TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volumn LVI, No. 2

February 1999

How Will Texas Lawmakers Effect the Future of Your Practice?

Continuing Coverage of the 76th Legislative Session — page 7

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Inside This Issue

Articles in the ***Texas D.O.*** that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising" according to Texas Gov't Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the ***Texas D.O.*** is required by that law: Terry R. Boucher, Executive Director, TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634.

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

FEBRUARY 1999

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Texas D.O. is the official publication of the Texas Osteopathic Medical Association.

Published eleven times a year, monthly except for July. Subscription price is $50 per year.

Texas D.O. does not hold itself responsible for statements made by any contributor. The advertising contained in this magazine is not necessarily endorsed by the Texas Osteopathic Medical Association.

Published by the Texas Osteopathic Medical Association, Volume LVI, No. 2, February, ISSN 0275-1453.

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

Publication Design and Layout
Sherry Dalton

CALENDAR OF EVENTS

FEBRUARY

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
Fax: 512-708-1415

21-26

"Ski & CME Midwinter Conference"
Sponsored by the Colorado Society of Osteopathic Medicine
Location: Keystone Lodge & Resort
CME: 39 AOA 1-A hours
Contact: Patricia Ellis, 650 S. Cherry Street, #440
Denver, CO 80246
303-322-1752 or 800-527-4578
Fax: 303-322-1956

24

"Physician Risk Management Seminar"
Sponsored by Osteopathic Health System of Texas
Time: Noon - 4:00 p.m.
Location: V. L. Jennings Outpatient Pavilion
1001 Haskell St., Fort Worth, TX
Contact: Julie at 817-735-4466, Ext. 212

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

6-9

"12th Annual Texas HIV/STD Conference"
Sponsored by the Texas Department of Health Bureau of HIV & STD Prevention
Location: Austin Convention Center
Contact: Dan Warr: 512-490-2535; Fax: 512-490-2538

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

22-25

"97th Annual Spring Convention"
Sponsored by the West Virginia Society of Osteopathic Medicine
Location: Glade Springs Resort, Daniels, WV
Contact: 304-345-9836

APRIL 29 - MAY 2

"102nd Annual Convention"
Sponsored by the Indiana Osteopathic Association
Location: Radisson Hotel at Star Plaza, Merrillville, IN
CME: 30 1-A hours anticipated
Contact: Indiana Osteopathic Association
800-942-0501 or 317-926-3009

MAY

3 - 5

"Environmental Trade Fair '99"
Sponsored by the Texas Natural Resource Conservation Commission
Presentations will concentrate on the "what to do" and""how to do it" of complying with environmental regulations.
Location: Austin Convention Center
Contact: Sandra Flores: 512-239-6651
e-mail sflores@tnrcc.state.tx.us
Israel Anderson: 512-239-5318
e-mail ianderson@tnrcc.state.tx.us

JUNE

17-20

"100th Annual Convention"
Sponsored by the Texas Osteopathic Medical Association
Location: Hotel Inter-Continental, Dallas, TX
CME: 26 Category 1-A hours
Contact: TOMA, 800-444-8662; 512-708-TOMA
Fax 512-708-1415

CMDS Seeks Assistance

Dear Doctor:

Each year, the University of North Texas Health Science Center-TCOM chapter of the **Christian Medical & Dental Society (CDMS) send a mission to undeserved areas of the Texas/Mexico border.** Student doctors, physicians, various health care professionals and other volunteers devote much time and energy to this Annual Spring Break Medical Mission, **serving several hundred impoverished patients each year**. This year, we will be serving the border area of Reynosa, Mexico/Mission, Texas, March 15-18.

Crucial to the success of the mission are the many generous donations and efforts of volunteers. **There is a great need for supplies, and especially dental care.** In addition to pharmaceuticals, we aim to supply each patient with a care package, consisting of personal hygiene products. We would also like to supply infant care packages to needy families.

Please seriously consider making a commitment to aid in this mission. If you can help in **ANY** way **please take a moment to complete the reply form**. Your help is essential to the ministry.

Thank you sincerely,

Please return replies to:
UNTHSC-CMDS
Laura Golightly, Box 306
3500 Camp Bowie Blvd.
Fort Worth, Texas 76107

Laura Golightly
President, UNTHSC-CMDS
Class of 2001

Inquiries can be made by email to: *lgolight@hsc.unt.edu*

.....

Name/Address _____

_____ I am interested in attending for the dates _____

_____ I can send _____ who is my nurse/hygienist on my behalf for the dates _____.

_____ Please send more information regarding _____

_____

_____ I am willing to collect pharmaceuticals/donate supplies. Please have someone from CMDS contact me at: office _____
home _____

_____ I cannot attend, please accept this donation in the amount of:
$25 $50 $100 $250 $500 other _____

THANK YOU!!!!

Additional Bills of Interest Filed by Texas Lawmakers

SB 99 relates to testing for accidental exposure to hepatitis B or hepatitis C. This legislation would add a new subchapter to the Health and Safety Code entitled, "Testing for Accidental Exposure." In the case of accidental exposure of a health care worker to blood or other body fluids of a patient in a licensed hospital, the hospital would be authorized to test the patient for hepatitis B or hepatitis C without the patient's specific consent to the test. The hospital would then notify the patient and the health care worker of the test results.

HB 141 relates to health benefit plan coverage for certain sight-corrective procedures. This bill would amend the Insurance Code to specify that certain health benefit plans must provide coverage for the diagnosis and treatment of deficient vision, including: 1) consultation with an eye care provider; 2) eye exams and other diagnostic procedures; 3) corrective lenses, including eyeglasses or contact lenses; 4) corrective surgery; and 5) other measures for the diagnosis and treatment of deficient vision to be determined by rule by the commissioner.

Additionally, the health benefit plan must provide coverage for at least one pair of eyeglasses or contact lenses each year, and must provide written notice to enrollees regarding this coverage.

HB 459 relates to the release of certain workers' compensation records to certain persons. The Labor Code would be amended to include the release of information on a claim to a litigant in a subsequent lawsuit in which the employee's prior injury information may be relevant. This legislation would take effect September 1, 1999, and would apply only to a request for information made with respect to a suit that is commenced on or after that date.

HB 494 relates to drug benefits available under certain health care programs administered by the Texas Department of Health. The Human Resources Code would be amended by adding a new section entitled, "Drug Reimbursement Under Certain Programs." This legislation stipulates that the department shall require a recipient of medical assistance to exhaust drug benefits available under the medical assistance program before reimbursing the recipient, pharmacist or other health care provider for drugs purchased by or on behalf of the recipient under the Kidney Health Care Program or the Chronically Ill and Disabled Children's Services Program.

The Health and Safety Code would also be amended by adding a section on Drug Rebates, which states that the department shall develop a drug manufacturers rebate program for drugs purchased by or on behalf of a client of the Kidney Health Care Program or the Chronically Ill and Disabled Children's Service Program for which rebates are not available under the Medicaid drug manufacturers rebate program. The average percentage savings from rebates in the new program may not be less than the average percentage savings from rebates in the Medicaid drug manufacturer rebate program. In addition, the department, by rule, would require all drug manufacturers to participate in the rebate program as a condition of reimbursement for the manufacturers' drugs under the two previously mentioned programs. Amounts received by the department under the drug rebate program would be appropriated only for the Kidney Health Care Program or the Chronically Ill and Disabled Children's Services Program.

HB 517 relates to Medicaid reimbursement for certain medical consultations. Basically, this legislation would ensure that physicians and other health care professionals who practice in a

The 76th Texas Legislature officially convened January 12

As always, TOMA is monitoring legislation of interest to the profession and will keep the membership informed of any action that may need to be taken on specific bills.

As a continuation of last month's article on pre-filed bills, this is a synopsis of additional bills of interest to the practice of medicine in Texas.

health facility, an accredited medical school or a teaching hospital that is affiliated with an accredited medical school, would be reimbursed for telemedical consultations. This deletes the requirement of reimbursement only in rural counties and/or rural health facilities.

HB 518 relates to the use of telemedicine in the state Medicaid program. The Human Resources Code would be amended by adding a section entitled, "Telemedical Consultations in Certain Medicaid Programs." This legislation relates to the Early and Periodic Screening, Diagnosis, and Treatment Program (EPSDT) and stipulates that a telemedical consultation may be held if an in-person consultation with a health care provider is not reasonably available where the child resides or works. A telemedical consultation would not be required if an in-person consultation with a health care provider were reasonably available.

The department, in its rules governing the EPDT Program, would require a health care facility that receives reimbursement for an EPSDT Program service provided through a telemedical consultation to establish quality of care protocols and patient confidentiality guidelines to ensure that the telemedical consultation meets acceptable standards of patient care and legal requirements. Further, the Texas State Board of Medical Examiners and the State Board of Dental Examiners, in consultation with the department, may adopt rules as necessary to: 1) ensure that appropriate care is provided to a child who receives an EPSDT Program service through a telemedical consultation; and 2) prevent abuse and fraud resulting form the use of a telemedical consultation in the EPSDT Program, including rules relating to the filing of a claim for reimbursement and the maintaining of records related to a telemedical consultation.

HB 519 relates to the creation and operation of a telemedicine pilot program to provide certain workers' compensation medical benefits. This legislation would amend the Labor Code by adding a new subchapter entitled, "Telemedicine Pilot Program." The commission, in cooperation with the Texas State Board of Medical Examiners and the governing body of the academic health center at The University of Texas Medical Branch at Galveston, would establish a pilot program in the use of telemedicine within the workers' compensation system to be provided through regional telemedical centers. The pilot program would be operated initially in the Houston-Galveston statistical metropolitan area. After April 30, 2000, the commission could expand the operating area covered by the pilot program as the commission determines to be appropriate.

The Texas Workers' Compensation Commission would analyze the results of the pilot program and report to the 78th Legislature not later than February 1, 2003. At that time, the commission would include any recommendations for further legislative action regarding the provision of workers' compensation medical benefits through the use of telemedicine.

10 YEARS AGO IN THE *TEXAS D.O.*

* A 19-member Commission on Nursing, convened by the Department of Health and Human Services, completed a report addressing the nurse shortage plaguing the U.S. The commission noted that the solution was not just higher pay, but also in letting nurses be nurses once again.

The report stated, "With increasing frequency, nurses provide services that should be carried out by other health care workers." In the last five years, the nation's hospitals had laid off 100,000 staff employees and added their duties to those of the nurses.

The panel did call for higher pay for nurses, but said: "Increasing compensation alone, however, will not be sufficient to resolve the shortage. Attention must also be given to increasing professional recognition, increasing representation of nurses on policymaking, regulatory and accreditation boards as well as increasing the use of more collaborative approaches between nurses, other health care professionals, and management." Without steps to counter it, the nurse shortage is likely to get worse, the report said.

* David M. Richards, D.O., president of the Texas College of Osteopathic Medicine, was named to the board of directors of Fort Worth Osteopathic Medical Center, which serves as the teaching hospital for TCOM.

* The Dallas Southwest Osteopathic Physicians, Inc., made two grants to the Southwest Division of the Dallas Police Department. One was the donation of a 1988 van for the police storefront and the other was a grant for two McGruff costumes. Dr. Joseph L. LaManna, chairman of the board of Dallas Southwest Osteopathic Physicians, Inc., presented the keys to the van to Deputy Chief Rick Hatler. This was the fifth van donated by the group.

* Richard M. Hall, D.O., of Eden, was one of seven D.O.s inducted as new Fellows by the American College of General Practitioners in Osteopathic Medicine and Surgery.

* Unisys Corp., an information systems firm based in Pennsylvania, was awarded a $15.9 million five-year contract to operate the national practitioner data bank. Authorized by the Health Care Quality Improvement Act of 1986 and the Medicare and Medicaid Patient and Program Protection Act of 1987, the data bank was scheduled to become operational by the summer.

"Healthy Families, Healthy Community" Health Fair

Student Movement of the Medicine Public Health Initiative

By John Paul Benavides, M.S., MSII

Most medical students find it exceedingly easy to overlook the reasons why medicine is their chosen path. You may recall your personal experiences with anatomy, biochemistry, pharmacology, microbiology, or pathology and quickly recall how immersed one can become in subjects that, at the time, seem so overwhelming. Even without the responsibilities of having a family of your own, you quickly learn how valuable your time can be. While in medical school, the time remaining in the day not spent on medicine is rationed with much thought and intention. Too often, important aspects of our lives suffer when faced with the demands of medical school. Whether it be our family life, our spiritual life or our physical well being, some aspects of ourselves may suffer when trying to survive medical school. Unfortunately, this often includes loosing sight of one of the main reasons for becoming a physician; the altruistic component of helping and caring for others.

It is in this light that my participation with the "Healthy Families, Healthy Community" Health Fair, lead by the University of North Texas Health Science Center - Texas College of Osteopathic Medicine (UNTHSC-TCOM) student chapter of the Medicine and Public Health Initiative (MPHI) and Texas Association of Latin American Medical Students (TALAMS), was such a grounding experience. The fair was held in observance of National Osteopathic Medicine Week at the Northside Multicultural Center in Fort Worth on November 1, 1998. Over 40 students, mostly first and second year TCOM students, devoted their time to this event. The health fair was a multi-student organization collaboration that also included the UNTHSC campus police, faculty physicians, and staff. Blood pressure screening, glucose checks, and flu shots, as well as some impromptu OMT, were provided to this largely Hispanic community, along with information on various subjects, including diabetes prevention, child vaccinations, safety and trauma prevention, and osteoporosis. Food and drinks were provided, as well as a raffle, which gave away over $600 worth of medically related door prizes. The Fort Worth Zoo provided entertainment for the families and students alike, which highlighted the afternoon activities. After all was said and done, the health fair attracted over 160 community participants; surpassing even the organizers' expectations.

To become excellent physicians we must all struggle through the rigors of medical school but we must also remember why we put ourselves through such a demanding workload. The principles of serving and helping people and their communities should be a part of the answer. Taking the time to reorient our priorities can help us emerge from our medical training more like the physicians we hoped we would be. Events such as the Northside Health Fair are vehicles that facilitate the recall to our individual missions in life. By participating directly in the well being of the community, we are not only serving, but are also training in becoming a caring physician. Congratulations to all those that helped see this event through its fruition and make it the success it was.

