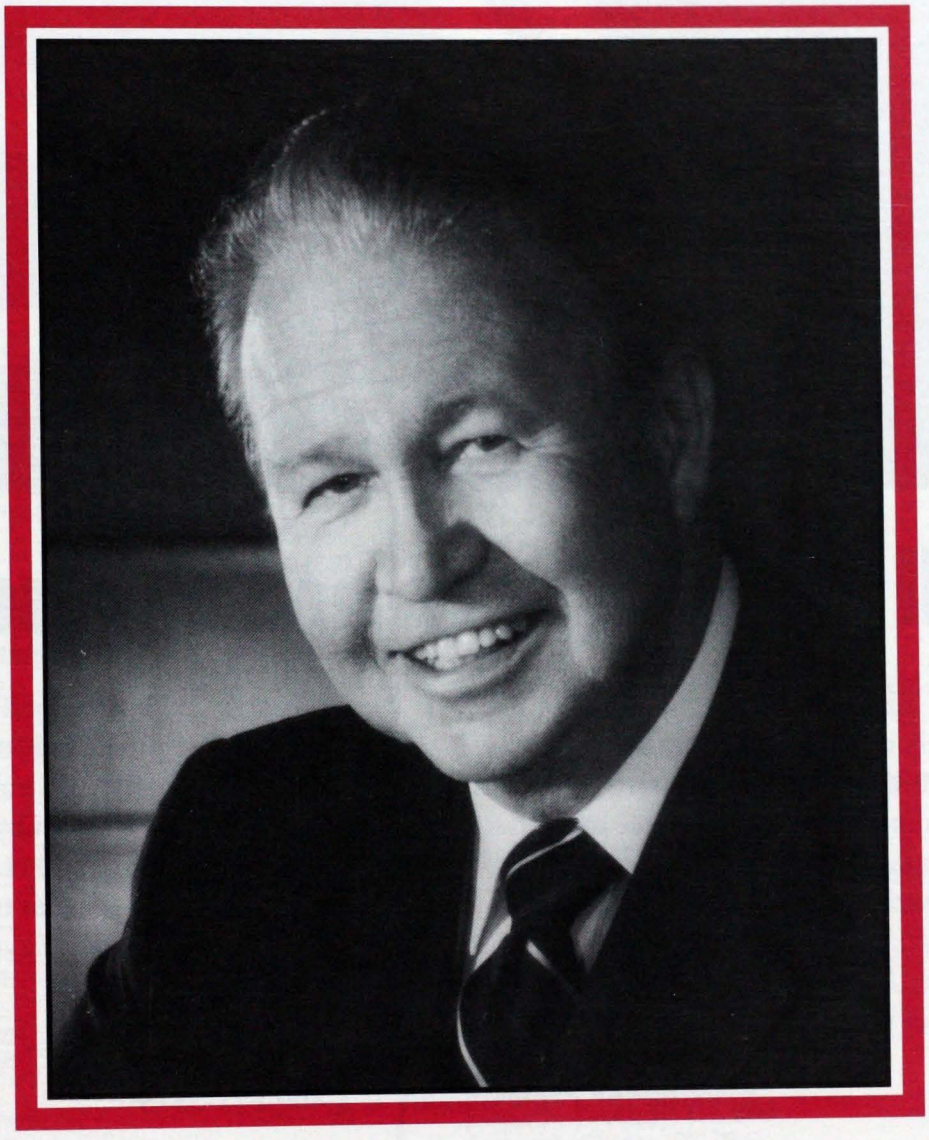
TEXAS DO

XXXXX, No. 11 TEXAS OSTEOPATHIC MEDICAL ASSOCIATION December, 1993



John H. Burnett, D.O. Receives AOA's Distinguished Service Certificate

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TOMA Major Medical Insurance	1-800/321-0246
TOMA Disability Insurance Program	1-800/321-0246
Texas College of Osteopathic Medicine	817/735-2000 Dallas Metro 429-9120
Medicare Office:	
Part A Telephone Unit	214/470-0222
Part B Telephone Unit	903/463-4495
Profile Questions	214/669-7408
Provider Numbers:	
Established new physician (solo)	214/669-6162
Established new physician (group)	214/669-6163
All changes to existing provider number records	214/669-6158
Texas Medical Foundation	512/329-6610
Medicare/CHAMPUS General Inquiry	800/725-9216
Medicare/CHAMPUS Beneficiary Inquiry	800/725-8315
Medicare Preprocedure Certification	800/725-8293
Private Review Preprocedure Certification	800/725-7388
Texas Osteopathic Medical Association	512/388-9400 in Texas 800/444-TOMA FAX No. 512/388-5957
TOMA Physicians Assistance Program	817/294-2788 in Texas 800/896-0680 FAX No. 817/294-2788
TOMA Med-Search	in Texas 800/444-TOMA
TEXAS STATE AGENCIES:	
Department of Human Services	512/450-3011
Department of Public Safety:	
Controlled Substances Division	512/465-2188
Triplicate Prescription Section	512/465-2189
State Board of Health	512/458-7111
State Board of Medical Examiners	512/834-7728
Texas State Board of Medical Examiners (for disciplinary actions only)	800/248-4062
State Board of Pharmacy	512/832-0661
State of Texas Poison Center for Doctors & Hospitals Only	713/765-1420 800/392-8548 Houston Metro 654-1701
Texas Workers' Compensation Commission	512/448-7900
FEDERAL AGENCIES:	
Drug Enforcement Administration:	
For state narcotics number	512/465-2000 ext 3074
For DEA number (form 224)	214/767-7250
CANCER INFORMATION:	
Cancer Information Service	713/792-3245 in Texas 800/392-2040

TEXAS DO

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

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TEXAS DO
TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

December, 1993

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Calendar of Events

JANUARY 29-30

TOMA's 38th Mid-Year Conference/ Legislative Forum
Location: Doubletree Hotel at Park West
Dallas, Texas
Contact: Texas Osteopathic Medical Association
One Financial Center
1717 IH 35, Suite 100
Round Rock, TX 78664-2901
512/388-9400 or 1/800/444-8662 in Texas
Fax: 512/388-5957

FEBRUARY 13-17

33rd Annual Convention of the Osteopathic Physicians and Surgeons of California, "A Step Ahead"
Location: Las Vegas, Nevada
Hours: 40 Category 1-A credits anticipated
Contact: Osteopathic Physicians and Surgeons of California
455 Capitol Mall, Suite 225
Sacramento, California 95814
916/447-2005
Fax: 916/447-4828

FEBRUARY 27 - MARCH 4

Ski & CME Midwinter Conference
Sponsored by Colorado Society of Osteopathic Medicine
Location: Keystone Lodge and Resort
Keystone, Colorado
Hours: 38 AOA Category 1-A; AAFP prescribed course credits
Contact: Patricia Morales
50 S. Steele Street, Suite 440
Denver, Colorado 80209
303/332-1752
Fax: 303/322-1956

MARCH 2-6

LAMBDA OMICRON GAMMA Medical Society's Annual Convention
(Formerly Log National Fraternity)
Location: Disney's Contemporary Resort
Lake Buena Vista, Florida
Topic: "Sports Medicine"
Hours: 16 AOA Category 1A credits requested
Contact: Lisa Mitchell
LOGMS Executive Secretary
215/649-8086

3-6

Florida Osteopathic Medical Association 91st Annual Convention
Location: Doral Ocean Beach Resort,
Miami Beach, Florida
Hours: Category 1-A, 30 hours anticipated; five hours of mandatory Risk Management three hours of mandatory AIDS/HIV required for licen renewal
Contact: FOMA Executive Office
2007 Apalachee Parkway
Tallahassee, Florida 32301
(904) 878-7364

4-8

"Fourth Annual Update in Clinical Medicine for Primary Care Physicians
Sponsored by TCOM and Osteopathic Health Systems of Texas
Location: Harvey's Resort Hotel
Lake Tahoe, Nevada
Hours: 20 Category 1-A, AOA
Contact: Pam McFadden
Program Director
817/735-2581

23-27

Pan American Allergy Society Training Course and Seminar
Location: Doubletree at Post Oak
Houston, Texas
Contact: Ms. Ann Brey
Executive Secretary
Pan American Allergy Society
P.O. Box 947
Fredericksburg, Texas 78624
210/997-9853
Fax: 210/997-8625

Articles in the *"Texas DO"* that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising," according to Tex Govt 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 DO"* is required by that law: Terry R. Boucher, Executive Director, TOMA, One Financial Center, 1717 IH 35, Suite 100, Round Rock, Texas 78664-2901.

John H. Burnett, D.O. Receives AOA's Highest Honor

John H. Burnett, D.O.

John H. Burnett, D.O., of Rockwall, was presented with the American Osteopathic Association's Distinguished Service Certificate during the 98th Annual Convention and Scientific Seminar of the AOA in Boston, held October 10-14.

The Distinguished Service Certificate is the AOA's highest award, granted only to deserving members for outstanding accomplishments in scientific or professional affairs. Dr. Burnett's award was presented in recognition of his outstanding service to the osteopathic profession.

In presenting the award to Dr. Burnett, AOA President Laurence E. Bouchard, D.O., noted, "Dr. Burnett served as president of the American Osteopathic Association in 1985-86 and held many positions on AOA bureaus and committees.

"He also served as president of the Texas Osteopathic Medical Association and the American College of Osteopathic Family Physicians as well as chairman of the American Osteopathic Board of Family Physicians."

Born in Abilene, Dr. Burnett is a 1952 graduate of the Kansas City College of Osteopathic Medicine (now known as the University of Health Sciences, College of Osteopathic Medicine).

He has been a practicing osteopathic physician in Dallas and a TOMA member since 1954, receiving TOMA life membership in 1990. Besides serving as TOMA president, he has served as a member of the House of Delegates; as a board member; on the Executive Committee; and on countless committees throughout the years. He is a longtime member of TOMA District V, of which he is a past president.

