "bottom-up" approach that used expert panel estimates of actual inputs for each procedure to build up to the direct practice expense.

The rules are scheduled to take effect January 1, 1999. Copies of the rule in the Federal Register can be accessed on the Internet at http://www.access.gpo.gov/su_docs.

DR. ROLAND CHALIFOUX EARNS BOARD CERTIFICATION IN NEUROLOGICAL SURGERY

Roland F. Chalifoux, Jr., D.O., of Fort Worth, has recently earned board certification in neurological surgery by the American Osteopathic Association.

He is a 1987 graduate of the University of New England College of Osteopathic Medicine in Biddeford, Maine, and a member of TOMA since moving to Texas.

"I have been in the Fort Worth, Texas, area now since July, 1995, and consider the Fort Worth metroplex my home, as do my wife and two children," Dr. Chalifoux notes. "I intend to continue practicing the art of neurosurgery and look forward to helping as many of Texas' residents for as long as I can."

TOMA extends its sincerest congratulations to Dr. Chalifoux on his achievement.

CDC Report: HIV Infection Rates Aren't Dropping

While the number of new AIDS cases has declined in recent years, data presented in the April 24 Mortality and Morbidity Weekly Report (MMWR) showed no accompanying decline in newly diagnosed HIV infections.

The report examined data from January 1994 to June 1997 for persons aged 13 and older who were diagnosed with HIV infection in 25 states that conduct name-based HIV surveillance in addition to AIDS surveillance. Texas was not among the states examined.

The number of new infections during this period remained "stable," with just a "slight" decline of two percent from 1995 to 1996, the most recent full year included in the analysis. In particular, the number of new infections among persons aged 13-24 are probably more indicative of current HIV trends because young people have initiated high-risk behaviors more recently.

Many of the new HIV infections in the 25 states occurred among African Americans, women, young men who have sex with men, and persons infected through heterosexual contact. Substantial increases were also observed among Hispanics.

The study tallied 72,905 infections during the survey period and reported that about 140,000 people in the survey area are infected with HIV. However, the 25 participating states only account for about 25% of HIV infections in the U.S., the Centers for Disease Control and Prevention (CDC) estimates that 200,000 people have HIV infection in states without HIV name reporting.

This survey is the first to track infection trends by looking directly at HIV test results as opposed to estimating the number of new infections by counting the people newly diagnosed with AIDS.

Source: *Texas HIV/STD Update*, Vol. 3, No. 2

Texas Department of Health Announces New Medicaid Expansion for Teenagers

As of July, 1998, more Texas teenagers are able to qualify for their health care through Medicaid. Medicaid has expanded the age and family income limits for teens, so that teenagers who are under 19 years old may now qualify, even if they did not qualify before.

Last year, Congress passed legislation helping states provide health care for children who are uninsured and whose families have low incomes. Each state develops its own Children's Health Insurance Plan (CHIP). The first phase of Texas' CHIP is an expansion of Medicaid for teens 15 to 18 years old whose family income is less than 100 percent of the federal poverty limits (FPL), which is about \$16,450 per year for a family of four. Teens born after September 30, 1983, are currently eligible at this family income level. Families must still meet other Medicaid requirements such as asset limits. This Phase I plan, to increase the number of Texas teens who can qualify for Medicaid, has been approved by the federal government.

Physicians are asked to help teenagers take advantage of this opportunity to get health care coverage. Through Medicaid, teens can receive medical and dental check-ups in addition to any necessary medical and dental treatments. Benefits include medicines, office visits, hospital care, medical equipment and supplies, and many other medically necessary services. Medicaid does not provide any cash benefits.

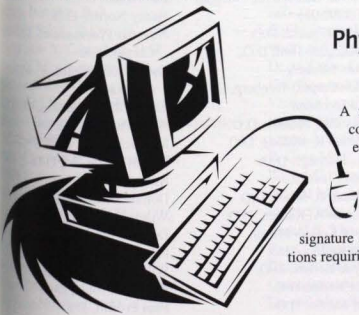
If you work with teenagers who need health care coverage and who may be interested in Medicaid, please ask families to contact their local Texas Department of Human Services (TDHS) office. The TDHS office will tell them how to apply for Medicaid and what documents and information they need to bring when they apply.

Teenagers from this new group who enrolled in Medicaid in July began appearing on the automation system after July 24, 1998.

Physicians Can Order Free Drug Samples Via the Internet

A new service from Physicians' Online, the largest Internet physician community, and Clark-O'Neil, the largest sample fulfillment company, can enable physicians to order free pharmaceutical samples via the Internet.

To use the free service, physicians must register with Physicians' Online at <http://www.po.com/>. After ordering samples online, physicians should print from their browser a pre-addressed, postage-paid signature form and mail it to Clark-O'Neil. This will satisfy government regulations requiring a signed form before samples can be mailed.