We ask for your support of these health care initiatives and your contributions - tax-deductible donations - will aid us in continuing with our objectives and expanding our project ideas. Thank you.

Please send contributions to

Student Chapter of the Medicine/Public Health Initiative
Box 298
University of North Texas Health Science Center
at Fort Worth
3500 Camp Bowie Boulevard, Fort Worth, TX 76107-2699

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

LEGAL ASSOCIATE APPOINTED AT HEALTH SCIENCE CENTER

Attorney William S. LeMaistre has been appointed associate general counsel for the University of North Texas, Denton, and for the UNT Health Science Center, Fort Worth.

Since 1990, LeMaistre has served as senior assistant attorney of Harris County, representing that county's hospital district that includes three hospitals and ten community clinics, including specialty clinics for dental care and for HIV/AIDS services. He also served as counsel for the Harris County Hospital District's HMO, Community Health Choice, Inc.

UNT and UNT Health Science Center officials note that LeMaistre will be based at the health science center and will work under the direction of Richard Rafes, J.D., Ph.D., vice chancellor and general counsel, together with other of the UNT system's legal staff.

LeMaistre earned his B.A. degree in political science from Austin College, Sherman, and his J.D. from the University of Texas School of Law. He also has a master's degree in pubic health from the University of Texas School of Public Health.

LeMaistre was a briefing attorney for Chief Justice McCloud of the Eleventh District, Texas Court of Appeals, from 1982 to 1983; and was law clerk to Judge Ricardo Hinajosa of the Southern District of Texas, U.S. District Court, from 1983 to 1984. He is a member of the Health Law Section of the State Bar of Texas and the American Health Lawyers Association.

THE FACTS ON BOARD CERTIFICATION

Why Become Board Certified?

Certification can be the key to a successful practice. It can increase your reimbursement rates and increase participation in many third party programs. A more knowledgeable public now uses certification as a factor in choosing a health care provider and certification reinforces the professional standing of osteopathic physicians in the health care community.

What to Expect on the Exam

The exam is in two parts: written examination and performance evaluation. The written consists of approximately 400 multiple-choice questions in a variety of areas, which include general medicine, surgery, behavioral sciences, pediatrics, OB/GYN and sports medicine. The other half day session is a "hands on" performance evaluation. The candidate is given a questionnaire to complete and is assigned a random case history. He or she is then asked to diagnose the case and demonstrate the osteopathic manipulative treatment.

When Are Exams Administered?

Exams are given twice a year: In the spring before the ACOFP Annual Convention and in the fall before the AOA/ACOFP Convention. Each has its own application cut off date. For the upcoming exams, applications must be postmarked July 2, 1999 for the October 23 - 24, 1999 exams in San Francisco and early December of 1999 (postmark deadline not yet determined) for the April 1 - 2, 2000 exams in Las Vegas.

Who is Eligible

You are eligible to sit for the certification exam if you completed an osteopathic family medicine residency program or if you are within four (4) months of completing your family medicine program.

If you did not complete a residency program, you have until the year 2001 to sit for the exam through the clinical pathway. After the year 2001, you must complete a residency program to be board eligible.

Those who have completed an ACGME Family Medicine residency program may still be able to become certified in osteopathic family medicine. Call the Education Department of the AOA at (800) 621-1733 to apply to have your ACGME program and training approved. There is no fee to apply for this approval.

Those completing an AOA approved internship but not a residency program may apply if they have practiced for a minimum of six years and have documented per the AOA Individual Activity Report at lease 600 applicable CME hours of AOA approved postgraduate work prior to application for the exam. All applicants must be a member in good standing of the AOA.

Questions?

Additional information is available by contacting the American Osteopathic Board of Family Physicians at 847-640-8477.

Texas ACOFP UPDATE

Delegates Needed to Represent Texas

Texas will be submitting three resolutions to the ACOFP Congress of Delegates for adoption. They are: Onsite Lab Work, which supports the ability of the family practitioner to perform appropriate in-office testing and diagnostic procedures; Patient Bill of Rights, which promotes equal access to the patient's choice of medical care; and HMO Reimbursement for OMT, which requires that medical payment plans reimburse OMT as a reasonable rate.

Texas ACOFP is still in need of delegates to represent us at the AOCFP Annual Congress of Delegates. If you are planning to attend this convention and are willing to serve on March 19 - 20 in San Diego, please contact Janet Dunkle at 888-892-2637.

Tips on Contacting Your Elected Officials

With the 76th Legislative Session underway, you may be interested in contacting your local representatives regarding health care issues.

Reminder of some rules of communication with members of the Texas Legislature

Letters from constituents carry more clout than letters from non-constituents. If you do not know your elected officials for state and federal offices, contact TxACOFP at 888-892-2637.

Form letters to elected officials at the state and federal level count as one response. Example: If 100 form letters are received on an issue, the 100 form letters carry the same clout as 1 hand-written letter from a constituent back home.

Mail from constituents of elected officials is opened before out-of-district mail is opened. A voter is ranked higher than a non-voter.

You will receive important updates on legislative issues concerning health care throughout the session.

You can also receive the most up to date information on legislative activities by accessing the legislative website at http://www.capitol.state.tx.us/stateleg.htm.

AOA EYE ON FEDERAL AGENCIES

The Department of Health and Human Services' Office of the Inspector General (OIG) will put physician evaluation and management coding under its microscope during Fiscal Year 1999. "Previous work by the OIG has found that physicians do not accurately or uniformly use visit codes," the OIG FY 99 Work Plan states. "We will assess whether physicians are correctly coding evaluation and management services in locations other than teaching hospitals and whether carriers are adequately monitoring physician coding."

Other topics to fall under OIG inspection

* Physicians with excessive nursing home visits (such as an excessive number of visits in a given day and excessive visits to the same patients) - OIG will identify and audit these billings.

* Financial impact of provider-based status of hospital-owned physician practices - OIG will determine "whether and to what extent Medicare expenditures are increased as a result of physician-hospital integration and identify other potential vulnerabilities, such as questionable patient referral practices."

* Improper billing of mental health services in nursing facilities - HCFA should develop guidelines for carriers, billing screens, focused medical review and physician education to prevent inappropriate payments.

* Physicians at teaching hospitals (PATH) - OIG will verify compliance with Medicare payment rules governing physician services provided in the teaching setting, and make sure that documentation supports the level of service billed.

HHS OFFICE OF THE INSPECTOR GENERAL FY 99 WORK PLAN FOCUS WILL INCLUDE OFFICE VISIT CODING AND EXCESSIVE NURSING HOME VISITS

* Automated coding software - OIG will contact physicians with recent billing errors to determine if they used automated software to prepare the claims. The Office "will determine if errors found in Medicare billings for physician services are associated" with such software.

* Billing service companies - a review will determine whether Medicare claims prepared by billing companies are properly coded, and whether contracts between providers and billing services meet Medicare criteria. Past OIG investigations have shown that billing service companies may be upcoding and/or unbundling procedure codes to maximize Medicare payments to physicians," OIG says.

* Reassignment of physician benefits - OIG will evaluate the practice of allowing doctors to reassign their billing numbers to clinics.

*Improper billing of psychiatric services - OIG will examine inappropriate billing of both individual and group psychotherapy.

*Patient billing records - OIG will review a sample of physician's patient billing records in one state. If significant problems are found, it will expand the review.

Hold off on billing new flu and pneumonia vaccine codes to Medicare until after April 1, 1999

Though new HCPCS codes for pneumococcal (90669) and influenza virus (90657, 90658 and 90659) vaccines were slated to take effect January 1, 1999, don't bill them until after April 1. "Because of required changes and testing tin our claims processing systems for Y2K compliance," HCFA explained in a letter to physician associations, carriers will not be able to update their systems until then. "We have informed our Medicare contractors to continue to accept and process bills containing the old codes and to hold claims containing the new codes until April 1, 1999."

HCFA engaged in review of physicians with five or more reassignments

If you have reassigned your billing number to five or more sites, you likely will be contacted by your Medicare carrier. "Reassignment" means turning over your billing rights (and number) for Medicare services performed in a facility to the facility in return for a flat fee or salary.

HCFA suspects that multiple reassignments may indicate that some are illegitimate or out of date. The agency instructed carriers to write physicians "with the highest numbers first," and ask them to "verify their active payment arrangements." HCFA will ask these physicians to turn in the Reassignment of Benefits form 855R for each arrangement.

Any arrangements other than those submitted by the physicians will be removed from carrier lists unless recent activity is discovered. In such a case, carriers will investigate whether a facility is misusing a physician's UPIN.

Omnibus Appropriations Act for FY 1999 funds health policy changes

The Omnibus Appropriations Act for Fiscal Year 1999 provides funds to create or continue other Medicare and Medicaid policies that will directly affect physicians. Some provisions of the Act:

* Number of Commissioners to serve on the Medicare Payment Advisory Commission (MedPAC) increased from 15 to 17. Terms for new members begin on May 1, 1999.

* Directs HCFA program management funds for more audits of physicians and other health care providers.

continued on next page

* The Administration on Aging will test different training models for teaching Medicare patients how to detect and report Medicare fraud and abuse.

* Rules governing physician supervision of anesthesia services should be based on scientifically valid outcome data. The Agency for Health Care Policy and Research and affected professional organizations should study mortality and adverse outcomes by different types of anesthesia providers.

* HCFA should increase Medicare payment for Pap smears and other cervical cancer screening technologies to bring it into line with costs for the tests.

* Prohibits any development of a unique individual health identifier until legislation on the topic is in effect.

* Creates a National Center for Complementary and Alternative Medicine within the National Institutes of Health.

Rx Rundown: New FDA-approved drugs/biologics, and warnings

Enbrel (etanercept) approved November 2, 1998 - a new genetically engineered protein that helps reduce the symptoms of moderate to severe active rheumatoid arthritis in patients who have not responded well to other treatments. It can be used in combination with methotrexate, but is not approved to treat other kinds of arthritis. The drug will be co-marketed by the Immunex Corporation, Seattle, Washington, and Wyeth-Ayerst Laboratories, Philadelphia.

Tasmar warning: issued November 16, 1998 - used for Parkinson's Disease. Due to findings of fatal liver injury associated with the drug, labeling now states that the drug should be reserved for use only in patients who do not have severe movement abnormalities and who don't respond to or who are not appropriate candidates for other available treatments. The warning calls for increased liver monitoring (every two weeks) if a physician elects to treat patients with Tasmar. Doctors should also advise their patients to self-monitor for classical signs of liver disease such as jaundice and nonspecific ones such as fatigue and loss of appetite. If a patient does not show a substantial clinical benefit within the initial three weeks of treatment, he/she should be withdrawn from the drug. Report all cases of liver injury in Parkinson's patients to MEDWATCH (800-FDA-1088). For more information, call the FDA at 888-INFO-FDA.

Bipartisan Medicare Commission considers reform options, but comes to no conclusions:

At its December 2 meeting, the National Bipartisan Commission on the Future of Medicare examined six "variables" that could be used to create savings in the Medicare program. Though the Commission must report to Congress by March 1, 1999, the members have not endorsed any of the options under discussion. In fact, material distributed at the meeting states that "These variables [listed below] are not Commission proposals or recommendations; they are analytic tools for demonstration and discussion purposes only." However, it is likely that the Commission will include some or all of the following in its plan for long-term Medicare reform:

* Variable A: Modernize cost-sharing by 1) combining Part A and Part B deductibles; 2) eliminating the limit on hospital day coverage; 3) establishing a hospital coinsurance; 4) offer Medicare catastrophic protection.

* Variable B: Reform Medigap - stop Medigap plans from covering Medicare deductibles.

* Variable C: Raise Medicare eligibility age from current 65 to 67 over 2003-2027.

* Variable D: Graduate Medical Education (GME) and disproportionate share hospital (DSH) changes: carve out Direct Medical Education and DSH payments from Medicare; reduce Indirect Medical Education payments from the 5.5% add on level mandated by the Balanced Budget Act of 1997 to 4.4%.

* Variable E: Prescription drug coverage: though this would be a cost, not a savings, to the Medicare program, "many Members have commented on the inadequacy of the current benefits package," as prescription drug costs represent a significant portion of patients' out-of-pocket expenses on health care spending.

* Variable F: Introduce premium support, using a "Federal Employee Health Benefit Premium (FEHBP) type approach towards private plan participation in the Medicare market."

HIPDB would join the National Practitioner Data Bank as a collection program for final adverse actions against physicians and others

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) mandated creation of the Healthcare Integrity and Protection Data Bank (HIPDB), which will exist alongside the extant National Practitioner Data Bank (NPDB). The Department of Health and Human Services recently released a proposed rule regarding the how, what and who of HIPDB, which is intended to "play a significant role in reducing public and private health care expenditures that result in health care fraud and abuse, by alerting system users to previous relevant adverse actions," the proposal states.

HERE'S QUICK COMPARISON OF A FEW KEY POINTS OF THE HIPDB AND THE NPDB

PROVISIONS	HIPDB	NPDB
What types of actions must be reported?	* Civil judgements in Federal or State court related to the delivery of a health care item or service; * Federal or State criminal convictions related to the deliver of a health care item or service; * Actions by Federal or State agencies responsible for the licensing and certification of health care providers, suppliers or practitioners; * Exclusion from participation in State or Federal health care programs; * Any other adjudicated actions or decisions that the Secretary establishes by regulations.	*On Physicians and Dentists:* * Adverse licensure action reports including suspensions, revocations, reprimands, censures, probations and surrenders for quality purposes. * Adverse clinical privilege actions; * Adverse professional society membership actions. *On All Health Care Practitioners:* * Medical malpractice payments made.
Who must report the data?	Federal and State government agencies and health plans.	Medical malpractice payers, State licensing medical boards, professional societies with formal peer review, hospitals and health care entities.
Who has access to the data?	Federal and state government agencies and health plans. Health care suppliers, providers and practitioners can self-query.	Hospitals, "other health care entities that conduct peer review and provider arrange for care," State Boards of Medical or Dental examiners and other health care practitioner State boards. Individual practitioners can self-query.
Who does the data cover?	All health care suppliers, providers and practitioners.	Physicians, dentists and for malpractice payments, all health care practitioners.