TOMA honored Dr. Burnett for his outstanding contributions to the profession during the annual convention this past May, presenting him with a plaque. Likewise, he was honored by the Texas State Society of the ACOFP during the TOMA convention.

Dr. Burnett has been twice honored as "GP of the Year" by the American College of Osteopathic Family Physicians and again by the Texas State Society of the ACOFP. A section of the ACOFP headquarters was transformed into a learning center, dedicated to Dr. Burnett and his wife, Mary Burnett, D.O. This tribute was in honor of their many years of faithful service to the profession.

Both he and his wife received Founders' Medals in 1984, the Texas College of Osteopathic Medicine's highest award for contributions to medical education and health care.

Congratulations to Dr. Burnett on this well-deserved award. ■

Small Districts Ad Hoc Committee Meets

The TOMA Ad Hoc Committee for Small Districts met Monday, September 27, 1993, at 1:00 p.m. by teleconference. Those able to be connected were: Committee Chairman Mark Baker, D.O., Daniel Saylak, D.O., Joe Montgomery-Davis, D.O., T. Eugene Zachary, D.O., Randy Rodgers, D.O. and Mr. D. Scott Petty, Associate Executive Director of TOMA. Monte Troutman, D.O. was unavailable to participate.

The committee closely reviewed the data compiled by the state office regarding the membership representation on the TOMA Board of Trustees. Small districts are represented by 8 (eight) board members or 47 percent of the Board of Trustees, while large districts are represented by 9 (nine) board members or 53 percent of the Board of Trustees. In defining large and small districts the TOMA districts with 51 members or more were considered large districts. Districts with 50 members or less were considered small districts.

Small districts represent 31 percent (or 368) of TOMA's members while large districts comprise 69 percent (or 826) of TOMA's members. It was also noted that 11 (eleven) of TOMA's 18 (eighteen) districts are represented on the Board of Trustees. The committee agreed that the membership is fairly represented across the state from both small and large districts. ■

Hopeful Findings For The Overweight

Promising developments were reported by researchers at the annual meeting of the North American Association for the Study of Obesity in late October. A natural brain protein that triggers a person's appetite for fat, as well as a second that blocks the craving, have been identified by scientists. It was reported that blocking the first protein or administering the second can lower body weight in animals by 50 percent.

Also announced was the development of a cream that can reduce the size of women's thighs. Twenty-four women who applied the cream for five weeks noted a reduction of one-half inch to one-and one-half inches. ■

TOMA Mid-Year Conference/Legislative Forum
January 29-30, 1994
Doubletree Hotel at Park West, Dallas, Texas

REGISTRATION FORM

Name_____ City_____
(Please Print)

AOA #_____ College_____ Year Graduated_____

Registration Fees:

_____ $175.00 — Clinical Seminar, to include at no additional charge, the "Risk Management and Coding Seminar"

_____ $200.00 At-The-Door Registration

NOTE: REFUND POLICY: A $10.00 processing fee will be deducted for any refunds prior to January 1, 1994. No refunds after January 15, 1994.

Return to: TOMA, One Financial Center, 1717 I.H. 35, Suite 100, Round Rock Texas 78664-2901.

HOTEL RESERVATIONS

CALL: Doubletree Hotel at Park West
1/214/869-4300

Room Rates:
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(When making your reservations, indicate you are with the Texas Osteopathic Medical Association's Mid-Year Conference)

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AOA Establishes Work Group on OMT Coding

American Osteopathic Association President Laurence E. Bouchard, D.O., has appointed a representative Work Group to develop a profession-wide strategy on implementation of osteopathic manipulative treatment (OMT) codes which will be published in the 1994 CPT Manual. Dr. Bouchard appointed two physicians experienced in coding negotiations to head the Work Group — Chairman Ray Stowers, D.O., a certified family practitioner from Medford, Oklahoma, and Vice-Chairperson Judith O'Connell, D.O., a certified osteopathic manipulative medicine practitioner from Dayton, Ohio.

Other members who represent various interests within the profession include: American Academy of Osteopathy, Judith L. Lewis of Seattle, Washington; American College of Osteopathic Family Physicians, Robert L. Peters, D.O., of Round Rock, Texas; American Osteopathic College of Rehabilitation Medicine, Wayne English, Jr., D.O. of Bedford, Texas; Association of Osteopathic State Executive Directors, Norman Pawlewski of the Iowa Osteopathic Medical Association; AOA Managed Care Task Force, Bruce Cunningham of Woodbury, Minnesota; AOA Council on Federal Health Programs, Edward A. Loniewski of Redford, Michigan.

The AOA previously had negotiated with the American Medical Association's CPT Editorial Panel the inclusion of uniquely osteopathic codes in the 1994 CPT Manual. The following is the description of these new OMT codes:

Osteopathic Manipulative Treatment

Osteopathic Manipulative Treatment is a form of manual treatment applied by a physician to eliminate or alleviate somatic dysfunction and related disorders. This treatment may be accomplished by a variety of techniques.

Body regions referred to are: head region; cervical region; thoracic region; lumbar region; sacral region; pelvic region; lower extremities; upper extremities; rib cage region; abdomen and viscera region.

98925 Osteopathic manipulative treatment (OMT); one to two body regions involved

98926 three to four body regions involved

98927 five to six body regions involved

98928 seven to eight body regions involved

98929 nine to ten body regions involved

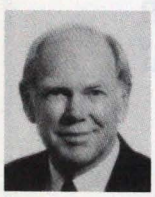
It behooves the profession to make every effort to ensure that every osteopathic physician who utilizes OMT in the practice of osteopathic medicine uses these new codes when billing third party payors for these procedures. These codes now should supplant the usage of HCPCS Codes M0702-730 and CPT Codes 97260-97261 by osteopathic physicians.

Hence the Work Group has been charged to prepare instructional materials on the use of these new codes. These materials will include background information on OMT coding, an outli of the new codes and their usag suggestions on documentation of OM in the patient's chart, and strategies f appealing denial of payment when usi these codes. The timetable calls for the materials to be in the hands of t nation's D.O.s by December 1, in plen of time for physicians who utilize OM in their practices to prepare for the u of the codes. The Work Group also h been charged with communicating to a third party payors that the new cod have been adopted so that these carrie can make required changes in the software programs to perm reimbursement for these procedure cod beginning January 1, 1994.

With some 1,500 insurance companie underwriting health insurance for thi nation's citizens, the AOA anticipate that there may be problems in th implementation of these new OM codes. Hence, the Work Group also ha been charged with training a pool o experts who can serve as trouble shooter in appealing to insurance carriers fo changes in policy to provide appropriat reimbursement for these codes.

Your state association will worl closely with the AOA in assistin individual physicians who may hav problems in getting reimbursed for thei services when using these new OM codes. Please watch your mail for these instructional materials and move quickl to prepare your office staff to implemen the codes on January 1, 1994. ■

Dr. Frank Bradley Inducted As Fellow In American Osteopathic College of Radiology



Dr. Frank Bradley, D.O., of Dallas, was presented for fellowship in the American Osteopathic College of Radiology (AOCR) by Anthony G. Bascone, D.O., FAOCR, on October 12, 1993, during the AOCR's Awards Banquet in Chicago.

Dr. Bradley is co-chairman of Tri-City Hospital in Dallas, and serves as a Clinical Associate Professor of Radiology at Texas College of Osteopathic Medicine.

A 1959 graduate of the Kansas City College of Osteopathic Medicine, Dr. Bradley interned at Dallas Osteopathic Hospital. He was in general practice for eight years prior to entering a radiology residency at Dallas Osteopathic Hospital in 1968.

Dr. Bradley was certified by the American Osteopathic Board of Radiology in 1973. He became an active member of the AOCR in 1973, serving on various committees including the Committee on Continuing Post Graduate Education.

An Honorary Life member of TOMA, Dr. Bradley served as president in 1981. He has been active in TOMA committees throughout the years and has served as a Texas delegate to the AOA House of Delegates for 14 years. Additionally, he is an active member of TOMA District V.

Dr. Bradley has lectured at national and state specialty meetings and published an article in the *Journal of the American Osteopathic Association* in 1985.

Congratulations to Dr. Bradley! ■

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AOA Annual Convention 1993

AOSED Report

Boston, Massachusetts

by D. Scott Petty, TOMA Associate Executive Director

During the AOA Annual Meeting and the House of Delegates, the TOMA staff regularly attends programming functions providing overviews from cost-saving measures in convention planning to legislative concerns problematic throughout the osteopathic profession. The Association of Osteopathic State Executive Directors (AOSED) promotes a critical link to the day-to-day efforts that make our association successful.

Recently, TOMA Executive Director Terry R. Boucher and I attended the AOA Annual Meeting in Boston, Massachusetts, taking part in the AOSED meetings. This organization is comprised of a skilled group of men and women, oriented with the day-to-day happenings in association management, with combined experience in years far exceeding the profession itself. This is a group that feels passionately for a profession which you call your livelihood. My initial reaction to this group was, how can you help me do my job in Texas? After the first meeting at the House of Delegates in July, I realized this group offered a wealth of knowledge and networking, which will benefit our association for years to come.

Terry's service on the AOSED Board of Trustees is a tremendous asset and provides Texas physicians an additional voice they would not otherwise have at the national level. The AOSED Board recommends to the AOA Board, the names of AOSED members, who can serve on specific AOA Bureaus and Committees.

The results of a random survey of D.O.'s conducted by an independent marketing firm, the Mages Company located in Germantown, Tennessee, was presented by the (NAOF) National Association of Osteopathic Foundations. Lew Riggs, Ed.D., Executive Director, Tucson Osteopathic Medical Foundation, was the presentor. Some interesting data about the osteopathic profession was noted as follows:

- **65.8%** Wanted to be a doctor and did not necessarily prefer osteopathic ove allopathic training.
- **48.8%** Indicated they became a D.O. because of their belief in the osteopathic philosophy.
- **58.2%** Applied to allopathic medical schools and 52.9 percent indicated allopathic training was their first choice.
- **30.1%** Felt there was a distinct philosophical difference between most M.D.'s and D.O.'s, while 69.7 percent felt there was little difference.
- **81.8%** Felt there was little or no difference in the way D.O.'s and M.D.'s practice medicine.
- **44.8%** Indicated it was generally important or very important that D.O.'s an M.D.'s remain distinct from one another.
- **70.3%** Said they use osteopathic manipulation less than 20 percent of the time and 27 percent indicated they did not use it at all.
- The majority of the D.O.'s sampled felt the major philosophical differenc with the M.D. was their "holistic approach" to patient care.
- **54.2%** Indicated they felt osteopathic medicine would remain a separate profession, 45.8 percent had some degree of doubt.