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INTERNAL MEDICINE — Immediate opening for BE/BC Internal Medicine D.O. at 54-bed hospital in Tyler, Texas. Approximately 30-member referral base with multiple specialties. Office space available within medical complex. PHO with approximately 400,000 insured individuals. Hunting, fishing, watersports, country clubs, university, junior college, many recreational facilities, civic and social opportunities. Contact Olie Clem, E.O., at 903-561-3771. (16)

DOCTOR NEEDED in various parts of Texas to work small hospital emergency rooms on weekends. Also, full-time/part-time primary care opportunities available. For more information, call Jerry at the Lewis Group at 800-460-8159. (20)

DALLAS/FORT WORTH — Physician opportunity to work in low stress, office based practice. Regular office hours. Lucrative salary plus benefits. No call, no weekends, and no emergencies. Please call Lisa Abell at 800-254-6425 or FAX CV to 972-256-1882. (25)

ORTHOPEDIC SURGEON needed in Dallas/Fort Worth for orthopedic consultations. No surgery, no weekends, no call. Contact Lisa Abell at K Clinic, 1-800-CLINIC K, (972) 255-5533 or fax CV to (972) 256-0056.

AMBULATORY FAMILY PRACTICE has opportunities for FT/PT BC/BE FP. Full benefits package for FT including malpractice, paid time off, expenses for CME/Lic. fees. Flexible schedule, no night call, no hospital work, no administrative hassles. Enjoy the lifestyle afforded by the Metroplex. Please FAX CV to 817-283-1059 or call Shannan at 817-283-1050. (36)

OFFICE SPACE AVAILABLE

GULF COAST CLINIC — 4,100 sq. ft. to include lab and (4) suites. Near Navy base on beautiful Gulf of Mexico. Growing community. Hospital and nursing home three blocks away. Lease (possible purchase in future). Contact Mrs. Kumm at 512-758-3660. (17)

MISCELLANEOUS

PRACTICE FOR SALE — Busy, lucrative, solo practice located in the mid-cities area of Dallas/Fort Worth. Good mix of family practice and industrial medicine. Fully equipped office. Take over/purchase this well established practice. Willing to finance purchase. Reply to: P.O. Box 201887, Arlington, TX 76006-9998. (08)

FOR SALE — 3 rooms of medical equipment for family practice, both old and new - all in excellent condition. \$5,500. Contact Dr. Laura Rice at 817-277-6444. (10)

FOR SALE — Late model MA X-ray and processor with view box and accessories; hydraulic stretcher; transport stretchers; Coulter counter and diluter; storage cabinets; office desk; assorted other items - very good condition. Contact: Dr. Glen Dow or Office Manager, 817-485-4711. (48)

FOR YOUR INFORMATION

OSTEOPATHIC AGENCIES

American College of Osteopathic Family Physicians	800/323-0794
Texas Society of American College of Osteopathic Family Physicians	888-892-2637
	512/708-9959
American Osteopathic Association	312/202-8000
	800/621-1773
Washington Office	202/544-5060
	800/962-9008
American Osteopathic Healthcare Association	
	301/968-AOHA (2642)
Dean, Jacobson Financial Services	
For Premium Rates, Enrollment & Information	800/321-0246
TOMA Major Medical Insurance	800/321-0246
TOMA Disability Insurance Program	800/321-0246
UNTHSC/Texas College of Osteopathic Medicine	817/735-2000
Dallas Metro	429-9120
Medicare Office	
Part A Telephone Unit	800/813-8868
Part B Telephone Unit	903/463-4495
Profile Questions	214/766-7408
Provider Numbers	
Established new physician (solo)	214/766-6162
Established new physician (group)	214/766-6163
All changes to existing provider number records	214/766-6158
Medicaid/NHIC	512/343-4984
CHAMPUS/General Inquiry	800/406-2833
Texas Medical Foundation	512/329-6610
Toll free	800/725-9216
Texas Osteopathic Medical Association	512/708-TOMA (8662)
in Texas	800/444-TOMA (8662)
	FAX: 512/708-1415
	E-Mail: tomta@txosteio.org
TOMA Physicians' Health and Rehabilitation Program	800/896-0680
TOMA Med-Search	800/444-TOMA

TEXAS STATE AGENCIES

Texas Health and Human Services Commission	512/416-0366
Department of Health	512/458-7111
Department of Public Safety:	
Controlled Substance Division	512/424-2188
Triplicate Prescription Section	512/424-2189
Texas State Board of Medical Examiners	512/305-7010
	FAX: 512/305-7006
Registration	512/305-7020
Formal Complaints	800/201-9353
Consumer Disciplinary Hotline	800/248-4062
Texas State Board of Pharmacy	512/305-8000
Texas Workers' Compensation Commission	512/448-7900
Medical Review Division	512/707-5889
Texas Hospital Association	800/252-9403
Texas Department of Insurance	512/463-6169
Texas Department of Protective and Regulatory Services	512/450-4800
Texas Poison Control Center Network	800/POISON-1
	800/764-7661

FEDERAL AGENCIES

Drug Enforcement Administration	
For state narcotics number	512/424-2000 ext. 2150
For DEA number (form 224)	214/640-0801
Diversion policy & related questions	214/640-0849

CANCER INFORMATION

Cancer Information Service	713/792-3245
in Texas	800/392-2040

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