News
from Osteopathic Health System of Texas

New Health & Fitness Connection to Offer More than Workout Equipment

A building that's bigger than a football field and facilities for community education and events are just two of the features planned for the newly expanded Health & Fitness Connection, set to open in the spring of 2000.

Daron Allen, executive director of the club, which is owned and operated by Osteopathic Health System of Texas, says the new facility will target the needs of young and old, members and non-members, by offering education in fitness, nutrition and maintaining a healthy lifestyle. Each class will be geared toward a specific audience, like seniors, young children or people with arthritis.

"We're already involved in community outreach in so many ways, through things like health fairs and the Cowtown Marathon & 10K, but there is a huge need for us to expand our services and open our doors not just to our members, but to the general public and area businesses, because the southwest Fort Worth area is booming," he said. "We have definitely outgrown our current space."

The club's greatest strength is the medical expertise through its link with the health system's hospital, Osteopathic Medical Center of Texas, and its sports rehabilitation facility, the SMART Institute, both located in Fort Worth's Cultural District. The new club will have an on-site physician and sports rehabilitation clinic.

The new HFC groundbreaking will be this spring with an expected completion in 2000 on Oakmont Boulevard, just west of the current facility at 6242-A Hulen Bend Boulevard, south of Hulen Mall.

NEW MEDICAID EXPANSION FOR TEENAGERS

Effective July 1, 1998, a new group of teenagers became eligible for Medicaid eligibility. Medicaid 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 previously.

In 1997, Congress passed legislation helping states provide health care for children who are uninsured and whose families have low incomes. Each state developed its own Children's Health Insurance Plan (CHIP). The first phase of Texas' CHIP was an expansion of Medicaid for teens 15 to 18 years old whose family income is less than 100% 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, was approved by the federal government.

Physicians are being asked to help get the word out on this program. 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.

To help in spreading this information, the forms entitled "*Important Information about Health Coverage for Teenagers*," on pages 15 and 16 of this issue, may be photocopied and given to your patients. Your assistance will ensure that eligible teens are aware of this new opportunity for health care coverage.

In addition, full-color posters and handouts are available by calling Christina Peeples at the Texas Department of Health at 512-458-7111, ext. 3110, or by e-mailing her at chipteens@tdh.state.tx.us.

Flyers in English and Spanish are also available for downloading from the TDH website, www.tdh.state.tx.us/child/chiphome.htm.

PHYSICIANS NEEDED TO HELP GET THE WORD OUT

Important Information about Health Coverage for Teenagers

Teenagers may now qualify for health care coverage through Medicaid, even if they did not qualify before.

As of July 1998, Medicaid covers more teens. Many teens who meet certain family income guidelines may now qualify for full health care benefits through Medicaid.

Services Teenagers Can Receive:
Medicaid will cover medical and dental check-ups and treatments. Benefits include medicines, office visits, hospital care, medical equipment and supplies, and many other medically necessary services.

For More Information:
Families can call or visit their local Medicaid representative to find out if they qualify and receive information on how to enroll. Contact the local Texas Department of Human Services office. The number is usually located in the "Government Services" section of the phone book, or in the Yellow Pages. A list of local Medicaid offices can also be found through the Internet at *www.tdh.state.tx.us/child/chiphome.htm.*

Información Importante sobre Cuidado de Salud para los Adolescentes

Ciertos adolescentes quizás ahora tengan derecho a recibir cuidados de salud por Medicaid, aunque antes no hayan podido recibirlos.

Medicaid empezó a ofrecer estos beneficios a los adolescentes desde julio de 1998. Muchos adolescentes que están dentro de ciertos ingresos ahora pueden recibir beneficios completos de salud por Medicaid.

Servicios que los adolescentes pueden recibir:
Todos sus chequeos y tratamientos médicos y dentales. Los beneficios incluyen las medicinas, las visitas al doctor, el cuidado en el hospital, aparatos y suministros médicos, y otros servicios médicos que sean necesarios.

Para más información:
Las familias pueden llamar o visitar a su representante local de Medicaid para saber si pueden recibir los beneficios de este programa y para recibir información sobre cómo registrarse. Llame a su representante de Medicaid en la oficina local del Departmento de Servicios Humanos. Su número de teléfono usualmente está en la guía de teléfonos en la sección "Government Services", o en las Páginas Amarillas. Una lista de oficinas locales de Medicaid también se puede encontrar por medio de "Internet" bajo *www.tdh.state.tx.us/child/chiphome.htm.*

HEALTH NOTES

FDA Announces New Alcohol Warnings for Pain Relievers and Fever Reducers

The Food and Drug Administration has announced that all over-the-counter pain relievers and fever reducers must carry a warning label advising people who consume three or more alcoholic drinks every day to consult their doctors before using these drugs.

The following specific warnings are included:

Acetaminophen: Alcohol Warning: If you consume 3 or more alcoholic drinks every day, ask your doctor whether you should take acetaminophen or other pain relievers/fever reducers. Acetaminophen may cause liver damage.

Aspirin, carbaspirin calcium, choline salicylate, ibuprofen, ketoprofen, magnesium salicylate, naproxen sodium and sodium salicylate: Alcohol Warning: If you consume 3 or more alcoholic drinks every day, ask your doctor whether you should take [insert ingredients] or other pain relievers/fever reducers. [Insert ingredients] may cause liver damage and stomach bleeding.

FDA Requires New Pediatric Labeling for Inhaled, Intranasal Corticosteroids

The Food and Drug Administration has informed companies of new pediatric information that will be required on the labeling of all orally inhaled and intranasal corticosteroids. The new labeling language will alert health care providers that using these drugs in children may reduce their rate of growth. It will also recommend using the lowest effective dose of these drugs and routinely monitoring patients' growth rates.

The following information can be used to answer questions:

Controlled clinical studies have shown that inhaled and intranasal corticosteroids may cause a reduction in growth velocity in pediatric patients. Growth velocity provides a means of comparing the rate of growth among children of the same age. In studies involving inhaled corticosteroids, the average reduction in growth velocity was approximately one centimeter (about 1/3 of an inch) per year. It appears that the reduction is related to dose and how long the child takes the drug.

The FDA's Pulmonary and Allergy Drugs and Metabolic and Endocrine Drugs advisory committees recommended that the agency develop class-wide labeling to inform health care providers so they would understand this potential side effect and monitor growth routinely in pediatric patients who are treated with inhaled corticosteroids, intranasal corticosteroids or both.

Long-term effects of this reduction in growth velocity on final adult height are unknown. Likewise, it also has not yet been determined whether patients' growth will "catch up" if treatment is discontinued. Drug manufacturers will continue to monitor these drugs to learn more about long-term effects.

Patients are advised not to stop using their inhaled or intranasal corticosteroids without first speaking to their health care providers about the benefits of these drugs compared to their risks.

"HeartMate" is Approved

The FDA has approved the use of the "HeartMate," a battery-powered heart assist device developed in part and first tested at the Texas Heart Institute.

The HeartMate will be used in patients with congestive heart failure while they wait at home for a heart transplant. It attaches to the heart's left ventricle, taking over the majority of the pumping action of hearts that are too weak to beat adequately on their own.

"With this technology, patients can leave the hospital and resume a fairly normal life, which includes working, going to school, raising a family, and other activities, while waiting for a donor heart," said Dr. O. H. Frazier, chief of Cardiopulmonary Transplantation and director of Surgical Research at the Texas Heart Institute.

Congestive heart failure affects approximately four million people in this country, of which 40,000 could benefit from a heart transplant. Only 2,000 donor hearts are available each year.

German Drug May Grow Blood Vessels

Doctors in Germany have developed a drug that appears to create new blood vessels when injected into the human body, a breakthrough that could revolutionize treatment of heart disease.

The doctors report blood flow to the heart is increased just days after injection, with no serious side effects observed in trials so far. The drug, called F.G.F. 1, or fibroblast growth factor, is currently used only in conjunction with heart bypass surgery. It is not known how much of the vessel growth is due to surgery or F.G.F. 1.

Development of a drug to grow blood vessels without bypass surgery is critical, since many patients have arteries that are too narrow for surgery. Medical researchers have been searching for a way to grow blood vessels since the 1920s.

Heart disease is the leading cause of death in the United States and one of the leading killers in the world.

(Source: The TSBR Reporter, Vol. 9, No. 5)

CLINICAL LAB PANEL IMPLEMENTATION

The American Medical Association (AMA) has discontinued the general multichannel automated panel codes 80002 through 80019 and G0058 through G0060. These panel codes are being discontinued because the panel does not define exactly what tests are performed.

Effective for dates of service on or after January 1, 1999, the new Medicare policy pertaining to laboratory paneling procedures has been implemented by the Texas Medicaid Program. The new organ and disease panel codes 80049, 80051, and 80054 must be used instead of the general multichannel automated panel codes: 80002 through 80019 and G0058 through G0060.

Beginning January 1, 1999, CPT codes 80002 through 80019 and G0058 through G0060 are not usable as billing codes, but the payment amounts associated with pricing of these automated profiles will continue. For example, if two automated profile tests are performed, the individual codes for the two automated tests must be billed instead of code 80002. For pricing, count the number of automated profile tests billed, and payment will be at the same rate as the former code 80002. HCFA continues to provide updated pricing for the deleted profiles of automated tests.

THE NEW ORGAN OR DISEASE PANELS INCLUDE THE FOLLOWING CODES

80049 - Basic metabolic panel includes

Carbon dioxide	82374
Chloride	82435
Creatinine	82565
Glucose	82947
Potassium	84132
Sodium	84295
Urea nitrogen (BUN)	84520

80051 - Electrolyte panel includes

Carbon dioxide	82374
Chloride	82435
Potassium	84132
Sodium	84295

80054 - Comprehensive metabolic panel includes

Albumin	82040
Bilirubin, total or direct	82250
Calcium	82310
Chloride	82435
Creatinine	82565
Glucose	82947
Phosphatase, alkaline	84075
Potassium	84132
Protein, total	84155
Sodium	94295
Transferase, aspartate amino (AST) (SGOT)	84450
Urea nitrogen (BUN)	84520

Claims submitted with procedure codes 80002 through 80019 and G0058 through G0060 are denied for incorrect procedure codes. NHIC no longer reformats procedure codes 80049 to 80007, 80059 to 80004, and 80054 to 80012.

Business Briefs

Third Party Billing Companies - New Enforcement Agents for the OIG?

Recognizing that third party medical billing companies "are providing crucial services that could greatly impact the solvency and stability of the Medicare Trust Fund," the OIG released its voluntary billing company compliance guidance (the "Guidelines") on November 30, 1998. The 33-page document reflects the seven compliance elements set forth in prior guidance by the OIG and identifies risk areas specific to billing companies, as follows:

- Billing for undocumented services/items
- Duplicate billing
- Unbundling
- Upcoding
- Inappropriate balance billing
- Inadequate resolution of overpayments
- Lack of integrity of computer systems
- Failure to properly use modifiers
- Routine waiver of copayments, and
- Improper discounts on professional services

The guidelines also establish a bifurcated reporting system for billing companies to report credible evidence of internal misconduct and violations as well as misconduct and violations that are committed by their provider-clients.

Reporting internal misconduct - If the billing company discovers credible evidence of misconduct that may violate criminal, civil or administrative law in its own activities, it should report such misconduct to the appropriate government authorities not more than 60 days after determining that there is credible evidence of a violation.

Reporting provider-client misconduct - A) If the billing company discovers evidence of misconduct by a provider-client, it should refrain from submitting the questionable claims and notify the provider-client in writing within 30 days of such a determination, or B) if the billing company discovers credible evidence of a provider-client's "continued misconduct or flagrant fraudulent or abusive conduct," it should 1) refrain from submitting any "false or inappropriate claims," 2) terminate the contract, and/or 3) report the misconduct to the appropriate federal and state authorities not more than 60 days after determining that there is credible evidence of a violation.

A complete copy of the Guidelines may be accessed through the OIG's website at www.dhhs.gov/progorg/oig.

Congress Approves Big Increase for Research

The Senate Appropriations has responded to an unprecedented call to action by research advocates by approving a $2 billion increase for the National Institutes of Health.

The increase for FY 99 is nearly 15 percent more from FY 98. Research advocates had lobbied congressional representatives and Senators for the increase, citing poll numbers showing voters strongly supported candidates who would increase federal spending for research.

The 15 percent increase was more than the nine percent proposed by the House of Representatives. Research advocates say the increase is a strong step forward in their goal to double the NIH budget over the next five years.

(Source: The TSBR Reporter, Vol. 9, No. 5)

Managed Care Legislation Struggle Evokes Tremendous Expenditures

The Associated Press has reported the following expenditures in the high-stakes struggle over managed care legislation. In the first half of this year, insurance companies and their allies spent $60 million - an average of $112,000 per lawmaker - to lobby Congress against new managed care regulations. This was four times the $14 million spent by medical organizations, trial lawyers, unions and consumer groups to press for passage of patients' rights legislation. It does not include the $11 million spent on advertising against managed care legislation, or any political campaign contributions. It is 50 percent higher than the $40 million spent during the same period by tobacco interests to oppose tobacco regulations.

(Source: AOHA Washington Update)

Tax Breaks Proposed for Families' Health Care

President Clinton has proposed tax breaks to ease the financial burden on families that care for a chronically ill or disabled relative.

The proposal, with a cost of $6.2 billion over five years, drew praise from many Republican members of Congress. Rep. Bill Thomas (R-CA) said the proposal was similar to one made by House Republicans in their 1994 Contract With America.

continued on next page

Home-health Agencies Get Relief

Prior to adjourning, Congress softened provisions in the Balanced Budget Act of 1997 that curbed Medicare payments to home-health care agencies. Signed into law by President Clinton, the relief measure raised Medicare payments to most home-health agencies and delayed for one year a 15 percent cut in payments to providers that had been scheduled to take effect on October 1, 1999.

In 1997, Congress tightened payments to agencies as part of an effort to curtail rising home-health costs and to curb fraud and abuse. However, when the cutbacks went into effect in early 1998, there was an outcry from many Medicare home-health recipients who said they lost all or some of the benefits.