Additional findings brought to light may be received by contacting Lew Riggs, Ed.D., at the Tucson Osteopathic Medical Foundation, St. Phillips Plaza, 4280 N. Campbell Avenue, Suite 200, Tucson, AZ 85718.

A presentation on managed care was given by Norman Vinn, D.O., Chair, AOA Managed Care Task Force. Dr. Vinn clearly demonstrated the necessity for all physicians to grasp the reality of change and what managed care means to osteopathic physicians. **TOMA is fortunate to have Dr. Vinn tentatively scheduled as a speaker for our annual meeting, June 16-19, 1994, at the Wyndham Greenspoint in Houston.** Please mark your calendar now, as this topic is generating a high level of interest in Texas and abroad.

A fantastic seminar on "How to Increase Convention Revenue and Attendance" was very insightful. This was developed and presented by executive directors from Pennsylvania, California, Michigan, Ohio and Kansas. Discussion and input from other states illuminated some common obstacles all states face and problem solving techniques commonly used when dealing with hotels, entertainment, registration, speakers and other planning elements of a successful convention.

We were updated on the FDA/CME Rules by W. Douglas Ward, Ph.D. Director, Department of Education AOA. Although many questions were left unanswered, we were assured efforts are being implemented to improve the lines of communication between this department and the state associations. In July, TOMA submitted the required application and mission statement regarding our CME objectives. We have been notified by the AOA our application was deemed complete and is about to be presented to the Council on CME for approval.

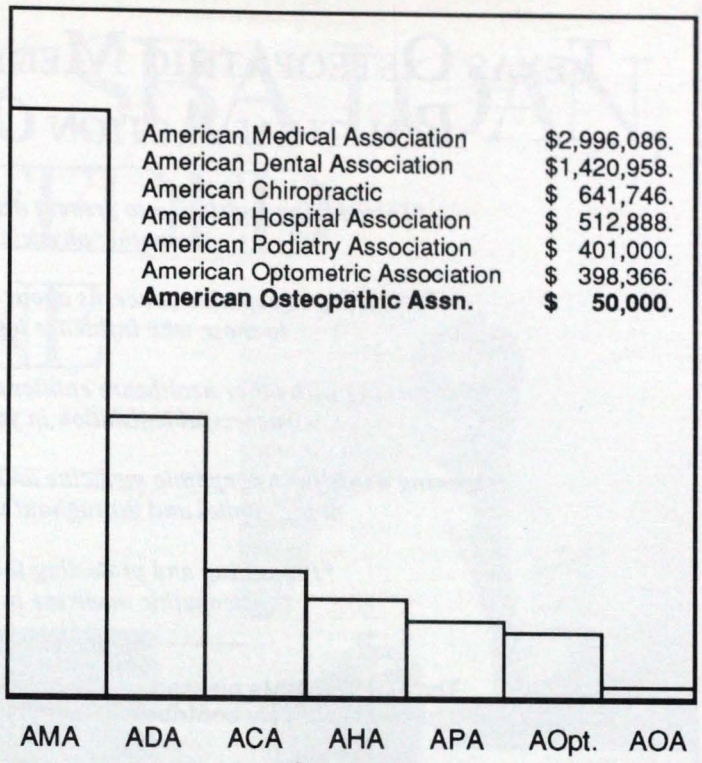
Mrs. Betsy Beckwith, the AOA Director of Government Affairs, reported on healthcare reform and federal actions pertinent to the osteopathic community. Medicaid certification was discussed and Mrs. Beckwith has requested AOSED members construct a "Legislative Tree" within their state associations. This network would provide an avenue with which the osteopathic community can uniformly voice concerns and establish a stance on legislative issues of importance to members of Congress in a timely and collective fashion. Please contact Terry or myself if you have an established relationship with a U.S. Representative or U.S. Senator so we may include you in this crucial network representing your interest at the federal level. ▶

Members of AOSED from across the country expressed concern over lobbying efforts and specifically laws prohibiting non-profit 501(c) (3) from engaging in lobbying activities. Mrs. Beckwith referred questions regarding this to AOA Executive Director Bob Draba, Ph.D., who addressed this later in his report. The AOA does employ three lobbyists, who are strictly limited to a certain percent of the budget for lobbying efforts. Political Action Committees (PAC's) were also addressed. It was noted physicians should report to the AOA all individual contributions to federal politicians, so the AOA may use these figures when printing the total contribution summary or follow-up on the doctor's behalf when needed. Minimal D.O. PAC dollars are represented from the 1992 election cycle. Lack of funds at the national **(Graph 1)** and state level **(Graph 2)** continue to make the D.O.'s voice very weak on the legislative front. TOMA and the Washington office will gladly follow-up on your behalf, so your dollars are not forgotten when an important vote is on the floor.

Mrs. Beckwith also discussed Medicaid certification and noted the state government offices will soon be moving from the Washington, D.C. office, to the AOA headquarters in Chicago. This came about in a move approved by the AOA Board of Trustees, while in Boston. Although the state government offices will be in Chicago, they will still report to Mrs. Beckwith in the Washington office.

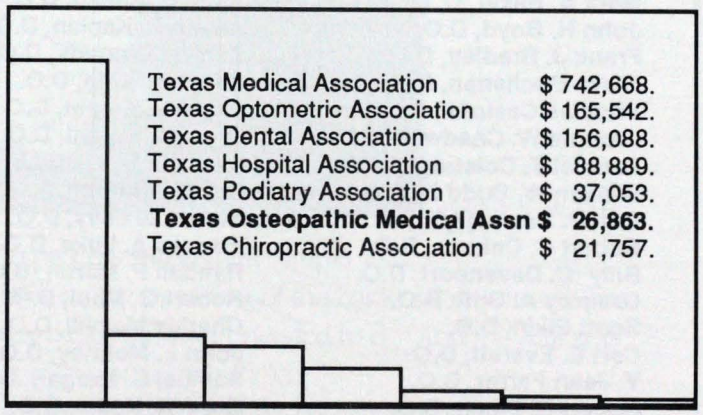
Communication was the main topic when the AOA Executive Director, Robert Draba, Ph.D., met with AOSED. Past problems in having the AOA headquarters return phone calls and respond to letters by many state association offices has created unnecessary tension. Dr. Draba was very receptive to the complaints aired and indicated steps had been taken to minimize this communication gap. It was also reported there are 11 new key positions within the AOA and they are keenly aware of past problems the state associations have encountered with communications. Dr. Draba reported on the AOA headquarters building debt, and detailed the variety of investment efforts in place to help reduce the debt. After discussing the lack of effectiveness of the 501(c) (3), with regard to lobbying interests in Washington, he concurred with the AOSED request to have AOA legal counsel study the feasibility of creating a 501(c) (6) to better utilize our lobbying interests at the federal level.

1992 Election Cycle PAC Contribution



Graph 1

Source: AOA Washington Office



Graph 2

Source: Texas Ethics Commission

A brief presentation was given by Continental Life and Health Insurance Company. They recently assumed the books of the now defunct OMIC. Representatives indicated they will continue to write insurance in the 44 states previously covered by OMIC. Privately, Terry asked them if they would consider writing insurance again for Texas and they said they would not. When pressed, they declared previous exorbitant claims led to their decision to halt writing malpractice insurance for Texas physicians.

Other presentations were made by Chris Meyer, D.O., relating to osteopathic postgraduate education reform and by George A. Reuther, Assistant Director, Department of Education, AOA, on the Clinical Lab Testing Program. Also a presentation was made by Judith O'Connell, D.O., relating to the new CPT Codes for 1994. This information is detailed on page 8 of this month's *Texas DO.*

Hopefully, this summary has provided insight to some of the activities your association has been closely following. We are continuing to make improvements in TOMA and the recent move to the state capital is only the beginning. ■

The

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION
POLITICAL ACTION COMMITTEE ...

**Introducing legislation to prevent discrimination against osteopathic physicians*

**Voicing osteopathic concerns about health care reforms to those who influence legislation*

**Networking with other healthcare entities to collectively work toward successful legislation in your favor*

**Opening doors for osteopathic medicine and fostering positive relations at the capitol and throughout state agencies*

**Promoting and protecting the interests of osteopathic medicine in Texas*

The TOMA-PAC is pleased to recognize those TOMA members who have collectively contributed nearly $12,000 to the PAC in 1993:

Sara Apsley Ambriz, D.O.
David R. Armbruster, D.O.
Jerome L. Armbruster, D.O.
Mark A. Baker, D. O.
John H. Boyd, D.O.
Frank J. Bradley, D.O.
Steve Buchanan, D.O.
Thomas Castoldi, D.O.
Jeannie W. Chadwell, D.O.
Samuel T. Coleridge, D.O.
William W. Cudd III, D.O.
Don D. Davis, D.O.
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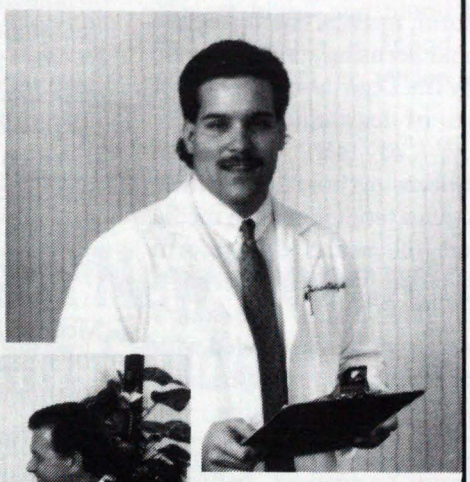

▲ *Dr. Richard Chatfield*

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◀ *Dr. Chatfield and Don Waters, President of Bank of North Texas*

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Summary of Legislation Passed by the 73rd Legislature

By Terry R. Boucher, TOMA Executive Director

Over 500 health-related bills addressing issues ranging from health insurance reform, medical liability, scope of practice, and licensing standards were considered by the Legislature. The most visible pieces of legislation were the "sunsetting" of all 21 health professional licensing boards and their practice acts. Also receiving much media attention were the health care reform measures inspired by the Governor's Health Policy Task Force. The state's medical liability laws were extended with noticeable improvements, including legal screens against frivolous lawsuits.

Following are some important pieces of legislation that were enacted. Unless otherwise noted, all legislation took effect on September 1, 1993:

S.B.211 — Prohibits illegal remuneration for securing or soliciting patients or patronage. Targets abuses in the admission of patients to psychiatric hospitals. If a person, in a manner permitted by the statute, accepts remuneration to secure or solicit patients, the patient must be informed at the time of initial contact and referral that remuneration will be received. Health care information services are exempt when they provide information to consumers only by telephone on a request initiated by the consumer. S.B.211 became effective August 30, 1993.

S.B.427 — Sets forth the duties and responsibilities of non-profit, tax-exempt hospitals to provide community benefits, including charity care and government-sponsored indigent health care. Charity care is defined to include the unreimbursed cost to a hospital of providing inpatient or outpatient health care services to financially or medically indigent persons. The services may be provided or funded through other non-profit hospitals or clinics. Hospitals must meet one of the following standards: (1) be designated as a disproportionate share hospital by Medicaid in either of the previous two fiscal years: (b) provide care equal to 100% of the hospital's state and local tax-exempt benefits; (c) provide care equal to at least four percent of the hospital's net patient revenues.

H.B.502 — Provides that the statement, "Directive to Physician has been filed at Telephone #(--------)" shall be printed on the reverse side of each driver's license.

S.B.1062 — Amends and renews the Medical Practice Act until September 1, 2005. Some of the more significant amendments are:

(a) New definitions of health care entity, surgery, and operation;

(b) Clarifies grounds for removal from a position on TSBME;

(c) Increased the number of positions for non-physicians from three to six;

(d) Requires physician members to have three years peer review experience;

(e) Requires the establishment of a training program for members of the Board and permits the Executive Director to employ a Chief Operating Officer and Medical Director.

(f) New provisions cover fees and conditions for renewal of expired licenses. Physicians must pay the renewal fee on or before the renewal date or be subject to a $400 late penalty. If the license is not renewed within 90 days, the fine increases to $800. If physicians allow their license to lapse longer than one year, they may be subject to re-examination.

(g) Continuing medical education is a prerequisite to license renewal. The Board has proposed that a physician must acquire 24 hours of CME per year, half of which may be composed of self-study. Physicians, who in the preceding 36 months have become board certified or recertified in a medical specialty, will meet the CME requirements for the licensure time frame.

(h) A formal mechanism for the handling, investigation, and disposition of complaints against a physician mu be established. TSBME must provide physician access to all information th will be offered into evidence at th hearing on a complaint, excludin materials covered by a privileg recognized by the Texas Rules of Civ Procedure or Civil Evidence.

(i) Section 5.08 (k) was amended t provide that a physician denying request to release medical records to patient must furnish a written statemer for the reason for the denial.

(j) Establishes the Texas State Boar of Acupuncture Examiners and set forth qualifications needed to obtai licensure as an acupuncturist. Licensur will be required of all persons practicin acupuncture after June 1, 1994.

H.B.2498 — Creates a nine-membe Physician Assistant Advisory Council, t the TSBME to administer the licensin and discipline of PA's.

H.B.1972 — Provides that a non profit clinic operated by a non-profi organizatin is exempt from prohibitio of the Corporate Practice of Medicine

S.B.1409 — Relates to the procedur for filing a health care liability claim The legislation renews and amends the Medical Liability and Insurance Improvement Act of Texas. The Act requires a claimant to file an affidavit attesting that the plaintiff or his/her attorney has obtained written opinion from a qualified expert witness stating that the acts or omissions of the health care provider were negligent and were a proximate cause of the damages claimed. Discovery concerning the affidavit is not permitted unless the health care provider who supplied the opinion is designated as an expert witness by the plaintiff. In lieu of an affidavit, the plaintiff may file a cost bond of $2000 within 90 days after the date the action was commenced. The law also authorizes a specially convened panel to develop, subject to approval by the Texas ▸

SUMMARY, *(continued)*

Supreme Court, standard sets of interrogatories and requests for production of documents appropriate for each of the categories of plaintiffs and defendants usually involved in health care liability claims.

H.B.2055 — Establishes the Texas Health Benefits Purchasing Cooperative, a non-profit organization created to make health care insurance available to small employers and their employees. To be eligible, at least 90 percent of the eligible employees must elect to be covered and the employer pays at least 75 percent of the insurance premium. Three different types of benefit plans will be offered.

S.B.346 — Created the University of North Texas Health Science Center at Fort Worth.

S.B.376 — Provides that a HMO or PPO that contracts with a hospital to provide services to covered individuals may not refuse to contract with a particular hospital solely because that hospital is an osteopathic hospital.

S.B.343 — Physicians must report spinal cord and submersion injuries to the Department of Health for evaluation as to the cause of the injury and frequency of occurrence. Information is confidential and unavailable to the public without the consent of the injured person.

S.B.1144 — permits a 17 year old to donate blood and blood components, but prohibits a blood bank from compensating any person younger than 18 for donation. ■

Osteopathic Education Sets New Records: Scholarships Up, Along With Student Loans

The ranks of osteopathic medical education grew to record numbers in the 1992-1993 academic year. AACOM's 15 member colleges together enrolled 2,035 freshmen*, breaking the "2,000-barrier" for the first time in their 101-year history.

Other records were also set: total enrollments reached a new high of 7,375; women comprised better than a third of all entering freshman (35.1%); of all enrolled students (34.1%); and of all June 1993 graduates (33.8%). Additionally, scholarship funds in 1991-92 increased 25% over last year providing 3,402 scholarships to osteopathic medical students totaling $17.9 million.

These and other statistics are in AACOM's *1993 Annual Statistical Report*, which is the 13th annual report issued by the national association.

"Statistics Are Eloquent Testimony"

"Those statistics are eloquent testimony to the growing strength of our schools," said AACOM Board Chairman Olen E. Jones, Jr., Ph.D., President of the West Virginia School of Osteopathic Medicine. "Today more and more young men and women are looking for a rewarding career in patient-oriented, hands-on osteopathic medicine. As this report indicates, our schools are ready to receive them and prepare them for just such a career."

For emphasis, Dr. Jones referred to the statistics regarding applicants. "In 1988 some 3,000 persons applied to our schools for the 1,780 available freshman spaces, for a ratio of less than 2-to-1. In 1992 we had 5,752 applicants competing for 1,968 new spaces. That's a ratio of 2.9-to-1. And, this year we jumped to 7,506 applicants for approximately 2,018 available new seats — producing a ratio of 3.7-to-1.

"We're very pleased with what that says about the future of osteopathic medicine and the future of health care in our country" he added.

Scholarship Aid Rising Again

Dollar value of scholarships for osteopathic medical students increased substantially in the 1991-1992 academic year, for the fifth year in a row, to a level of $17.9 million. In the late 1980s, scholarship aid had dropped, but it has now rebounded to a level surpassing that of 1981-1982.

Sharp Rise in Student Loans

Unlike scholarship aid, student loans have been rising steadily and steeply since the early 1980s. In the 1991-1992 academic year, students of osteopathic medicine borrowed a total of $131.3 million, equivalent to $17,763 for every enrolled student. Consequently, the average debt borne by graduating seniors in June 1992 was $79,800 each.

Such a large burden of debt tends to discourage osteopathic medical students from establishing their practices in rural or inner city areas, and impels many of them to practice in large cities or suburbs where the income potential is greater.

AACOM's *Annual Statistical Report*, compiled by Allen M. Singer, Ph.D., provides extensive data on students, faculty, and curricula for the 1992-1993 academic year and complete fiscal data (*i.e.*, revenues, expenditures, grants, contracts, etc.) for the 1991-1992 fiscal year. In addition, the report contains some of the most recent data from AACOM's centralized application service (AACOMAS) on applicants for the 1993 entering class.

Copies of the *1993 Annual Statistical Report* may be ordered from the American Association of Colleges of Osteopathic Medicine (AACOM), 6110 Executive Boulevard, Suite 405, Rockville, MD 20852. Price: $13.00 per copy. ■

The AACOM is the umbrella organization for the nation's 15 fully accredited member osteopathic medical colleges.

**Figure includes 1,968 new freshmen and 67 repeat freshmen.*

TRS Coordinated Care Physician Network Seeks Physician Participation

The Texas Public School Retired Employees Group Insurance Program (TRS-Care) is a statutory program established under Article 3.50-4 of the Texas State Insurance Code. Since 1986, the program has provided group health insurance coverage for over 90,000 retired Texas public school employees and their dependents. To date, TRS-Care has paid health care benefits totaling $527 million.

The Teacher Retirement System of Texas (TRS) is the program Trustee and the law provides it with the authority and responsibility to establish the plan design and the rules necessary to ensure an effective program.

On September 1, 1992, the Trustee incorporated into the plan design a change to its prescription drug benefit presenting a managed care approach to providing prescription drug benefits. This was followed by the TRS Coordinated Care Hospital Network, which became operational on September 1, 1993.

TRS-Care would now like to introduce Texas physicians to the TRS Coordinated Care Physician Network, to becom effective September 1, 1994. It will b owned and operated by the Teache Retirement System of Texas and will b a "participating" network rather tha a "preferred" network. An approac based upon TRS-Care experience will b used by the network rather than dee discounts.