Proposed HMO Rules Draw Opposition

Business and insurance groups are up in arms over proposed Clinton administration rules that would force them to make quicker decisions about paying for care and make it easier for patients to take cases to court.

Although Congress considered but did not pass legislation last year to regulate managed care, the Clinton administration wants to institute a few changes on its own. "This is one of the few things we can do without new legislation," said Meredith Miller, acting assistant secretary for the pension and welfare benefits administration at the Labor Department, which issued the new rules late in the fall.

The Labor rules require health insurance plans regulated by federal law to make several changes in the way they decide whether to pay a claim. They also address patient rights in appealing denials. The rules shorten the number of days that insurance companies have to decide whether to pay a claim and allow for expedited appeals.

For example, a health plan has 15 days to decide whether to pay for a procedure and fewer days if it is an emergency situation. Current law gives plans more time.

President Clinton and congressional Democrats have said that HMO legislation will be a top priority this year.

COLA Increase is the Smallest Ever

Social Security payments rose 1.3 percent this year, which is the smallest increase since automatic cost-of-living adjustments (COLAs) were first made in 1975.

Beginning January 3, the average Social Security payment rose from $770 a month to $780. The top monthly Social Security benefit for those who reached age 65 in January increased from $1,342 to $1,373.

Additionally, the amount retirees ages 65-69 can earn without losing benefits rose from $14,500 to $15,500 a year.

Number of Uninsured is Rising

A new Census Bureau report notes that the number of uninsured people in the United States increased in 1997 by 1.7 million and now stands at 43.4 million. According to the report, the groups most likely to lack coverage are young adults from 18 to 24, part-time workers, and people with lower levels of education. Due to Medicare, however, only one percent of all Americans 65 and older were uninsured.

One Number to Fax Texas HIV Medication Program

If you are faxing information to the Texas HIV Medication Program, you should always fax it to 512-490-2053 only. Do not fax Medication Program information to other fax numbers in the Texas Department of Health Bureau of HIV & STD.

This is particularly important when faxing anything that contains a client's name or other identifying information. The Medication Program fax machine can only be accessed by Medication Program staff. Materials faxed to this machine are processed to ensure confidentiality. Call the Texas HIV Medication Program at 512-490-2510 or 800-255-1090 if you have any questions about faxing information.

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

FDA Broadens Prescribed Uses for Aspirin

The FDA has expanded the professional labeling for prescribing aspirin to treat patients with cardiovascular and cerebrovascular problems. The FDA recognizes aspirin's potential to reduce the risk of death if taken during a suspected heart attack, and noted that research shows that as little as one-half of a regular-strength aspirin tablet (162.5 mg) reduces the risk of death by up to 23%, if administered when a heart attack is suspected, and for 30 days thereafter.

The agency did recommend, however, lower dosages of aspirin - 81 mg. or one-quarter of a tablet - which is lower than physicians usually prescribe to help prevent a heart attack or stroke in men and women.

In addition, the agency does not recommend aspirin for healthy individuals to lower their risk of heart attack, or for patients who have peripheral vascular disease.

A summary of the updated labeling, which goes into effect in one year, is as follows: Aspirin is recommended for both men and women to treat transient ischemic attack, ischemic stroke, angina, acute and recurrent myocardial infarction, specific revascularization procedures and rheumatologic diseases.

OHST Names New Director of Information Services

Rodney Edge, Ph.D., has been named the new Director of Information Services at Osteopathic Health System of Texas.

Dr. Edge has 34 years of experience in managing computer systems for health care organizations. He comes to OHST from the Daughters of Charity National Health System office, where he was vice president of research and development.

Cardiovascular Disease & Stroke

Any GOOD News?

In the past several issues, TOMA has printed excerpts of the Report of the Texas Coalition on Cardiovascular Disease & Stroke. The health and economic burden the nation faces from CVD and stroke is staggering, and states and communities continue to grapple with this national problem. The last issue listed various steps and approaches being implemented in an effort to achieve meaningful reductions in CVD and stroke.

In the meantime, research and clinical trials continue worldwide in an effort to better treat and prevent the underlying causes of heart disease. The following, as well as the reports from the American Heart Association, provide a brief look at some of the research currently being conducted.

- Emerging Risk Factors - Science's Agenda for the Next Century

One of the most remarkable health advances of the past 50 years has been a better understanding of how blood pressure, cholesterol and other factors increase a person's risk of heart disease. Yet some puzzles remain. For example, why do most heart attacks happen in patients with moderately high, but still average, blood cholesterol? What still unidentified factors might work with known risk factors to trigger heart disease?

"More than 300 possible new risk factors have been proposed; of those, nine are 'now entering prime time," noted Dr. Jeffrey M. Hoeg, chief, Section on Cell Biology, Molecular Disease Branch, of the National Heart, Lung and Blood Institute (NHLBI), during a national conference press briefing. That is, they are close to or are now being studied in clinical trials in humans. Here's the latest on the three most likely:

Homocysteine - Findings from the NHLBI's Framingham Heart Study and elsewhere show that high levels of this amino acid may contribute to heart disease, stroke and a reduced blood flow to the hands and feet. Researchers believe that homocysteine may work in one or all of these ways: be involved with atherosclerosis; make blood more likely to clot; and make blood vessels less flexible and less able to widen to allow increased blood flow.

Homocysteine levels are determined partly by genetics but also by the consumption of vitamins, especially folic acid, B6 and B12. Those vitamins help process homocysteine and, in theory, could be used to control abnormally high homocysteine levels. However, people who follow a well-balanced diet should get plenty of these vitamins; recommended daily values are 400 micrograms for folic acid, 2 milligrams for B6, and 6 micrograms for B12.

Lp(a) - This is a type of low-density lipoprotein, often called the "bad cholesterol" because it carries most of the cholesterol in the blood. Lp(a) is now thought to be a risk factor for early onset of heart disease. Apparently the Lp(a) molecule has an extra protein particle attached; the particle resembles the protein involved in blood clotting. Lp(a) does its damage by preventing the breakup of clots.

Infectious agents - Viruses and bacteria may harm blood vessel walls, starting the atherosclerotic process. For example, researchers have found a kind of herpes virus, cytomegalovirus (CMV), in lesions from diseased coronary arteries. NHLBI researchers found that patients with antibodies for CMV have a high rate of artery reclosure after the artery is cleared out with an artherectomy. Chlamydia pneumoniae, an airborne bacterium that causes respiratory infections, may be another culprit. In small pilot studies, chlamydia-infected patients who had had a heart attack were treated with antibiotics and had a reduced risk of a second heart attack.

How might these infectious agents work? Microbes invading the vessel wall could trigger an immune response so that the tissue tries to heal itself, forming a type of scar tissue that can narrow the vessel. Or the blood vessel also can narrow as it tries to "remodel" itself; the vessel constricts, producing a smaller opening.

"We now realize that atherosclerosis is more than just an accumulation of sludge and rusty pipes , the blood vessel is actually a living structure," states Dr. Peter Libby, director, Vascular Medicine and Atherosclerosis Unit, Brigham and Women's Hospital, Boston, explaining the connection between infection, inflammation and atherosclerosis. Like any other tissue, this living structure can react to invading microbes, triggering an inflammatory response that changes the vessel's shape and character.

(Source: HeartMemo, a publication of the NHLBI)

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Reports from the American Heart Association

The American Heart Association held its 71st Scientific Sessions on November 8-11, 1998 at the Dallas County Convention Center. The following information is excerpted from those sessions.

NEW TECHNIQUES/ADVANCES IN REDUCING OR COMBATING HEART DISEASE

❤ *A protein switch may turn on heart cells to combat heart disease- W. Robb MacLellan, M.D., University of California at Los Angeles School of Medicine* - Scientists are finding ways to switch on and off key proteins that may make heart cells come out of biological "dormancy" and replace the damaged cells that result from heart disease, as reported in two presentations. The research may lead to new gene therapy to treat heart enlargement and improve function in people who have heart disease.

Based on an earlier study suggesting that the "retinoblastoma" gene was critical in controlling cell division, MacLellan and his colleagues focused on the protein that this gene produces, retinoblastoma protein, called Rb. Scientists believe the Rb protein may help keep heart cells "dormant" so they no longer can divide. To test this theory, MacLellan's group "turned off" the Rb in a group of mice and compared heart sizes between the genetically altered mice and mice who still had the Rb genes in their hearts. The heart cells continued to divide for a longer time in the genetically altered mice (those without the heart Rb gene). At eight weeks of age, the hearts in mice without Rb were 8 percent bigger than the hearts of mice that still had the Rb gene active in their heart cells.

While this represents an important step forward in manipulating cells in the heart to grow, MacLellan says researchers still must investigate how the Rb gene works over time and whether these heart cells will multiply after a stress, such as a heart attack.

Extending these studies, MacLellan and colleagues identified a protein in the heart that binds to Rb. Called MRP1, this protein appears to oppose Rb's effect in the heart and is turned off by binding to Rb. Although the full effects of this protein are to be determined, it appears that MRP1 can return cells to an earlier phase similar to fetal cells.

While fetal heart cells are capable of dividing, shortly after birth these cells stop dividing and express specialized "adult" genes. "We think Rb and MRP1 are key parts of this process. If we can turn on MRP1 in adult cells, we may be able to get them to "think" they are fetal cells and start dividing," he said.

"Now we are searching for the right combination of these factors to trigger cell division. We hope by overcoming Rb, possibly with MRP1, we can set the heart cells up so that with the right stimulus they will divide," said MacLellan.

The researchers hope that the same signals that stimulate dormant heart cells to enlarge - such as stress from high blood pressure or having to "take up the slack" for damaged cells after a heart attack - may be able to stimulate cells treated with MRP1 to divide and replace the damaged cells, he said.

❤ *Never too late for vitamin E? - Andrea Mezzetti, University of Chieti, Italy* - Lower blood levels of the antioxidant vitamin E that relate to higher levels of lipid "peroxides" - artery-damaging fat particles laden with extra oxygen atoms - can forecast future heart attacks and strokes in the elderly.

Italian scientists measured vitamin E and peroxides in 104 healthy people over age 80 and followed them for five years. During that time, there were 32 heart attacks and strokes due to blood clots. After adjusting for blood cholesterol levels, the researchers found heart attack and stroke risk decreased significantly in individuals with increasing vitamin E levels and increased significantly in those with high lipid peroxide levels.

❤ *A gene defect in cholesterol absorption may shed light on manning cardiovascular risk - Shailesh B. Patel, University of Texas Southwestern Medical Center, Dallas* - Scientists say they have pinpointed the gene responsible for a rare inherited disease that causes the body to absorb unusually large quantities of cholesterol and develop advanced atherosclerosis and early coronary artery disease.

Researchers studied individuals from 10 families with the disorder and localized the defect to a part of chromosome number 21. Their research may have found a key to help more generalized efforts to understand the body's bottom-of-the-line mechanisms that control how - and how much - cholesterol is absorbed from the foods we eat, said the Dallas researchers.

❤ *The heart-healthy cup runneth over - with grape juice - Jane E. Freedman, M.D., Georgetown University Medical Center, Washington, D.C.* - Purple grape juice seems to have the same effect as red wine in reducing the risk of heart disease.

Researchers studied blood platelets in a solution containing purple grape juice and in "control" solutions that did not. Platelets in purple grape juice clotted about 30 percent less than did the controls and released three times more nitric oxide, a chemical that dilates blood vessels and also serves as a powerful inhibitor of clotting. Both effects of nitric oxide help reduce the likelihood that blood clots will block the arteries and cause a heart attack.

In addition, platelets in purple grape juice released 55 percent less superoxide - one of the reactive oxygen molecules known as free radicals.

Freedman noted that the grapes used to make red wine and purple grape juice are often different from the red and white grapes at the grocery store. "Eating pitted purple grapes may not have the same effect as drinking purple grape juice because of the variety of grapes available and the concentration of flavonoids that results from juice processing," she said.

❤ *Working out the risk for stroke - Kelly R. Evenson, Ph.D., University of North Carolina, Chapel Hill* - Physical activity not only reduces the likelihood of heart disease but also may decrease the risk of strokes.

Researchers examined 15,371 individuals 45 to 64 years old who had not had a stroke and were included in the Atherosclerosis Risk in Communities (ARIC) study. The rela-

tionship between physical activity and the risk of ischemic stroke was examined. Though other studies have investigated the link between physical activity and stroke risk, Evenson said it is an area of research in need of more examination.

"Individuals who were more active at work had a 49 percent lower risk of stroke than those who were more sedentary. For people with the highest levels of sport activity, there was a 23 percent reduced risk, and those with very active leisure time had an 11 percent reduced risk of stroke," reported Evenson.

❤ *Nuts and oats may build a strong heart - Christine M. Albert, M.D., Harvard University School of Medicine, Boston* - Heart-Healthy components in oats may help lower high cholesterol levels and a nutrient in nuts may help prevent death from heart disease.

In a 12-year study of 22,071 doctors participating in the Physicians Health Study, men whose diets contained high quantifies of nuts had a decreased risk of dying from heart disease. Nuts contain unsaturated fats, including alpha-linolenic acid, which may help prevent fatal disturbances in the heart's rhythm.

In another study funded by Quaker Oats at Tufts University in Boston, another group of researchers examined 43 men and women eating a diet rich in oats. People on the diet had lower blood pressure and reduced blood levels of cholesterol at the end of the study. The oat diet lowered total blood levels of cholesterol by 34 milligrams per deciliter (mg/dL), while study participants who ate a diet that substituted wheat for oats lowered their cholesterol only 13 mg/dL. The individuals' blood levels of low-density lipoprotein cholesterol followed the same pattern. The oat group's LDL was 23 mg/dL lower and the wheat group's LDL was 8 mg/dL lower.

Lead author of the oat study, Edward Saltzman, M.D., of the Energy Metabolism Laboratory at the USDA Human Nutrition Research Center on Aging at Tufts University in Boston, attributes the benefits of oats to its soluble fiber. "There are several reasons why foods such as oats that contain soluble fiber, or soluble fiber itself, could have beneficial effects on blood pressure cholesterol. The presence of soluble fiber in foods slows the rate of digestion and absorption." The slower digestion causes a more gradual rise in insulin levels. "There may be other as yet unidentified factors in oats that affect the way the blood vessels react," said Saltzman.