Texas physicians are invited t participate in the TRS Coordinated Car Physician Network. To receive a application package, complete th following information form and return as soon as possible.

TRS Coordinated Care Physician Network Information Form

Please complete and return this form in order to receive a detailed application package about the TRS Coordinated Care Physician Network.

Name of Physician or Medical Group _____

Address _____

City _____ State _____ Zip _____

Specialty _____ Phone _____

Mail To: TRS Coordinated Care
c/o Aetna Health Plans
P. O. Box 781057
San Antonio, Texas 78278-1057

The Aetna Life Insurance Company will act as the agent in the contracting process and the Aetna/TRS Coordinated Care administrator is Ms. Frances C. Willmann.

Physicians who have any questions prior to receipt of their detailed application package may contact any of the following:

Frances Willmann
Aetna Network Management, San Antonio
(210) 697-1423; (800) 610-1799

Rene Rosenberg
Aetna Network Management, Houston
(713) 683-5815; (800) 801-3205

Tom Wicklund
Aetna Network Management, Dallas
(214) 401-8587; (800) 869-9071

How do you treat severe paralysis of the paycheck?

Medical school probably covered everything except how to deal with a disability. It can happen to anyone. Even you. In fact, if you're 35 now, you have a 45 percent chance of becoming disabled before age 65.[1] Without disability insurance, that's a 45 percent chance your income could wind up in critical condition. Should disability strike, how long could you keep your home? Make car payments? Provide for your family?

Provident, the nation's leader in individual non-cancellable disability insurance,[2] can provide the perfect prescription, offering comprehensive "your occupation" protection. That means Provident pays if you can no longer work in your own medical specialty regardless of how much you earn working in a new career or a new specialty. And the policy is non-cancellable, so your premium rate will be guaranteed for as long as you own the policy.[3]

Make an appointment for a disability insurance checkup. Call Dean, Jacobson Financial Services for more information about this important coverage. We have more than 25 years of experience in the medical profession. Discounts are available to TOMA members.

[1] 1985 Commissioner's Individual Disability Table-A, Seven-day Elimination Continuance Table. Rates are male only. Disability rates are higher for females.

[2] Life Insurance Marketing and Research Association, 1992 survey, individual, non-cancellable disability income insurance as measured in annualized premium in force, new paid annualized premium, new paid policies, and policies in force.

[3] Coverage for mental disorders can be limited in certain circumstances for a reduced premium.

Dean, Jacobson Financial Services

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Fort Worth, TX 76147

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Report on the September 18, 1993 TOMA Board of Trustees Meeting

All members were present for the September 18, 1993 meeting of the TOMA Board of Trustees, with the following exceptions: Donald F. Vedral, D.O., Arthur J. Speece, III, D.O., Charles R. Hall, D.O., Hector Lopez, D.O., and Joe W. Morrow, D.O.

Present as guests were Phil Dunn, Texas Medical Foundation Executive Director, and Royce Keilers, D.O.

The minutes of the May 11, 1993 and the May 15, 1993 Board of Trustees meetings were approved.

TMF Executive Director Phil Dunn, reviewed *TMF Progress Notes, Vol. II, No. 3,* which introduced the Health Care Quality Improvement Initiative. Mr. Dunn noted that under HCQII, TMF will place less emphasis on individual audits and more on analyzing patterns of care. He updated board members as to TMF's Fourth Scope of Work and the UCDS; the notification to both physicians and facilities of each potential utilization, quality and DRG concern beginning October 1, 1993; the importance of accurate documentation by all hospital staff in cases reviewed by HCFA; and the restructuring of TMF from six to two regions, with a central office in which William R. Jones, D.O., and Fred Brenner, D.O., will serve on the TMF Board.

Mr. Dunn also stated that the TMF maintains its opposition to physician office review.

Dr. Zachary presented an update on the new TCOM class, consisting of 110 students. Of this total, made up of 74 males and 36 females, 106 are Texas residents. He noted that the overall grade point average is 3.37, the highest in TCOM's history.

Dr. Zachary mentioned the move of the graduate school from the University of North Texas to TCOM, and reported that the recipient of the Founders' Medal was Murray Goldstein, D.O. He stated that an upscale recruitment of minority students is beginning, and noted that the failure rate of 19 percent on the FLEX scores was most likely due to the unavailability of verbatim questions on file at TCOM.

Discusson was held as to TOMA strategies for keeping TCOM alive under the Health Science Center. It was suggested that TOMA members should collectively work on the appointment of a D.O. on the UNT Board of Regents; that TOMA keep in close contact with the President of the Alumni Association; and that the next meeting of the TOMA Board of Trustees be held on campus.

The TOMA Board went on record as supporting Mary Burnett, D.O., for the 1994 AOA Trustee Position, dependent upon her decision for renomination. In the event Dr. Burnett does not desire re-election, the Board will support Robert L. Peters, Jr., D.O., for the position.

Additionally, the Board went on record as supporting Dr. Zachary as Speaker of the AOA House of Delegates; and the decision was made to invite the chairman and vice-chairman of the TOMA House of Delegates Caucus to the pre-convention meeting of the TOMA Board of Trustees.

A discussion regarding the Texas Workers' Compensation Commission began, at which time concerns were voiced over the TWCC's establishment of fee guidelines without a fee schedule, as well as the six-week limit on treatment.

The AOA Building Fund was discussed. The AOA House of Delegates is trying to reduce its mortgage debt, currently $6 million, and is requesting donations for this purpose. The TOMA Board of Trustees agreed to approve a $500 donation toward this fund.

The appointment of David Tyler, D.O., to the Vendor Drug Advisory Subcommittee was discussed, at which time the TOMA Board approved Dr. Tyler's nomination.

Mr. Terry Boucher, TOMA Executive Director, presented the financial report and an annual meeting expense report. Mr. Boucher pointed out several problems in both reports, due to TOMA's relocation, resulting in a temporary lack of staff, as well as reassignment of duties. He noted the problems would be corrected and both documents would be presented at the December 11, 1993 Board of Trustees meeting.

Several changes to the TOMA Administrative Guide were reviewed. Among these were that the SGA President be added as an ex-officio member, as described in the TOMA Bylaws. Reviewed changes, as well as correction of several typographical errors, will be made to the guide.

Mr. Boucher presented highlights of the last legislative session. *(Editor's note: these are noted in a separate article in this issue.)*

A relocation update was given by Mr. Boucher, who announced that the hiring of three new staff members had completed the final steps necessary to get the TOMA office in good shape. Mr. Scott Petty, TOMA Associate Executive Director, noted that advantages were already evident, insofar as TOMA's relocation was concerned, in that TOMA has increased visibility by attendance at receptions and other events.

The Board of Trustees approved the AOA CME Accreditation Mission Statement.

Continuing Medical Education Mission Statement

The overall mission of Continuing Medical Education (CME) of the Texas Osteopathic Medical Association is to promote the art and science of Osteopathic Medicine and the betterment of public health to the benefit of all people. To accomplish this mission, TOMA as a state association, provides leadership in the field of CME that will enhance the knowledge and skills of Osteopathic Physicians through coordinated CME programs.

As approved by the TOMA Board of Trustees Executive Committee

Mr. Boucher announced that a new federal law mandates that association members be informed as to what portion of annual dues are allocated to legislative influencing. That portion is not tax deductible as a business expense. A discussion began as to how this will be designated on the TOMA dues statements.

The next item brought up was the non-recognition of AOA certification for Medicaid programs. It was mentioned that Betsy Beckwith, of the AOA Washington Office, stated that this was an oversight in the *Federal Register.* Steps are being taken to get this situation changed.

Dr. Joseph Montgomery-Davis mentioned the seven percent freeze in Medicaid fees over the next two years. Although inpatient hospital care is not affected, outpatient, home health care and physician office visits are affected. TOMA will work with the Texas Medical Association in legal action against the Department of Health and Human Services, if such action is needed.

Mr. Boucher stated that all members should forward OMT reimbursement denials by insurance companies and HMOs to his attention.

Dr. R. Greg Maul submitted the membership report. All applications were approved as presented. One member, requesting a waiver of 1994 dues, was granted a retired membership status.

Results of an Ad Hoc Committee to investigate small district representation on the Board were discussed. *(Editor's note: the report of this committee can be found on page 5 of this issue.)*

There were concerns expressed over a decrease in TOMA members this year. Mr. Boucher felt that the recent hiring of a new membership secretary, Brenda Gross, would have a positive impact on next year's total.

Dr. Knight recommended that Mr. Petty be appointed to the Physician Assistance Program Committee so that he could review confidential files, as needed, in the event Mr. Boucher was unavailable. The Board approved the appointment.

The next item discussed was the Governmental Relations Committee. A memo from the committee chairman, William R. Jenkins, D.O., was reviewed, which recommended that TOMA's contract with Capitol Consultants be discontinued due to TOMA's new accessibility to the Legislature. The Board approved the recommendation that the contract be discontinued.

The Texas Osteopathic Medical Association's Political Action Committee was discussed. An issue brought up was that district presidents needed assistance in increasing contributions. It was felt that it would be helpful to continue providing them with TOMA-PAC activity reports.

The Board approved the creation and establishment of two new awards: a Distinguished Service Award to be presented to a D.O. for significant contributions to the profession; and a Meritorious Service Award for significant contributions, by a non-D.O.

District officers would nominate individuals by signing a petition, which would require at least five signatures or the majority of the district (whichever is less). Nominations would be submitted to Mr. Boucher no later than February 1. The TOMA Board can also submit nominations which require support of one-third of the Board. The nominees' credentials must be attached and submitted to a committee for review. The committee will present nominees to the TOMA Board of Trustees and a three-fourths vote must occur for an individual to receive the award, which would be presented at the annual convention during the President's Banquet.

Mr. Petty announced a TOMA partnership with the Bergstrom Federal Credit Union, which will allow TOMA members special rates on loans and credit cards. It is hoped that other services, such as special car rental rates, will be offered in the near future. ■

In Memoriam

Robert O. McCorkle, D.O.

Dr. Robert O. McCorkle passed away November 7 in a Dallas hospital after a long illness. He was 72 years of age.

Funeral services were held November 9 at Central Assembly of God Church in Arlington, where he was a member. Burial was in Greenwood Memorial Park.

Dr. McCorkle was born in Zephyr and had lived in the Dallas/Fort Worth area since 1972.

He was a graduate of Howard Payne University in Brownwood, and received his D.O. degree from the Kansas City College of Osteopathy and Surgery, Kansas City, Missouri.

Dr. McCorkle had a family practice in Lubbock from 1956 to 1961, and in Comanche from 1961 to 1972. From 1972 until his retirement in 1978, he served as an emergency room physician at Doctor's Community Hospital, now Harris H.E.B., in Bedford.

He was an Air Force veteran of World War II.

Survivors include his wife, Peggy McCorkle of Grand Prairie; son, John R. McCorkle, D.O., of Grand Prairie; brother, Roy McCorkle of Coleman; sister, Mary Hunter of Brownwood; and three grandchildren.

TOMA extends condolences to the family and friends of Dr. McCorkle.

NCI Reviews Mammogram Studies

The National Cancer Institute says that routine mammograms are effective in saving lives only in women age 50 and over, or those who have a family history of breast cancer. The NCI came to this conclusion after reviewing eight studies.

What's Happening In Washington D.C.

- ***Medical Expense Plans Gone?*** It could happen. The Clinton health plan will wipe out medical expense reimbursement plans that allow employees to pay uninsured medical bills with pre-tax dollars. A member of the Treasury Department recently stated that such plans are contrary to the Clinton philosophy of a level playing field for health care.
- ***Medical Savings Accounts.*** It is a new idea offered by a number of Republicans as a partial alternative to Clinton's health proposal. Tax deductible contributions could be made to an account that would work much like an IRA, except the funds would be applied to cover the premiums on a $3,000 deductible major medical policy. Additional funds could be withdrawn on a tax-free basis to cover uninsured medical expenses.
- ***New Auto Plan.*** A plan to encourage mass transit has been proposed by the Clinton Administration. Employees who receive employer-paid parking would have the option of receiving the cash equivalent to cover car pool and mass transit expenses. The cash payment would be taxable to the employee and deductible by the employer.
- ***Executive Salary Tax Hit.*** Bills to limit tax deductions for large salaries paid to executives keep coming. The latest, proposed by the House Budget Committee Chairman, would limit the deduction to twenty-five times the amount paid to the lowest paid employee in the company.
- ***Social Security Hike.*** Beginning in 1994, the Social Security taxable wage base will increase from $57,600 to $60,000. The combined tax rate for Social Security and Medicare will remain at 7.65%.
- ***What the Others are Doing.*** Other countries are making an effort to stimulate their economies by lowering taxes. Mexico, Japan and Germany all have recently reduced their tax rates in an effort to boost their economies. Even with these reductions, each of these countries will have general income tax rates that are higher than comparable U.S. rates.

Planning With a New Spouse

It's a simple fact that many individuals get married more than once. In some cases, it's three or four times. Statistics confirm each year that over one-half of all first marriages end in divorce.

The horrors of poor planning in second marriage situations manifest themselves regularly. The children of one spouse's prior marriage are inadvertently disinherited. Or one spouse ends up being dependent on the generosity of the other spouse's children of a prior marriage. Or a full blown dispute breaks out over who owns what when one spouse dies. The consequences of poor planning are serious and real.

The key is to identify the uniquene of each situation and address specifi objectives that couples have in jumpin into a second, third or fourth marriag Factual differences are critical. The ag of the children, the number of childre and the sizes of the spouses' estates a make a difference. There are tax issue and tax planning tools, but often the need to be subordinated to unique famil objectives. Strategies that work well i first marriage situations often are not th answer for spouses who have childre from previous marriages.

If you would like more information o this issue, call us at 817-335-3214.

The above information was provided by Dean Jacobson Financial Services, Fort Worth.

Workers' Comp Options for Texas Businesses

Workers' compensation reforms are stabilizing rates and offering businesses new ways to cut their insurance costs.

Employers can check out money-saving options and learn more about workers' compensation by ordering two new Texas Department of Insurance publications.

The 1993-94 edition of *Questions and Answers About Workers' Compensation* deals with such matters as:

- Saving money with deductibles, authorized for the first time by a reform law that took effect in 1992.
- "Alternatives" to workers' compensation.
- Workplace safety incentives, including retrospective rating plans.
- The Texas Workers' Compensation Insurance Fund, capitalized by a state bond issue and operated by an all-employer board of directors.

The other publication is the September 6, 1993, edition of the *Texas Workers' Compensation Rate Guide,* which compares rates of all workers' compensation carriers in Texas.

With workers' compensation rates coming down, TDI updates the rate guide regularly to reflect the latest changes.

Employers can get both publications and the related brochure, *The Dangers of Going Bare*, by calling TDI at 1-800-252-3439 or writing to:

Texas Department of Insurance
Publications (MC 108-5A)
P. O. Box 149104
Austin, TX 78714-9104

Measles In U.S. Close To Extinction

A massive inoculation program in 1990 is credited with the near eradication of measles in the United States, according to the Centers for Disease Control and Prevention. Only 175 cases were reported during the first half of 1993, and it was estimated that the total number by the end of October would reach 260, the lowest ever reported since reporting began.

The 175 reported cases represents a 99 percent decrease from the almost 14,000 cases reported for the first half of 1990, at which time a severe measles epidemic was raging. This epidemic prompted the inoculation campaign, combining federal, state and local efforts. An interesting note is that half of the nation's 2,200 measles cases in 1992 were reported in Texas - 1,097 cases. An absence of three years is necessary for a disease to be declared eradicated.

ATOMA NEWS

President's Corner
By B. J. Czewski

ATOMA'S Quick Look At The AAOA Convention

ATOMA was well represented with six voting delegates and one S.A.A. voting president at the 98th Annual Convention and Scientific Seminar of the American Osteopathic Association. It was held October 10-14, 1993, at the Boston Marriott, Copley Place, in Boston, Massaschusetts. This year marked the AAOA's 54th Annual Convention.

Three days of House of Delegates, Leadership Workshops, Special Lecture, Reports of Officers, Committee Chairman Reports and Election of Officers once again proved to be most informative and productive, especially in the field of membership.

The following bylaw changes were approved by the AAOA House of Delegates:

ARTICLE III. MEMBERS

Section 3. Dues and Assessments. The annual dues shall be:

A. Regular Members, except (1.), (2.) and (3.).....$50.00 (was $40)
C. Associate Members .....$25.00 (was $20)
D. Student Associate Members.....$ 5.00 (was $1)

Note: The dues increase will be effective starting with the 1994-95 dues billing.

ARTICLE IV. AAOA COMPONENT AUXILIARIES

Section 4. Bylaws
By adding a new D to read:

D. Affiliate Auxiliaries (State and District) and Student Associate Auxiliaries may provide for a Supporting Membership for those who choose to support and promote the osteopathic profession but who are not eligible to be a regular member. This member shall not serve as a President or President-elect, nor be seated as a delegate or alternate to any convention.

Reletter the existing D to E

Amend Article IV, Section 4C (2) by adding the "Except for Supporting Membership" to read:

C. (2) Student Associate Auxiliaries Bylaws shall provide for all members to be members of AAOA except for the Supporting Membership.

AAOA Board to Consider Alternative Names for Auxiliary

A resolution was adopted at the 1993 AAOA House of Delegates in Boston as follows:

"That the AAOA Board consider an alternative name for the organization and propose the name to the general membership for consideration at the 1994 House of Delegates."

This resolution does not mean that the name will actually change, only that the Board propose a name at the next House of Delegates. Any name change must be voted on at the annual meeting — the Board cannot change the name. Help out the AAOA Board by submitting your suggestions for a name to AAOA Board, 142 East Ontario Street, Chicago, Illinois 60611.

AAOA President, Dee Angel, made a presentation to ATOMA of award ribbons for the following contributions:

Scholarships	$11,610.50
Student Loan and Research	$ 1,411.00
Educational Endowment Fund	$ 1,911.00
National Ad Campaign	$ 1,801.00
Total	16,733.50

Again, ATOMA has donated more monies than any state in AAOA.

Thank you, TOMA and ATOMA, who contribute so much of your time and money to make all of this possible. We feel very proud of ourselves for this big accomplishment.

AAOA Appointments

B. J. Czewski, ATOMA President, was elected and installed as a director of the National Auxiliary. She will serve a two-year term as Editor of the AAOA's *Accents* magazine.

Rita Baker continues her two-year term as AAOA Student Associate Advisor.

Get Well Note!

A Get Well Note to our ATOMA and AAOA past president: Mary Luibel of Fort Worth, who recently had surgery after breaking her leg. After a long stay in the hospital, Mary is now recovering at home. Take care, and we love you! George, take care of her.

By Diedre Froelich
ATOMA President-Elect
and Membership Chairman

I CHALLENGE YOU...ONE TO ONE... How many new or inactive ATOMA members can you, as an individual, bring into our organization by the beginning of 1994?

As ATOMA adjusted its fiscal year to run concurrently with TOMA, we also adjusted the time frame in which we approach our active and potential members for membership dues. Now is the time to send in your payments if you haven't already. Just $20, please.

Okay, so you may be busy. What can you offer with so little time on your hands? Okay, so you live in an isolated area with no local auxiliary in which to participate. Guess what? YOU still may be the difference we need! If you would like to personally participate in ATOMA activities, write to me. We have opportunities for the compulsive volunteer and for the free-time impaired. Some activities can be completed via telephone; some through busy work after kids are in bed. Most importantly, we need your support of ATOMA.

ATOMA helps to promote osteopathic medicine through public relations and educating the public and by raising funds to provide scholarship opportunities to promising students who will carry on in the tradition of A.T. Still.

If you absolutely cannot give of yourself personally, please assist the active membership by paying your dues now. The funds you provide, added to others, provide a base for our larger fundraising activities and educational projects.