In the Harvard investigation linking nut consumption to a reduced risk of heart disease, Christine M. Albert, M.D., noted that alpha-linolenic acid, a component of nuts, may protect the heart by preventing a rhythm disturbance called ventricular fibrillation. Albert reported that previous studies in animals have hinted at this link as well. She stressed that her results are preliminary because the questionnaires asked only whether the physicians had eaten nuts, not what kind or how many. Also, other factors of diet or risk factors for heart disease might skew the results. "Most nuts are also high in other unsaturated fats and nutrients that might contribute to reduced heart disease," Albert said.

However, those questioned who ate the highest amount of nuts had the lowest risk for any heart-related death - even after adjusting for age, exercise habits, high blood pressure, cholesterol levels, diabetes, alcohol use, other dietary habits and whether individuals were being treated for heart disease.

❤ *Fatty acids from fish oil linked to reduced risk of heart attack - Tiina H. Rissanen, University of Kuopio, Finland* - In a study of 1,871 men in eastern Finland, high proportions of two "omega-3" fatty acids found in fish oil were associated with reduced risk of heart attack.

Scientists measured blood levels of the fatty acids DHA (docosahexaenoic acid) and DPA (docosapentaenoic acid) in the healthy men. During the 12-year study, there were 161 fatal or non-fatal heart attacks. Men were divided into five groups based on their blood levels of DHA and DPA. Those with the highest proportion of DHA and DPA had a 44 percent lower risk of heart attack compared to those in the lowest fifth. Men in the highest fifth of DHA and DPA also had higher HDL, lower blood insulin levels and less blood platelet "stickiness."

❤ *Clarifying heart risk from various saturated fats in women - Frank B. Hu, Harvard University* - A major new trial involving 80,990 women in the Nurses' Health Study validates current dietary recommendations to lower overall saturated fat.

Boston researchers conducted a trial to sort out differences in coronary heart disease risk according to the different saturated fatty acids found in the nurses' diets over 14 years. While other studies have suggested that stearic acid, found mainly in beef, may not cause a higher level of risk, the new finding indicates that intake of all so-called "long-chain" fatty acids, which include stearic acid, is associated with increased CHD risk, scientists say. Short- and medium- chain fatty acids, which also were in diary products, were not linked to higher risk.

❤ *The trouble with diets: How can we help people stick to eating healthy? - Lora E. Burke, University of Pittsburgh, Pittsburgh* - Pittsburgh researchers found that calling patients twice a week to send a "yes you can!" message assisted them in making the transition into healthier eating patterns. Phone calls from a nurse focused on discussing the times when patients felt it was most difficult for them to choose low-cholesterol alternatives to their usually fatty foods.

This study examined 65 men and women with high cholesterol, average age of 55, who reported difficulty in staying on a cholesterol-lowering diet. A nurse made biweekly phone calls to the 31 participants who were assigned to usual care plus intervention. This group was compared to the 34 participants who received usual care but no phone calls. Researchers found that telephone intervention had a positive effect on improving people's adherence to a low-cholesterol diet.

❤ *Get me to the ER on time - Russell V. Luepker, M.D., University of Minnesota School of Public Health* - The amount of time people delay in deciding to seek care for heart attack symptoms may be declining.

This is a key finding from the Rapid Early Action for Coronary Treatment, or REACT, trial. The study, funded by

the National Heart, Lung, and Blood Institute, tested community campaigns to reduce the time people delay seeking emergency care for heart attack in 20 medium-sized cities in five regions of the country. The 18-month campaign was conducted in half the cities, and the other half served as controls in the 22-month study.

During the 1990s, median delays had been between three and four hours - half the individuals delay longer and half delayed less than three to four hours. The REACT study examined the influence of medical campaigns in educating the public about heart attack symptoms and the need for rapid action. REACT found median delay of 2.2 hours, far lower than most U.S. studies have found. "That's very good news," Luepker said. "It shows that there is now likely significant improvement in patients seeking care earlier."

Although the REACT campaign was unable to shorten patient delay further, the study saw a rise in the number of people with heart attack symptoms coming to the emergency department in the intervention cities and an increase in the number choosing to call EMS/911 for transport.

Luepker noted that denial and confusion about heart attack symptoms are major reasons why many individuals delay seeking emergency care. Other factors often linked to delays in seeking help include old age, being female, lower socioeconomic status and having mild or unusual symptoms.

Because the study was large and distributed over a wide geographic region, Luepker says more data from the REACT project will be forthcoming.

Note: The American Heart Association has a new program to promote early diagnosis and treatment of heart attacks called Operation Heartbeat. This new, multi-faceted program involves community volunteers and staff working to identify ways to improve the local "chain of survival." Strengthening the "chain of survival" will be accomplished through a variety of activities chosen after assessing each link to identify priority areas for improvement.

❤ *Survival curve continues after clot-buster drug use - John K. French, Green Lane Hospital, Auckland, New Zealand* - Benefits from prompt use of the clot-busting drug streptokinase to treat clots that block blood vessels were still evident a dozen years after treatment, a new study shows.

Researchers compared survival rates of 107 individuals who were treated with streptokinase within four hours of symptom onset with the survival rates of 112 others who received a placebo. Survival rates after five years were 84 percent for streptokinase-treated people versus 70 percent for placebo recipients. After 12 years, the rates were 66 percent for the drug-treated group compared to 51 percent for the placebo group.

❤ *Fine-tuning the diet may lower risk of high blood pressure-Suma Vupputuri, Tulane University School of Public Health, New Orleans* - Increasing dietary consumption of carbohydrates may decrease the risk of high blood pressure, new findings suggest.

New Orleans researchers conducted a 10-year study of the effects of so-called macronutrients on the incidence of high blood pressure in 5,727 participants with normal blood pressures taking part in a major national trial. The researchers found that the higher the intake of carbohydrates, the lower the risk of high blood pressure. The study controlled for age, race, gender, body mass index and dietary intake of calories, sodium, potassium and total fiber. Limitations in the data precluded looking at the effects of simple versus complex carbohydrates or assessing water-soluble fiber, indicating possible directions for future research.

❤ *Test for genetic trait may indicate heart benefits of hormone replacement therapy - H. Robert Superko, M.D., Berkeley HeartLab and the Lawrence Berkeley National Laboratory, Berkeley, California* - A new study shows that a woman's genetic makeup can reveal how well hormone replacement therapy will reduce her risk of developing heart disease. Researchers suggest that postmenopausal women with a family history of heart disease be tested to determine if they have large or small low-density lipoproteins (LDL). The research shows that women with larger sized LDL particles may be more likely to reap heart-related benefits from hormone replacement therapy than women with smaller LDL particles.

Research conducted by Superko and other researchers during the last decade suggests that a person's response to cholesterol-lowering diets and drugs is inherited - driven, in part, by what is called the atherosclerosis susceptibility trait. The researchers tested whether this trait might also influence how a woman's cholesterol levels respond to HRT. The trait determines if a person has one of two patterns of LDL. Pattern A people have mostly large, buoyant LDL particles; those with pattern B have smaller, dense forms of LDL. Pattern B increases heart disease risk three-fold.

"If you are a pattern A woman who wants to lower her LDL cholesterol profile, it turns out HRT isn't the best choice," said Superko. He suggests that these women try the AHA Step II diet or ask their doctor about cholesterol-lowering drugs.

Superko noted that women with pattern B are subject to a sort of "bad metabolic stew" of characteristics that put them at higher risk for heart disease. The first being that their smaller LDLs lodge into the artery wall 40 percent faster and contain about half the amount of protective antioxidants as the larger LDLs - this makes pattern B LDLs more susceptible to oxidative damage. Pattern B women are also insulin resistant, he said, making them more susceptible to diabetes, a known risk factor for heart disease.

Researchers studied 44 postmenopausal women, average age 58 years. Half of the women took estrogen plus progestin and the other half took a placebo. After four months, the researchers reversed the two groups' medications.

"We wanted to test if the reduction would be greatest in the pattern B women, which we believed it would be based on clinical experience," Superko said. The average decrease in LDL cholesterol was 7.9 percent and the average increase in HDL was 10 percent for all women.

"The really interesting part came when we looked at how the women with pattern A compared to women who were pattern B," he said. The pattern B women reduced their LDL cholesterol by 15 percent compared to a drop of only 4.6 percent in the pattern

A group. HDL cholesterol rose 14 percent in the pattern B women compared to only eight percent for those with pattern A.

Superko and his colleagues have some thoughts on why HRT may work better for pattern B women than pattern A women, but do not have solid proof of their theories. "We think pattern A women don't have the inherited disorder causing the "bad metabolic stew" and B women do. However, estrogen suppresses the genes that cause pattern B women to have the high risk for coronary artery disease. These problems are evident after menopause because the women no longer produce enough estrogen to suppress these bad effects. We're always concerned when health advocates recommend that everybody should be on the same diet or the same drug because there is tremendous diversity within the human population. Metabolically, people just work differently," he said.

The researchers suggest that postmenopausal women with a family history of heart disease or with actual heart disease be tested to determine if they are pattern A or pattern B. The test used to distinguish pattern A from pattern B was developed at the Lawrence Berkeley National Laboratory and is now marketed by the Berkeley HeartLab, in San Mateo, California. Superko says the test is available to physicians through a government program at the Lawrence Berkeley National Laboratory and the Office of Technology Transfer. The program includes the test, interpretation of test results, education and reimbursement information. Further information about the testing program can be obtained by called 1-800 HEART-89.

About 5,000 physicians around the country use the new test on a routine daily basis. The cost is $160 and most insurance covers about 80 percent of the price. Superko says the base price of the test is likely to drop as it becomes more widely available.

American Heart Association announces statement on homocyst(e)ine - Citrus fruits, tomatoes, vegetables and fortified grain products - good sources of many of the B vitamins - are recommended "as the first line of defense" in treating elevated homocyst(e)ine, according to a new AHA statement released November 10, 1998.

Homocyst(e)ine is a natural byproduct of the body's metabolism of protein. Many studies have shown a direct relationship between the level of homocyst(e)ine and coronary heart diseases. Studies found a graded association of blood plasma homocyst(e)ine levels with cardiovascular risk. In the future, laboratory tests, which are currently not widely available to determine the level of homocyst(e)ine in blood, may improve the assessment of risk in people with a personal or family history of cardiovascular disease but who may not have other known risk factors such as high cholesterol or high blood pressure. However, the AHA does not currently advocate routine testing for homocyst(e)ine.

Although evidence for the benefit of lowering homocyst(e)ine levels is lacking, people at high risk for cardiovascular disease who also have high homocyst(e)ine levels in their blood should be advised to follow a diet based on a wide variety of foods that ensures an adequate intake of folic acid and vitamins B-6 and B-12.

"The nature of the studies to date have not been conclusive. Until there is convincing evidence of both a predictive relationship between blood homocyst(e)ine and cardiovascular disease, and a benefit of homocyst(e)ine lowering, its role will remain unproved," says Ronald M. Krauss, M.D., of the Lawrence Berkeley National Laboratory, one of the authors of the advisory.

The association recommends an increased intake of these vitamins for individuals with hyperhomocysteinemia who have had heart disease and are at increased risk for coronary heart disease because of family history of heart disease. Additional research will be needed to determine if vitamin supplements could be considered in lieu of diet.

The intakes of folic acid, vitamin B-6 and vitamin B-12 recommended by the AHA fall within the Recommended Daily Allowances recently set by the Food and Nutrition Board of the Institute of Medicine. Taking any more than these levels "is still considered experimental." Several studies have shown that consumption of folic acid-fortified foods or multi-vitamin supplements can reduce blood levels of homocyst(e)ine.

"Despite abundant epidemiologic evidence for a relationship between plasma homocyst(e)ine and cardiovascular disease, and the potential for reducing homocyst(e)ine levels with increased intake of folic acid, it is not known whether reduction of plasma homocyst(e)ine by diet and/or vitamin supplements will reduce cardiovascular disease risk," the advisory warned.

"High-risk individuals should check with a dietitian about how to improve dietary intake of folic acid and other B-vitamins in order to reduce homocyst(e)ine level," said Krauss. For some individuals who cannot or will not consume enough of the vitamin rich foods, vitamin supplements could also lower homocyst(e)ine."

Other authors of the advisory were M. Rene Malinow, M.D., of the Oregon Regional Primate Research Center and Oregon Health Sciences University, and Andrew G. Bostom, M.D., Memorial Hospital of Rhode Island.

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1998 Tested Investors' Mettle

Over the past year the stock market, in keeping with a tumultuous 1998, took investors on quite a ride. The Wall Street Journal put it best: "When the Dow Jones Industrial Average soared a week ago its first new high since July 17, it completed a stunning round trip which had taken it down 19 percent by Aug. 31 and then all the way back."

Several key events worldwide contributed to the U.S. stock market's rollercoaster ride in 1998:

- **Interest rate cuts by the Fed.** Three cuts by Fed Chairman Alan Greenspan totaling 75 basis points did much to boost investor morale. Overall, the interest rate cuts were intended to strengthen economic production through an increase in credit liquidity.

- **Increased merger and acquisition activity.** A flurry of M&A activity, including a blockbuster acquisition of Netscape by America Online, propelled the Dow to record levels. Not two months after bottoming out in the bear market, the Industrial Average was above 9400, on the strength of a record nine $1 billion-plus merger agreements or negotiations on November 23.

- **Economic problems in Russia, the Pacific Rim and South America.** Questions about the economies of Japan, Russia and Brazil, among other countries, have threatened to drag the United States into a world recession. However, the Dow Jones Global Index for the Asian Pacific, excluding Japan, has risen 15 percent since mid-July.

- **Uncertainty in the White House.** The ongoing allegations of presidential wrongdoing and the impeachment proceedings currently in Congress have at times caused questions in the market.