YOU CAN MAKE A DIFFERENCE, by joining ATOMA now, if you have not already, and by bringing at least one new or inactive member into our organization. Our strength is in our numbers and enthusiasm. Osteopathic medicine gives much to our lives. Membership in ATOMA provides opportunities to share with the people of TEXAS the importance of osteopathy, to educate patients

(Continued on page 23)

AOA Graduate Medical Education Conference Addresses Needs of the Future

"Osteopathic Medicine: New Beginnings Toward Quality Education" was the theme of the American Osteopathic Association's (AOA) Fourth Annual Conference of Osteopathic Graduate Medical Education (GME) Leadership, held September 10-12 in Chicago. The conference, funded by The Upjohn Company, gathered experts in graduate medical education and healthcare delivery to assess the future needs of postdoctoral education in a newly structured healthcare system.

As the nation prepares to meet the challenges of healthcare delivery in the 21st century, America's 35,000 osteopathic physicians (D.O.s) are continuing to look for ways to ease the transition, maintain cost-effectiveness and benefit the most patients.

Keynote speeches were given by Ley S. Smith, President and Chief Operating Officer, The Upjohn Company, and Marc L. Rivo, M.D., M.P.H., Director Division of Medicine, U.S. Department of Health and Human Services. Mr. Smith discussed "Medical Education, Industry and Healthcare Policy."

Dr. Rivo's presentation, titled "Healthcare Reform and Osteopathic Medicine; Making Good on the Promise," emphasized the need to expand the number of primary care providers in the U.S., while also doubling the amount of minority medical students by the year 2000.

"We need to address and eliminate the number of primary care shortage areas in this country as an immediate goal," Dr. Rivo said. "We, at least for now, need to set a national goal that 50-percent of all residency graduates complete their training in internal medicine, pediatrics or family medicine and enter generalist practice."

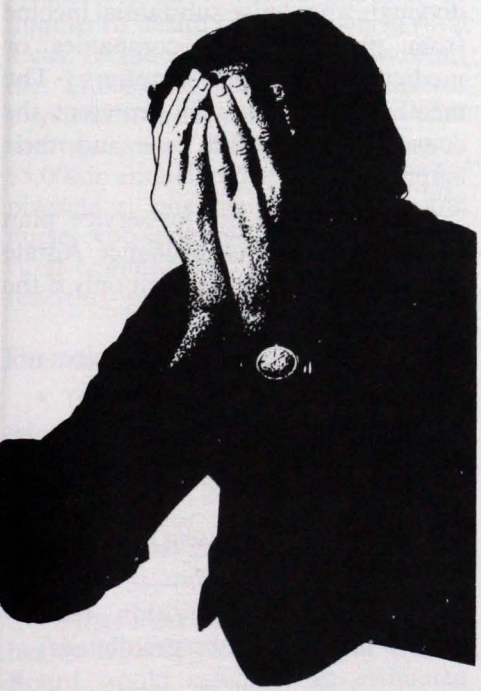
Dr. Rivo praised osteopathic medicine's commitment to primary care, noting that osteopathic medical colleges continually graduate 50-percent of their students into primary care, compared to a 15-percent average in allopathic schools.

Among the other speakers, Neil A. Natkow, D.O. moderated a workshop titled; "The Role of Managed Care in GME: Is There One?" Stephen C. Gleason, D.O., Chief Medical Officer, Mercy Clinic System and Chairman, White House Health Professions Review Group, spoke on healthcare reform from his unique perspective as a Clinton Administration adviser.

The conference featured workshops on ambulatory care, clinical research, specialty oriented internships and discussion of new primary care initiatives.

"The weekend was a success, with many new ideas and thoughts about the future of postdoctoral education coming to light," said conference chairman Robert J. George, D.O. "And as the healthcare system enters uncharted territory, the AOA will continue to sponsor forums serving the best interests of patients and physicians alike. ■

Future Looks Dismal To Midlife Americans



A massive, continuing study of Americans between the ages of 51 and 61 is being conducted by the University of Michigan. The study is sponsored by the National Institute on Aging and will continue until the year 2005.

Some of the findings thus far, after 12,600 persons had been questioned, are as follows:

- Almost half fear they might be laid off during the next year.
- In the event of a lay-off, almost half feel their chances of landing a new job are less than 50-50.
- Approximately one-third are victims of "job lock." These people won't leave their current jobs out of fear of losing insurance benefits or pensions.

Other findings from the study reveal that about two in five persons will not have any private pension income; about one in five is heading toward retirement with no assets; and about one in seven persons in the 51-61 age bracket lacks health insurance. ■

ATOMA NEWS, *(Continued)*

to educate patients about the osteopathic difference and to make life as an osteopathic physician as rewarding as possible for our spouses.

Now, until December 31, reach out to those who would join with us. I challenge you. If you have any questions, write to me: Deidre Froelich, ATOMA President-Elect and Membership Chairman, 407 Jo Aynn Circle, Bonham, Texas 75418, or call 903-583-4812. I'll give you a reason to say "YES" to supporting ATOMA. ■

AOA Washington Update

President's Health Care Reform Plan Released

On Wednesday, September 22, 1993, President Clinton unveiled his much anticipated national health care reform proposal. Dubbed the "American Health Security Act of 1993," the President's plan would: provide universal coverage for all Americans; create large health care purchasing pools called "health alliances"; require employer-paid health coverage; and, attempt to control costs with global budgets and increased spending cuts.

From the introduction of its "Statement on National Health Care Reform" in December 1992 to the profession's representation at the September 20, 1993 physicians' White House Conference, the AOA has played an active role in advising and educating the President's Task Force on National Health Care Reform on how best to achieve universal access for all Americans as well as how to ensure access to osteopathic services. The invitation to send three osteopathic physicians to the September 19th briefing with Ira Magaziner and the September 20th breakfast with President Clinton and 97 other physicians reflects the fact that the President's Task Force not only recognizes the osteopathic profession but seeks its counsel and advice.

For example, in the AOA's December '92 Statement which was communicated often both in writing and in face-to-face meetings with the President's Task Force, the AOA urged the President to include in his reform package the following provisions: coverage of prescription drugs; a managed competition delivery model inclusive of osteopathic services, as well as fee for service delivery models; and an abolition of the pre-existing condition rule. Further, the profession has long called for patient responsibility through the practice of preventive health care and was gratified to learn that the President had heeded that call.

This entire issue of the *AOA Washington Update* will be dedicated to a synopsis of several important provisions included in the American Health Security Act.

Coverage

- Employers would be required to pay 80 percent of health insurance coverage for all their employees, whether full or part time, and regardless of immigration status. Employees, in turn, would pay 20 percent of the costs through co-payments and deductibles.
- Individuals would obtain health coverage through either a corporate health alliance, a regional health alliance or a fee-for-service plan. Fee-for-service plans would require higher deductibles and co-payments than would an alliance.
- Employers with over 5000 employees would have the option to create their own corporate alliance which would be required to meet the same federal standards as regional alliances.
- Beginning in 1996, prescription drugs would be covered under the Medicare program with a 25 percent co-payment and a $250 deductible. Pharmaceutical companies would be required to sign rebate agreements with HHS in order to participate in the Medicare and Medicaid programs.
- Health insurance plans would not be able to refuse to cover anyone, drop anyone because of pre-existing conditions or newly-developed sicknesses, nor raise premiums for individual subscribers.
- Coverage would become effective on a state by state basis from 1995 and would be fuly implemented by 1997.

Guaranteed National Benefit Package

- A National Health Board would be constructed and charged with the duties of setting the national benefit package, approving health care plans, overseeing a national health care expenditure budget, and ensuring quality within all plans.
- A wide variety of services would be required to be covered by all health plans. These services would include hospital services, preventive health services, mental health services, hospice and home health care, outpatient laboratory tests, prescription drugs durable medical equipment and healt education classes.
- Membership of the National Healt Board would consist of seven membe appointed by the President and con firmed by the Senate. At least on member would represent the interest o the states. Health care providers woul not be eligible for membership.
- An Advisory Committee to the Na tional Health Board would be created i order to provide technical advice an recommendations. The Advisory Com mittee would be composed of fifteer representatives of health plans, alliances consumers, experts, employers and health care providers.

Health Alliances/Fee-for-Service/ Supplemental Insurance

- Regional health alliances could serve as a not-for-profit corporation or as an independent state agency. A board of directors would govern each alliance. Members of these boards could *not* include: health care providers; owners of health care plans; members of associations, such as law firms, that represent the interests of a health care plan or provider; or, owners, employees or the individuals who derive substantial income from pharmaceutical companies or medical equipment suppliers. The members would equally represent the consumers of health care and their employers.
- At least one fee-for-service plan must be offered by each alliance. A state could waive this requirement only if the alliance demonstrated that:

1. a fee-for-service plan was not financially viable in that area;
2. there was insufficient provider interest in participating in a fee-for-service plan; or,
3. there was insufficient enrollment in such a plan.

- Balance billing within fee-for-service plans would be prohibited.

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• Each corporate alliance would be required to contract with at least one fee-for-service plan unless excused from the requirement via state waiver. The corporate alliance would be required to also provide at least two other plans.

State Responsibilities

• Each state would be required to submit plans for one or more regional health alliances to the National Health Board, demonstrating that its health care system meets federal requirements.

• Health alliances would not be permitted to cross state lines. States would be able to offer financial incentives to health plans so that disadvantaged groups are more readily provided with health services. States would be able to require that health plans reimburse and/or contract with certain specialty providers and centers of excellence.

• A state would have the option to establish a single-payer system rather than an alliance system, even if the single-payer system serves only part of the state.

Rural Area Considerations

• In order to ensure the delivery of health care to rural areas, various financial incentives would be provided including the requirement that alliances service rural areas, the provision of infrastructure investments and incentives to expand rural community-based networks and plans.