- **Bailed-out hedge funds.** Investors found out that even a secretive hedge fund, Long-Term Capital Management, can have repercussions on the world economy. The bailout of the fund by top investment firms prevented Long-Term Capital from dragging down creditors along with it, thereby putting a squeeze on available credit. Also, the giant conglomerate Citigroup announced a down quarter, due in part to an investment unit that lost $300 million in bad hedge fund-type bets. For a time, investors feared that overextended hedge funds would have an adverse effect on the economy.

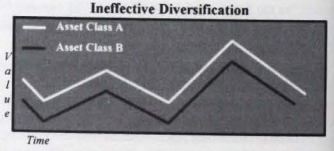
While multiple factors have contributed to the volatility of the stock market, the U.S. economy has remained strong. Economic growth, while slowing, remains positive. The economy expanded at a rate of 1.6 percent in the last quarter, consistent with the Fed's non-inflationary targets.

Inflation under control. Consumer prices have advanced a mere 1.7 percent in the past year as compared with 2.2 percent in the 12-month period following July 1997. The Producer Price Index, or PPI, has fallen 0.3 percent from last year's levels. The PPI, which measures inflation where goods and services are actually produced, is a closely watched statistic and a reliable indicator of potentially higher prices at the consumer level.

Interest rates are at historically low levels and are positioned to decline further still in coming months. As of this writing, the long-term Treasury bond yield stands at a historically low 5.06 percent. Slowing economies here and abroad coupled with continued turmoil in many areas of the globe point to an accommodating Federal Reserve for the foreseeable future.

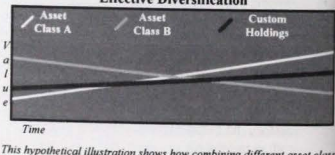
Even as the Dow returns to record levels, investors should proceed with caution. A well-diversified portfolio can offer the best defense against fluctuations in the economy. This does not simply mean different types of stocks, but also different types of investment vehicles. Combining different asset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

Ineffective Diversification



This hypothetical illustration shows how combining similar assets classes can subject investments to similar market ups and downs, and therefore increase risk. (This is not intended to reflect the past or future performance of any mutual fund or investment portfolio.)

Effective Diversification



This hypothetical illustration shows how combining different asset classes can help reduce the portfolio's overall risk. (This is not intended to reflect the past or future performance of any mutual fund or investment portfolio.)

So what is in store for 1999? Of course, no one can accurately predict the future. Internet-related companies, through electronic commerce, are poised to change the way America, and the world, does business. With the rapid development of the World Wide Web, this year's unknown Internet startup could be next year's Amazon.com. President Clinton's recent declaration of intent to help facilitate Internet commerce can only help this sector.

The staggering number of recent mergers and acquisitions has Wall Street wondering which giant companies will be next to join forces. America Online and Netscape, and Exxon and Mobil were just a couple of the blockbuster mergers that captured Wall Street's imagination.

However, some timeless advice still applies. It's always wise to stay the course, and to not act rashly in the face of volatility. Historically, time spent in the market has been far more important to investor's returns than the ability to time the market. Investors who sold equity positions during the last bear market are now faced with buying back into a Dow hovering around 9,000 points. As financial planners, we can help you develop an investment portfolio that matches your long-term financial needs.

So enjoy your holidays and buckle in for 1999. Whatever happens, it promises to be another exciting ride.

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02/99

New Interns and Residents, Continued

The following are among the new interns and residents in training for the 1998-1999 year in Texas hospitals and medical centers:

DALLAS SOUTHWEST MEDICAL CENTER (DALLAS)

Rory Allen, D.O.
Intern
UNTHSC

Karen Birdy, D.O.
Intern
UNTHSC

Michelle Clay, D.O.
Intern
OUCOM

Elizabeth Karashin, D.O.
Intern
UNTHSC

Cecilia Okafor, D.O.
Intern
UNTHSC

Charles Roberts, D.O.
Intern
UNTHSC

Thomas Shima, D.O.
Intern
UNTHSC

(Left to right) Karen Birdy, D.O.; Elizabeth Karashin, D.O.; Michelle Clay, D.O.; Thomas Shima, D.O.; Cecilia Okafor, D.O.; and Charles Roberts, D.O.

Self's Tips & Tidings

By Don Self

Medicare Carrier Manuals

For those of you that have adapted to the '90s and have Internet access, you can access and download the Medicare Carrier Manuals at the following website: http:/www.hcfa.gov/pubforms/progman.htm and choose Pub 14 for the carrier manual. This is the manual from HCFA to the Medicare carriers. It has policy numbers referenced, such as 15016 for teaching physicians, etc.,

Determining Fees for Injectables

How do you determine your fees for injectable drugs? If you're using what Medicare pays or a percentage of that, you may be losing money. We recommend you use the following to help you determine your fees.

Each of the following is based on your cost for the drug, so you need to have it available:

* If cost is less than $5.00 - triple cost
* If cost is $5.01 to $10.00 - double cost
* If cost is $10.01 to $20.00 - multiply cost by 1.5
* If cost is more than 20.00 - multiply cost by 1.3

Also, since at the time of this writing, the Clinton administration wants to slash Medicare reimbursement on injectable drugs, you need to make sure you are paying the absolute lowest amount you can. Negotiate as much as possible with your suppliers.

Nebulizer Treatments

Every once in awhile, we are asked about the proper codes to use for Nebulizer treatments. They are:

94640 = therapeutic non-pressurized tx
(neb) 94650 = therapeutic pressurized tx
(IPPB) 94664 = diagnostic tx

If billing Medicare, you may also wish to bill K0504 or K0505 for the Albuterol used.

When to Expect 1999 E/M Guidelines

HCFA recently reported that we should not expect to see the new E/M guidelines until at least the first quarter of 2000. This does not mean that you shouldn't continue to ensure your documentation meets either the 1995 or 1998 documentation guidelines. I'm still absolutely amazed at the number of physicians who are sticking their head in the sand when it comes to the ever-changing requirements for documenting Evaluation & Management services. In my travels, I still see physicians using the S.O.A.P. method for documenting - which definitely does not meet the 1995 or 1998 guidelines. In one office I opened the documentation for the hospital visit and saw two words: "Pt Static." I checked the billing records and found the doctor had billed for 99232. Those two words do not even support a level one visit, much less a level two.

In another office, I found absolutely no documentation of review of systems. With that documentation, the office was not even justified in billing for one instance of 99213 or above. Per HCFA, in more than 60% of the pre-pay audits performed by Medicare, the physician is losing. In more than 60% of the audits, the claim is either denied or down-coded, and those audits will intensify in 1999. We are scheduling seminars throughout the country on the documentation requirements for E/M services for physicians. If you wish to be notified of one in your city, call us at 1-888-DONSELF. *(Note - this toll free area code is 888 and not 800.) If you wish us to teach a two-hour seminar on this at your hospital - call us.*

Another Way to Buy Computer Products

So far, we've bid and won great prices on several computer products at the following website auctions: www.ezbid.com, www.onsale.com and www.egghead.com.

Nutritionalist Counseling

If you bill Medicare as a covered service for nutritionalist counseling in your office, it can only be billed at 99211 under incident to guidelines (physician must be on premises). If your practice bills in this manner, you will not be collecting enough money to pay the nutritionist and cover the cost of the resources used to provide it. Therefore, you will be constantly providing the service as an economic loss. Since HCFA still cannot understand that diet control is one of the most critical elements for the medical success of the renal, cardiac, gastric, and obese patient (it can save a lot of money in health care if the patient is trained and followed properly), it is best to bill a patient as a non-covered service and not use an office visit code on your records. Create your own billing code and avoid CPT codes for this service. Conscious Sedation is not covered. Medicare will not pay for conscious sedation, no matter how you bill it, so don't bother.

Who Gets the Patient to Sign ABN Medicare Waivers?

That job goes to everyone in the office. Now, obviously it will be easier for some than others, depending on the circumstances, willingness of the nurses to do what is needed, the physician's willingness to participate in the reimbursement paperwork, etc. Here are some examples.

1. Patient calls for an appointment and when asked why, "annual exam," the word "routine," "periodic" or the word "screening" is used. In that case, the Medicare patient should be told that Medicare does not normally cover screening services, and the patient should be expected to pay for the service at the time of service. When the patient arrives,

prior to being put into the examination room, the waiver should be signed - obvious choice is the receptionist.

2. Patient tells staff he is there for shoulder pain. The nurse takes vitals and logs in chief complaint of "shoulder pain." The patient is grimacing and complains of it. Doctor walks in, nurse walks out and first thing out of the patient's mouth is "Doc, my shoulder is really fine, but the missus wants me to get some of that Viagra." Stop the presses. Now it's the doctor's turn to have a waiver signed. He or she reaches up onto the shelf in the exam room, pulls out the waiver and has the patient sign it before going any further, explaining that Medicare does not cover Viagra visits. *(Note: Medicare does cover impotence visits, but not visits strictly for a Viagra prescription.)*

3. Doctor examines the patient who requests a B-12 injection for malaise or fatigue. Prior to giving the injection, the nurse has the patient sign a waiver. Keep in mind that if the patient refuses to sign the waiver and you're going to go ahead and do the service, the notation "patient refuses to sign" should be on the waiver. Then, two of your office employees need to sign it if you wish to try to collect from the patient at a later time.

Norplant Capsules and Medicaid

Depending on your state Medicaid carrier, insertion or removal of Norplant Capsules may or may not be covered. In Texas, Medicaid covers it with codes 11975 or 11977 and the HCPCS code a4260.

Changes in Medicare, Managed Care and Insurance

To help everyone get a grasp of all of the changes, coverages and issues affecting your reimbursement, Don is teaching workshops in February and March in the cities listed below. To receive fax or email information on the following seminars, call 1-800-256-7045, fax Don at 903-839-7069 or email donself@donself.com. Be sure to visit the website at www.donself.com

Tyler: February 18 - Sheraton Hotel
Longview: February 19 - Holiday Inn
Fort Worth: February 25 - Holiday Inn at Beach & I-30
Beaumont: March 4 - Holiday Inn on I-10
Houston: March 5 - Holiday Inn S.W.
Abilene: March 12 - Ramada Hotel
Orlando, Florida: March 24 - Marriott Downtown

Billing for Hospital H&P

Due to the fact that H&Ps (hospital admits) are considered to be a hospital in-patient service, and the place of service on the claim must be 21 for billing purposes, it is a requirement that you physically have a face-to-face encounter with the patient on the day the H&P is billed. You cannot, legally, examine the patient in your office and admit them through a phone call to the hospital without physically presenting yourself to the hospital on the same date.

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By Alecia Hathaway, M.D., M.P.H.

Epilepsy & Women

When this article was being written, it was the beginning of November, which was National Epilepsy Awareness Month. Although the national awareness focus has passed, I would like to share some aspects of this chronic disease with you which I have found worthwhile. Epilepsy is a subject that touches the lives of so many of us and something we often have to be mindful of when managing patients with simple and complex problems. Simple medical and health issues can become fairly complex to manage when the patient has underlying epilepsy, and certain forms of epilepsy are enough of a challenge on their own to manage. Women and children in general have been recognized as a vulnerable population for special health issues, and epilepsy can pose a handicap for women in fulfilling some of life's functions and dreams. Understanding the gender considerations influencing epilepsy may help physicians to better manage this condition in women, and understanding the impact of epilepsy on the gender can give hope to women for minimizing the impact of this disease on their lives. The following is a reprint of an article which appeared in the Texas Department of Health's "Disease Prevention News," *Oct. 26, an issue devoted to epilepsy and featuring a special piece on women. I hope you'll find the statistics and information to be beneficial as well as interesting.*

In the United States, about one of every 100 people has epilepsy. Twenty percent of epilepsy cases develop before the age of 5, and 50% of cases develop before age 25. Every year, 125,000 new cases of this common neurological condition are diagnosed. At least 2.5 million Americans and 50 million people worldwide have epilepsy.

Although epilepsy is often considered to be primarily an inherited condition, it actually can be acquired in many ways. Other potential causes include:

* Moderate head injury
* Severe head injury
* Alcohol abuse
* Bacterial meningitis
* Stroke
* Alzheimer's disease
* Heroin abuse
* Family history of epilepsy
* Viral encephalitis
* Viral meningitis

More than 1 million American women and girls have seizure disorders. The Epilepsy Foundation has launched a Campaign for Women's Health to raise awareness about epilepsy's impact on women and to alleviate the psychosocial consequences women face.

While an equal number of men also are affected, women are uniquely challenged by this disorder. They face an increased risk of sudden, unexplained death, prolonged life-threatening seizures, and elevated rates of depression and suicide. Other major concerns include:

Hormone-sensitive Seizures. Gonadal, adrenal, pituitary and thyroid hormones are among those that can alter the excitability of neurons in the cerebral cortex. Therefore, many women with epilepsy experience changes in seizure patterns during times of

hormonal fluctuation (e.g., at menarche, during the menstrual cycle and during menopause).

Congenital Malformations. Seizures and the medications that control them present a variety of risks for pregnant women and their babies. Although there is no increased risk of early fetal death, there is an increased incidence of late fetal loss among women with seizures (as much as twice that of the general population). In general, antiepileptic drugs (AEDs) are associated with increased incidences of birth defects in infants born to women with epilepsy.

Sexuality. Women taking AEDs may experience lowered fertility rates and sexual dysfunction. The causes are multifactorial. Psychosocial causes include poor self-esteem, limited social opportunities, and fears that sexual activity will precipitate a seizure. The findings of one study evaluating self-reported sexual function found physiologic effects that included a high incidence of dyspareunia, vaginismus and a lack of vaginal lubrication.

Parenting. Until recently, women with epilepsy were discouraged from having children. Although much of the misinformation regarding parenting has been dispelled, concerns remain regarding how women with seizure disorders can safely care for their children. The most important single factor in the ability of these women to have good parenting experiences is for them to have optimal seizure control Appropriate lifestyle and environmental adaptations are also important to ensure successful parenting.

Age. Seizures often begin in puberty, exacerbating an already difficult time in a young woman's life. Postmenopausal women are as likely to experience worsened seizure control as they are to experience improved seizure control. Women are more likely than men to develop epilepsy later in life.

Economics. The legal, economic and social consequences of epilepsy can be particularly severe for women with this disorder. Women with epilepsy often are unable to obtain insurance of any kind and are not permitted to drive.

The Campaign

The Epilepsy Foundation's National Campaign for Women's Health is divided into two initiatives. The community initiative provides information and support to help women with epilepsy work more effectively with their health care providers to manage the effects of epilepsy in their daily lives.

The second initiative targets the scientific and provider communities to generate support for research into causes and solutions and raise awareness among health care providers about the difficulties that women with epilepsy face.

Through these initiatives, the campaign seeks to empower women with epilepsy to improve their own health care and develop a network of mutual support to help them cope with the condition and its impact on their lives.

The foundation has developed a packet of educational materials for the media, patients and health care providers. For further information regarding these materials, contact the TDB Epilepsy program at 512-458-7796.

When counseling female patients on how they can help manage their condition, it may be useful to share the following tips with them. Typing up a little fact sheet or obtaining something similar from the referenced epilepsy organizations could prove useful to give them among other educational materials.

Tips for Women with Epilepsy

* Tell your doctor if you notice a pattern to your seizures. It may be possible to reduce the number of episodes by changing when and how much medication you take.

* Don't decide against having children just because you have epilepsy. About 90% of women with this condition have normal, healthy children. However, some epilepsy medications can affect an unborn child, so check with your doctor before you conceive. Certain vitamin supplements may reduce the chance of some birth defects. If you find that you are already pregnant, don't stop your medication on your own.

* Some epilepsy medications are known to reduce the effectiveness of oral contraceptives. Check with your doctor before using birth control pills or implants.

* Be aware of possible changes in seizure patterns whenever you experience a shift in hormone levels, such as during pregnancy, following childbirth and at menopause. Check with your doctor for help in managing the situation if the seizure pattern changes.

* Remember, you are not alone. Share your experiences with other women who have seizures. You may find that they've developed coping skills you can use.

For information about issues facing women with epilepsy, contact your local Epilepsy Foundation, or call the national office at 800-EFA-1000. Information about the Women and Epilepsy Campaign can be found the foundation's website at www.efa.org

Active-duty Family Member Inpatient Hospital Rate Increase

Effective October 1, 1998, the daily amount active-duty family members paid for inpatient care in civilian hospitals under TRICARE Standard and TRICARE Extra increased from $10.20 to $10.45.

The rate increase means that an active-duty family member who's admitted to a civilian hospital for care (except mental health care) under TRICARE Standard or TRICARE Extra now pays the $10.45 daily rate, multiplied by the number of days spent in the hospital - or a flat fee of $25, whichever total is greater. The flat $25 cost-sharing rate also applies to ambulatory (same-day) surgery.

The $10.45 inpatient rate does not apply to any other category of TRICARE-eligible patients, only to active-duty family members. Inpatient care for other categories of TRICARE beneficiaries will, in most cases, be cost-shared under the diagnosis-related group (DRG) payment system for TRICARE Standard and TRICARE Extra.

Inpatient mental health care at civilian facilities costs $20 per day for active-duty family members under TRICARE Standard, TRICARE Extra or TRICARE Prime. This rate applies to admissions to:

* Any hospital for mental health services;

* Any residential treatment facility or substance use disorder rehabilitation facility;

* Any partial hospitalization program offering mental health or substance use disorder rehab services.

The daily inpatient mental health rate for other (non-active-duty family member) patients is $40 per day under TRICARE Prime. The TRICARE Extra cost-share is 20 percent of institutional and professional charges.

Under TRICARE Standard, for lower-volume hospitals and units, the mental health care-substance abuse disorder treatment cost-share will be the lesser of a specific daily rate ($140 in Fiscal Year 1999) or 25 percent of institutional billed charges. For high-volume hospitals and units, the cost-share is 25 percent of the hospital's specific per diem amounts and separately billed professional charges.

"DRG" Rate Increase

The TRICARE Standard diagnosis-related group (DRG) daily rate for most civilian non-mental health hospital admissions increased on October 1, 1998, to $376, or 25 percent of the hospital's billed charges, whichever is less.

The daily rate will be $376 for TRICARE Standard-eligible persons other than active-duty family members. They will pay either the fixed daily rate of $376, or 25 percent of the hospital's billed charges, whichever is less.

The inpatient daily rate for non-active-duty family members at a TRICARE network facility is cost-shared using TRICARE Extra. The cost-share for TRICARE Extra users is the lesser of $250 per day, or 25 percent of the institution's billed charges, plus 20 percent of the charges by individual professional providers who treat the patient during the hospital stay.

Active-duty family members' cost-shares are not affected by the DRG rates. As noted earlier, they will pay a small daily fee of $10.45 for each day in a civilian hospital ($20 per day for inpatient mental health care) or a total of $25 for each hospital stay, whichever is greater.

When non-active-duty family members are admitted to hospitals that are exempted from the DRG payment system, their cost-share will be 25 percent of the TRICARE-determined allowable charges. DRG-exempt hospitals include: psychiatric, cancer, long-term care, rehabilitation, and sole community hospitals exempt from Medicare's prospective payment program. Hospitals in the state of Maryland are also exempt from the DRG payment system because of its stricter state law.

For more information about DRG payments, contact the health benefits adviser at the nearest uniformed services medical facility, or talk to a staff member at your nearest TRICARE service center.

FROM THE OFFICE OF INSPECTOR GENERAL —

FRAUD ALERT

Physician Liability for Certifications in the Provision of Medical Equipment and Supplies and Home Health Services

(Issued January, 1999)

The Office of Inspector General (OIG) was established at the Department of Health and Human Services by Congress in 1976 to identify and eliminate fraud, waste, and abuse in the Department's programs and to promote efficiency and economy in departmental operations. The OIG carries out this mission through a nationwide program of audits, inspections, and investigations. To reduce fraud and abuse in the Federal health care programs, including Medicare and Medicaid, the OIG actively investigates fraudulent schemes that obtain money from these programs and, when appropriate, issues Special Fraud Alerts that identify segments of the health care industry that are particularly vulnerable to abuse.

Copies of all OIG Special Fraud Alerts are available on the Internet at: http://www.dhhs.gov/progorg/oig/frdalrt/index.htm

We are issuing this Fraud Alert because physicians may not appreciate the legal and programmatic significance of certifications they make in connection with the ordering of certain items and services for their Medicare patients. While the OIG believes that the actual incidence of physicians' intentionally submitting false or misleading certifications of medical necessity for durable medical equipment or home health care is relatively infrequent, physician laxity in reviewing and completing these certifications contributes to fraudulent and abusive practices by unscrupulous suppliers and home health providers. We urge physicians and their staff to report any suspicious activity in connection with the solicitation or completion of certifications to the OIG.

Physicians should also be aware that they are subject to substantial criminal, civil, and administrative penalties if they sign a certification knowing that the information relating to medical necessity is false, or with reckless disregard as to the truth of the information being submitted. While a physician's signature on a false or misleading certification made through mistake, simple negligence, or inadvertence will not result in personal liability, the physician may unwittingly be facilitating the perpetration of fraud on Medicare by suppliers or providers.

Accordingly, we urge all physicians to review and familiarize themselves with the information in this Fraud Alert. If a physician has any questions as to the application of these requirements to specific facts, the physician should contact the appropriate Medicare Fiscal Intermediary or Carrier.

The Importance of Physician Certification for Medicare

The Medicare program only pays for health care services that are medically necessary. In determining what services are medically necessary, Medicare primarily relies on the professional judgment of the beneficiary's treating physician, since he or she knows the patient's history and makes critical decisions, such as admitting the patient to the hospital; ordering tests, drugs, and treatments; and determining the length of treatment. In other words, the physician has a key role in determining both the medical need for, and utilization of, many health care services, including those furnished and billed by other providers and suppliers.

Congress has conditioned payment for many Medicare items and services on a certification signed by a physician attesting that the item or service is medically necessary. For example, physicians are routinely required to certify to the medical necessity for any service for which they submit bills to the Medicare program. Physicians also are involved in attesting to medical necessity when ordering services or supplies that must be billed and provided by anindependent supplier or provider. Medicare requires physicians to certify to the medical necessity for many of these items and services through prescriptions, orders, or, in certain specific circumstances, Certificates of Medical Necessity (CMNs). These documentation requirements substantiate that the physician has reviewed the patient's condition and has determined that services or supplies are medically necessary.

Two areas where the documentation of medical necessity by physician certification plays a key role are (i) home health services and (ii) durable medical equipment (DME). Through various OIG audits, we have discovered that physicians sometimes fail to discharge their responsibility to assess their patients' conditions and need for home health care. Similarly, the OIG has found numerous examples of physicians who have ordered DME or signed CMNs for DME without reviewing the medical necessity for the item or even knowing the patient.

Physician Certification for Home Health Services

Medicare will pay a Medicare-certified home health agency for home health care provided under a physician's plan of care to

a patient confined to the home. Covered services may include skilled nursing services, home health aide services, physical and occupational therapy and speech language pathology, medical social services, medical supplies (other than drugs and biologicals), and DME.

As a condition for payment, Medicare requires a patient's treating physician to certify initially and recertify at least every 62 days (2> months) that:

* the patient is confined to the home;
* the individual needs or needed (i) intermittent skilled nursing care; (ii) speech or physical therapy or speech-language pathology services; or (iii) occupational therapy or a continued need for occupational therapy (payment for occupational therapy will be made only upon an initial certification that includes care under (i) or (ii) or a recertification where the initial certification included care under (i) or (ii));
* a plan of care has been established and periodically reviewed by the physician; and
* the services are (were) furnished while the patient is (was) under the care of a physician.

The physician must order the home health services, either orally or in writing, prior to the services being furnished. The physician certification must be obtained at the time the plan of treatment is established or as soon thereafter as possible. The physician certification must be signed and dated prior to the submission of the claim to Medicare. If a physician has any questions as to the application of these requirements to specific facts, the physician should contact the appropriate Medicare Fiscal Intermediary or Carrier.

Physician Orders and Certificates of Medical Necessity for Durable Medical Equipment, Prosthetics, Orthotics, and Supplies for Home Use

DME is equipment that can withstand repeated use, is primarily used for a medical purpose, and is not generally used in the absence of illness or injury. Examples include hospital beds, wheelchairs, and oxygen delivery systems. Medicare will cover medical supplies that are necessary for the effective use of DME, as well as surgical dressings, catheters, and ostomy bags. However, Medicare will only cover DME and supplies that have been ordered or prescribed by a physician. The order or prescription must be personally signed and dated by the patient's treating physician.

DME suppliers that submit bills to Medicare are required to maintain the physician's original written order or prescription in their files. The order or prescription must include: 1) the beneficiary's name and full address; 2) the physician's signature; 3) the date the physician signed the prescription or order; 4) a description of the items needed; 5) the start date of the order (if appropriate); and 6) the diagnosis (if required by Medicare program policies) and a realistic estimate of the total length of time the equipment will be needed (in months or years).

For certain items or supplies, including supplies provided on a periodic basis and drugs, additional information may be required. For supplies provided on a periodic basis, appropriate information on the quantity used, the frequency of change, and the duration of need should be included. If drugs are included in the order, the dosage, frequency of administration, and, if applicable, the duration of infusion and concentration should be included.

Medicare further requires claims for payment for certain kinds of DME to be accompanied by a CMN signed by a treating physician (unless the DME is prescribed as part of a plan of care for home health services). When a CMN is required, the provider or supplier must keep the CMN containing the treating physician's original signature and date on file.

Generally, a CMN has four sections:

Section A contains general information on the patient, supplier, and physician. Section A may be completed by the supplier.

Section B contains the medical necessity justification for DME. This cannot be filled out by the supplier. Section B must be completed by the physician, a non-physician clinician involved in the care of the patient, or a physician employee. If the physician did not personally complete section B, the name of the person who did complete section B and his or her title and employer must be specified.

Section C contains a description of the equipment and its cost. Section C is completed by the supplier.

Section D is the treating physician's attestation and signature, which certifies that the physician has reviewed sections A, B, and C of the CMN and that the information in section B is true, accurate, and complete. Section D must be signed by the treating physician. Signature stamps and date stamps are not acceptable.

By signing the CMN, the physician represents that:

* he or she is the patient's treating physician and the information regarding the physician's address and unique physician identification number (UPIN) is correct;
* the entire CMN, including the sections filled out by the supplier, was completed prior to the physician's signature; and
* the information in section B relating to medical necessity is true, accurate, and complete to the best of the physician's knowledge.

Improper Physician Certifications Foster Fraud

Unscrupulous suppliers and providers may steer physicians into signing or authorizing improper certifications of medical necessity. In some instances, the certification forms or statements are completed by DME suppliers or home health agencies and presented to the physician, who then signs the forms without verifying the actual need for the items or services. In many cases, the physician may obtain no personal benefit when signing these unverified orders and is only accommodating the supplier or provider. While a physician's signature on a false or misleading certification made through mistake, simple negligence, or inadvertence will not result in personal liability, the physician may unwittingly be facilitating the perpetration of fraud on Medicare by suppliers or providers. When the physician knows the information is false or acts with reckless disregard as to the truth of the statement, such physician risks criminal, civil, and administrative penalties.

Sometimes, a physician may receive compensation in exchange for his or her signature. Compensation can take the form of cash payments, free goods, or any other thing of value. Such cases may trigger additional criminal and civil penalties under the anti-kickback statute.

The following are examples of inappropriate certifications uncovered by the OIG in the course of its investigations of fraud in the provision of home health services and medical equipment and supplies:

* A physician knowingly signs a number of forms provided by a home health agency that falsely represent that skilled nursing services are medically necessary in order to qualify the patient for home health services.
* A physician certifies that a patient is confined to the home and qualifies for home health services, even though the patient tells the physician that her only restrictions are due to arthritis in her hands, and she has no restrictions on her routine activities, such as grocery shopping.
* At the prompting of a DME supplier, a physician signs a stack of blank CMNs for transcutaneous electrical nerve stimulators (TENS) units. The CMNs are later completed with false information in support of fraudulent claims for the equipment. The false information purports to show that the physician ordered and certified to the medical necessity for the TENS units for which the supplier has submitted claims.
* A physician signs CMNs for respiratory medical equipment falsely representing that the equipment was medically necessary.
* A physician signs CMNs for wheelchairs and hospital beds without seeing the patients, then falsifies his medical charts to indicate that he treated them.
* A physician accepts anywhere from $50 to $400 from a DME supplier for each prescription he signs for oxygen concentrators and nebulizes.

Potential Consequences for Unlawful Acts

A physician is not personally liable for erroneous claims due to mistakes, inadvertence, or simple negligence. However, knowingly signing a false or misleading certification or signing with reckless disregard for the truth can lead to serious criminal, civil, and administrative penalties including:

* criminal prosecution;
* fines as high as $10,000 per false claim plus treble damages; or
* administrative sanctions including: exclusion from participation in Federal health care programs, withholding or recovery of payments, and loss of license or disciplinary actions by state regulatory agencies.

Physicians may violate these laws when, for example:

* They sign a certification as a "courtesy" to a patient, service provider, or DME supplier when they have not first made a determination of medical necessity;
* They knowingly or recklessly sign a false or misleading certification that causes a false claim to be submitted to a Federal health care program; or
* They receive any financial benefit for signing the certification (including free or reduced rent, patient referrals, supplies, equipment, or free labor).

Even if they do not receive any financial or other benefit from providers or suppliers, physicians may be liable for making false or misleading certifications.

What to do if you have Information about Fraud and Abuse Against Medicare or Medicaid Programs

If you have information about physicians, home health agencies, or medical equipment and supply companies engaging in any of the activities described above, contact any of the regional offices of the Office of Investigations of the Office of Inspector General, U.S. Department of Health and Human Services, at the following locations:

FIELD OFFICE	STATES SERVED	TELEPHONE
Boston	MA, VT, NH, ME, RI, CT	617-565-2664
New York	NY, NJ, PR, VI	212-264-1691
Philadelphia	PA, MD, DE, WV, VA, DC	215-861-4586
Atlanta	GA, KY, NC, SC, FL, TN, AL, MS	404-562-7603
Chicago	IL, MN, WI, MI, IN, OH, IA, MO	312-353-2740
Dallas	TX, NM, OK, AR, LA, CO, UT WY, MT, ND, SD, NE, KS	214-767-8406
Los Angeles	So. CA, AZ, NV	714-246-8302
San Francisco	No. CA, AK, HI OR, ID, WA	415-437-7961

NEWS you can USE

Hepatitis B Immunization (Medicaid)

Effective March 1, 1998, all children from birth through 18 years of age are approved to be vaccinated against Hepatitis B with vaccine supplied by the Texas Department of Health, Texas Vaccines for Children (TVFC) Program. It is no longer necessary to be included in a Hepatitis B high-risk group to be eligible for the state-supplied vaccine. Children who begin the series before their 19th birthday are eligible to complete the series in later years with vaccine supplied by TVFC.

Individuals who are 19 years of age or older and beginning the series have the vaccine provided under THSteps-CCP, without the requirement of determining medical necessity. Providers should use procedure code 9-5739X to bill for the vaccine provided under THSteps-CCP. Providers will be reimbursed the actual cost of the vaccine (receipt required) and the $5.00 administration fee. Clients age 20 years and older will require the adult formulation of Hepatitis B.

CCP benefits end on the date of the client's 21st birthday. If the series has not been completed by that time, the physician will make the determination of medical necessity in order to complete the series under the Medicaid program.

Senate Bill 30 Update: RE-ENROLLMENT

During the next few months, all Medicaid providers will, or may have already, received a re-enrollment packet for every Medicaid provider number currently in the provider database at NHIC. It is not necessary to complete a packet for each of these provider numbers. You may:

*Complete each packet separately, for each of your provider numbers that you wish to continue to use for billing, or

*Complete one packet, including all your individual practice Medicaid and CIDC numbers, and

*Indicate the provider numbers for which you are re-enrolling by checking the appropriate provider type on the application, and listing your provider numbers on the Addendum Statement of the provider agreement.

Reminder: Multiple numbers may be combined onto one application/agreement if the information reported is the same for each individual provider number listed.

Any provider numbers that are not included in these return documents will be disenrolled as of September 1, 1999. If you have questions about the re-enrollment, contact NHIC Customer Service at 800-925-9126.

A few important key notes to remember in completing your re-enrollment:

* Sign and notarize all appropriate sections of the packet
* Keep a copy for your records (return the original)
* Return (mail) the entire completed packet to NHIC Provider Enrollment
* Use the checklist to help prevent your packet from being returned incomplete
* Complete the packet and return as soon as possible to prevent delays in processing of your application

Please remember that those providers who have not completed this process, according to NHIC's records, will be disenrolled from the Medicaid program effective September 1, 1999; therefore, Medicaid claims with dates of service on or after September 1, 1999, will be denied and ineligible for appeal. It is very important for all providers to compete re-enrollment before September 1, 1999. Current claims processing will not be affected by the re-enrollment.

Texas Board of Health Proposes Revised Immunization Requirements

The Texas Board of Health has proposed revised immunization requirements for children and students attending Texas public and private schools, child-care facilities and institutions of higher education. The proposed revisions have been published in the Texas Register and information is also posted on the Immunization Division's website at www.tdh.state.tx.us/immunize/immpage1.htm. If approved, the rules will be effective August 1, 1999.

The following summarizes the changes and the groups who would be affected.

VACCINE	AGE GROUPS AFFECTED	GEOGRAPHIC AREA
Hepatitis A	1) Children ages 2 through 5 years who attend child-care facilities.	32 counties: Brewster, Brooks, Cameron, Crockett, Culberson, Dimmitt, Duval, Edwards, El Paso, Frio, Hidalgo, Hudspeth, Jeff Davis, Jim Hogg, Kenedy, Kinney La Salle, Marverick McMullen, Pecos Presidio, Real, Reeves, Starr, Sutton, Terrell Uvalde, Val Verde, Webb, Willacy, Zapata and Zavala.
	2) Children 5 years old or older who were born on or after September 2, 1992 who attended public or private school.	
	EXISTING REQUIREMENT	
Hepatitis B (3 doses)	1) Children 5 years old or older who were born on or after September 2, 1992 who attend public or private school.	Entire state
	PROPOSED ADDITIONAL REQUIREMENT	
	2) Children 12 years old or older who were born on or after September 2, 1987 but before September 2, 1992 who attend public or private school.	
Varicella (1 or 2 doses)	1) Children 12 months old and older who attend child-care facilities.	Entire state
	2) Children 5 years old or older who were born on or after September 2, 1993 who attend public or private school.	
	3) Higher education students pursuing health-related professions course work which involves direct patient contact.	

Welcome New TOMA Members – Part I

The TOMA members and Board of Trustees would like to welcome the new members who joined the association in 1998. This month we list new members from Districts I through VII.

DISTRICT I

Douglas A. Albracht, D.O.
212 S. Bliss
Dumas, TX 79029
TCOM '92; Orthopedics

DISTRICT II

Paul E. Barrus, D.O.
1614 Scripture #3
Denton, TX 76201
WESTERN U '87;
Family Practice

Margaret C. Basiliadis, D.O.
UNTHSC/TCOM
3500 Camp Bowie Blvd.
Fort Worth, TX 76132
OUCOM '91; Family Practice, Geriatrics

Mary Ann Block, D.O.
1721 Cimarron Trail #4
Hurst, TX 76054
TCOM '89; Family Practice, OMM

Mary H. Caffrey, D.O.
OMCT
1000 Montgomery
Fort Worth, TX 76107
TCOM '87; Diagnostic Radiology

Shae M. Chaffin, D.O.
Brazos Medical Clinic
305 W. Pearl
Granbury, TX 76048
UNTHSC/TCOM '95;
Family Practice

Burke G. Delange, D.O.
901 Montgomery
Fort Worth, TX 76107
NSU/COM '91; General Surgery

Stanley C. Evans, D.O.
2412 Old North Rd. #100-B
Denton, TX 76201
TCOM '91; Family Practice

Jill A. Gramer, D.O.
5613 Pershine
Fort Worth, TX 76107
OSU-COM '94; Family Practice

Jamie D. Inman, D.O.
UNTHSC/TCOM
3500 Camp Bowie Blvd.
Fort Worth, TX 76107
UNTHSC/TCOM '95;
Family Practice

Neil M. Levine, D.O.
1322 Paluxy #C
Granbury, TX 76048
CCOM '74;
Obstetrics/Gynecology

Paul T. Marsh, D.O.
3603 West 7th
Fort Worth, TX 76107
TCOM '90; Diagnostic Radiology

JoAnne C. Paulk, D.O.
902 W. College
Cross Plains, TX 76443
KCOM '96; Family Practice

Irvine D. Prather, D.O.
UNTHSC/TCOM
3500 Camp Bowie Blvd.
Fort Worth, TX 76107
WVSOM '84; Family Practice

David R. Rittenhouse, D.O.
999 Montgomery
Fort Worth, TX 76107
OSU-COM '83; Urology

Suzanne H. Shenk, D.O.
UNTHSC/TCOM
3500 Camp Bowie Blvd.
Fort Worth, TX 76107
MSU-COM '87;
Internal Medicine

Jeanine Thomas, D.O.
6737 Brentwood Stair Road #124
Fort Worth, TX 76112
OSU-COM '93; Internal Medicine

DISTRICT III

James A. Facello, D.O.
815 S. Washington
Marshall, TX 75670
OSU-COM '94; Internal Medicine

James F. Holleman, Jr., D.O.
2708 East 5th
Tyler, TX 75701-5021
UHS-COMS '68; Family Practice, Sclerotherapy

Kathleen A. McCrory, D.O.
2606 Northhaven
Longview, TX 75605
UNTHSC/TCOM '95; Pediatrics

Charles B. Pruitt, D.O.
719 W. Coke Rd. #3
Winnsboro, TX 75494
UNTHSC/TCOM '94;
Family Practice

Anthony S. Rector, D.O.
1300 North 6th
Longview, TX 75601
TCOM '88; Family Practice, Emergency Medicine

Samantha J. Roworth, D.O.
Primary Care Associates
2101 West Loop 281
Longview, TX 75604
KCOM '94; Pediatrics

Mike K. Smith, D.O.
3215 West Oak #115
Palestine, TX 75801
TCOM '93; Family Practice

James A. Thurow, D.O.
120 Williamsburg
Bullard, TX 75757
CCOM '71; Internal Medicine, Nuclear Medicine

Roy B. Wadle, D.O.
719 W. Coke Rd. #3
Winnsboro, TX 75495
UNTHSC/TCOM '94; Family Practice

DISTRICT V

Gerald G. George, D.O.
4116 S. Carrier Pkwy #250
Grand Prairie, TX 75051
UNTHSC/TCOM '95;
Family Practice

William H. Jones, D.O.
Texas Anesthesia, LLP
6757 Arapaho Rd. #711
Dallas, TX 75248
PCOM '93; Anesthesiology

Daniel K. Leong, D.O.
4436 Walnut
Garland, TX 75042
UHS-COM '81; Family Practice

Lance J. Miller, D.O.
3500 I-35 #B-210
Mesquite, TX 75181
UNTHSC/TCOM '95; Family Practice

Joe A. Phipps, D.O.
200 Dalton
DeSoto, TX 75115
KCOM '70; Family Practice

John F. Priestley, D.O.
2085 Promenade Center
Richardson, TX 75080
TCOM '87; Family Practice, Sports Medicine

DISTRICT VI

Elroy T. Cantrell, D.O.
685 Elkins Lake
Huntsville, TX 77340
TCOM '84; Family Practice, Emergency Medicine

David G. Carpenter, D.O.
18842 Memorial South #208
Humble, TX 77338
TCOM '78; Family Practice

James E. Cary, D.O.
25410 I-45, #100
Spring, TX 77386
KCOM '51; Family Practice

Gerald R. Garwood, D.O.
2901 East 29th #113
Bryan, TX 77802
UHS-COM '69; Internal Medicine

Gary H. Lew, D.O.
1111 Hwy 6 South #225
Sugar Land, TX 77478
NYCOM '86; Family Practice, OMM

Elliot C. Maness, D.O.
4427 Broadleaf
Kingwood, TX 77345
UOMHS/COMS '92; Surgery

Cuong K. Nguyen, D.O.
6601 Tarnef #104
Houston, TX 77074
KCOM '84; Otorhinolaryngology & Facial Plastic Surgery

Jack A. Nuszen, D.O.
11818 Gladewood La.
Houston, TX 77071
NYCOM '90; Internal Medicine, Emergency Medicine

Charles A. Popeney, D.O.
2225 Williams Trace Blvd. #110
Sugar Land, TX 77478
TCOM '91; Neurology

Gary L. Rhame, D.O.
Kelsey-Seybold Clinic
920 Medical Plaza Dr.
The Woodlands, TX 77380
UNTHSC/TCOM '94; Family Practice, Sports Medicine, Orthopedics

John L. Urbanek, D.O.
2002 Holcombe
Houston TX 77030
OSU-COM '80; Emergency Medicine

Alan G. Zond, D.O.
1700 11th Street #1
Huntsville, TX 77340
PCOM '92; Family Practice

DISTRICT VII

John S. Bennett, D.O.
106 S. Cypress
Luling, TX 78648
TCOM '83; Family Practice

Neal H. Blauzvern, D.O.
Central Texas Spine Institute
6818 Austin Center Blvd. #200
Austin, TX 78731
NYCOM '83; Anesthesiology, Pain Management

Jerry W. Morris, D.O.
5114 Balcones Woods Dr.
Austin, TX 78754
KCOM '75; Family Practice

Aaron M. Trone, D.O.
1929 E. Payton Gin
Austin, TX 78757
KCOM '96; Family Practice, OMT

Continued Next Month

TEXAS STARS

The following people have made pledges or have contributed to TOMA's Building Fund Campaign. These people are now known as "Texas Stars" because of their commitment to the osteopathic profession.

Rene Acuna, D.O.
Bruce Addison, D.O.
Ted C. Alexander, Jr., D.O.
Richard Anderson, D.O.
Sara Apsley-Ambriz, D.O.
David Armbruster, D.O.
Astra Merck
ATOMA
ATOMA District II
Aus-Tex Printing and Mailing
Mark Baker, D.O.
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