• Various tax and financial incentives would be established under the National Health Service Corps to increase the number of health care providers in rural areas. Included among these provisions are: $1,000/per month tax credits for physicians who work in physician shortage areas; deductibility of up to $5,000 in annual student loan interest for physicians, physicians' assistants and nurses who serve under agreements with rural communities; and, allocation of residency positions in rural areas.

Financing

• The growth in health care premiums would be limited to the annual national inflation factor. The National Health Board would be permitted to adjust the inflation factor for each alliance to reflect unusual changes in demographic and socio-economic characteristics.

• After final bids are submitted by all health alliances, the National Health Board would calculate an estimated weighted average premium for each alliance.

• If an alliance's weighted average premium exceeds its per capita budget target, an assessment would be imposed on each plan whose premium increase exceeded the alliance's premium inflation factor. Revenues from assessments on plans would be used to reduce required employer premium contributions.

• Total savings would be achieved through:

1. the restriction of growth of Medicare payments;

2. the folding of the acute care portion of Medicaid into the alliance system;

3. a variety of "sin taxes" as yet to be determined; and,

4. the reduction in administration of claims processing.

• No new taxes would be imposed.

• A 100 percent tax deductibility would be allowed for self-employed individuals. Federal subsidies would be afforded to those self-employed individuals who earn less than $24,000 per year.

Quality Management

• A National Quality Management Advisory Council would be established and would advise the National Health Board. The Advisory Council would consist of fifteen members representative of consumers, providers, employers and states.

• The Advisory council would develop practice guidelines and establish a clearinghouse for their evaluation.

• Regulations under the Clinical Laboratory Improvement Act would be refocused to reduce administrative burdens and to emphasize quality.

Information Systems/ Administrative Simplification

• Every American would receive a health security card which would function much like ATM cards. The cards would permit access to information regarding health coverage.

• A single claims processing form would be developed by 1995. Electronic claims processing would be encouraged.

Malpractice Reform

• Alternative Dispute Resolution Systems would be required of every health plan and consumers would be required to first submit their claim to an ADR.

• Attorney's fees would be limited to one-third of the monetary damages awarded, although states may apply stricter limits. Periodic payments of malpractice awards would be permitted. New rules would require reduction in the amount of any award by the amount of recovery from other sources, such as health insurance payment, etc.

• The National Practitioner Data Bank would remain intact. All malpractice awards and settlements would be reported to the Data Bank.

Graduate Medical Education

• An increase in the number of primary care graduate training programs for physicians would be instituted in order to achieve a 50 percent balance between primary care and specialty physicians. Medicare payments would be adjusted to reflect this goal.

• Investments in training of nurse practitioners and physicians' assistants would be increased.

• Investments in training of nurse practitioners and physicians' assistants would be incresed.

• The Secretary of HHS would determine the number of training program positions in each specialty area per the recommendations of the National Council on Graduate Medical Education and its regional councils. The National Council would include medical educators, practicing physicians, consumers, hospital administrators and nurses. The regional councils would then allocate these slots among the individual residency training positions.

• Funds for residency training programs would be pooled with each insurer paying an amount reflective of the benefits of graduate medical education its consumers enjoy.

• A program to retain specialists as primary care physicians would be implemented.

The reform game will continue in the near future when President Clinton will translate the American Health Security Act Plan into actual legislation. Look for future issues of the ***AOA Washington Update*** *for a summary of the legislation and the AOA's action plan to effect such legislation.* ■

Public Health Notes

Who Has the Formula for Eliminating Adolescent Pregnancy?

Nick U. Curry, M.D., M.P.H., F.A.C.P.M.

At the national level, the birth rates for adolescent females have shown no significant decline over the past decade. When compared with other developed nations, the adolescent pregnancy rate ranks as one of the highest. For example, compare the U.S. rate of 95 pregnancies per 1000 women aged 15 to 19 with that of Canada (46/1000) or the Netherlands (15/1000).

The Centers for Disease Control and Prevention undertook a study of childbearing patterns in the United States in 1990. The results were published in the May 28, 1993 edition of MMWR. It revealed that African-Americans, Puerto Rican-Americans, Mexican-Americans and native Hawaiians had the highest rates of births to teens. The overall teen birth rates among these groups was two to three times the rate among non-Hispanic Whites. As examples, the birth rate for African-American girls ages 10-14 was 5.0/1000 while that for white girls was 0.5/1000; for African-American girls ages 15-19 the rate was 84.1/1000 and for Mexican-American, Puerto Rican-American and non-Hispanic Whites the rates were 69.7, 71.6 and 22.9, respectively. Our own Tarrant County has held the distinction of having one of the highest pregnancy rates in Texas among females 10-14 years of age and 15-18 years of age. Our pattern parallels the nation with the rates being highest among African-Americans, followed by Hispanics and non-Hispanic Whites.

Now with the confirmation of a new surgeon general, the heated debate over how this problem should be addressed is getting even hotter. There are those who have advocated temporary chemical sterilization of sexually active teens. Others take the position that if a person chooses to have a baby as a teen that person should be left to bear the responsibility for her actions. Some concentrate on providing services to the pregnant and parenting teen in an effort to get her back in the educational system and provide an environment in which the baby can develop normally. Still others concentrate on providing sexuality education and birth control supplies. Then there are those who maintain it is an issue of establishing proper morals among adolescents.

It seems to me that in my latter years I have been more and more at odds with the public health and medical establishments. This is one of those occasions. I am not totally in disagreement with the conventional wisdom, but I am very much in disagreement on one point: That point deals with why teens become pregnant teens.

The new surgeon general, Dr. Elders, spoke to this point the day after her confirmation in a television interview which I saw. I admire and am inspired by Dr. Elders. I have heard her speak on several occasions and spoken with her briefly twice. She is a dynamic and inspirational speaker and leader and I believe she will serve the country well. On the occasion of the interview just mentioned, she said something about adolescent pregnancy that at this point I just cannot accept. Dr. Elders claimed that most pregnant teens did not want to be pregnant. She implied that if they had the means of preventing the pregnancies, they would use them.

I simply do not believe this is the case in the population with whom I deal. Most of the adolescent women with whom I talk and with whom a number of my associates talk are not naive concerning the cause of pregnancy or its prevention. neither are they suffering from major birth control supply access problems since condoms are readily available in our community and family planning services are offered in various parts of the country.

In fact, many teens elect to become pregnant teens. I believe this is a much more serious problem than lack of condom access. One of the greatest challenges facing the public health and medical communities is to unravel the family dynamics and social disease (or social pathology if you prefer) that leads girls of thirteen or fourteen years of age to decide to have a baby and then another and another. The social dynamics are complex. There is no one simple answer to this question. Once th mystery is solved, we must set abou making things right in our society s that adolescent pregnancy will be muc reduced.

My sense is that much of this problem has to do with an increasingly dysfunctional American society and dysfunctional families within which these young women and men grow into unhappy and dysfunctional adolescents seeking love, affection and meaning. Oftentimes they find more disillusionment and despair while perpetuating the cycle in which they and their parents and their parents' parents have become victim.

So, while we are sorting out this complex mess, what do we do? I believe we must devote adequate resources to explore the root causes of these problems and their solutions. Those solutions are not the simplistic answers of making condoms more readily available or teaching "morals" in the schools. Both have their role, but neither is sufficient. We must certainly provide age appropriate family life components throughout our school curricula from kindergarten through college. This not only means sexuality education, but also education on the effects of drugs, alcohol and tobacco, family and community responsibilities, violent behavior, and so forth. Realizing that many adolescents will become involved in sexual experimentation or even frequent sexual intercourse, we must not deny them the means of preventing pregnancy and disease transmission. Lastly, we must support family integrity in its broadest sense. This is not a plea for the "family values" of Mr. Quayle, but for support of family units so that they may remain together in order to give the young a dependable point of reference. This involves in some cases teaching parents how to be parents and developing within them the economic skills to compete and hold their family together. It involves communities helping each other; and those of us who *have* helping those who *do not.*

I suggest that using this formula, we may have a chance at reducing adolescent pregnancy, and a number of other social ailments. ■

AOA Launches Capital Campaign— "Building For The Future"

The AOA agrees with leadership from throughout the osteopathic profession that emerging trends associated with reform may be dangerous to the profession. As changes occur in the healthcare delivery system, it is vital that the AOA have the resources necessary to advocate on behalf of the osteopathic profession. Thus, a financially strong AOA is necessary to help secure the osteopathic medical profession for tomorrow.

With these thoughts in mind, the AOA has launched a campaign to reduce the headquarters building debt so that more resources will be available to assist members with crucial issues. The campaign was officially launched by Laurence Bouchard, D.O., and William G. Anderson, D.O., AOA President and President-Elect and Campaign Chairmen, on October 10 during the AOA convention.

Through refinancing, the AOA staff and leadership have already reduced the debt on the building from $15 million to $6 million. Additionally, more than $262,000 in donations have been received through gifts made at the AOA House of Delegates and at the annual convention.

If you would like to help the AOA in this endeavor, please complete the following form and return to the AOA as soon as possible.

YES! I want to help the American Osteopathic Association build for the future!

Name_____

Address_____

City/State/Zip_____

Home Phone_____ Office Phone_____

My pledge to build a strong financial future for the American Osteopathic Association and its membership is:

____Platinum Donor – $25,000 ____Gold Donor – $10,000 ____Silver Donor – $5,000

____Bronze Donor – $1,000 Other $_____ *(These gifts may be paid over a two year period of time)*

☐ I have enclosed my check. ☐ Please bill me.

All paid contributions will be acknowledged by name in *The DO* and *The JAOA*. Please indicate how you or your organization would like to be listed. If you do not wish to be listed, please check here ☐.

_____

_____ _____

Signature Date

Contributions to the Capital Campaign are tax deductible to the extent allowed by law. Please return your pledge card to: American Osteopathic Association, Capital Campaign Fund, 142 East Ontario, Chicago, IL 60611.

Have A Happy and Prosperous New Year!

Self's Tips & Tidings

Don Self & Associates

GIVE BC/BS A REPORT CARD

April is the target for HCFA's launch of its contractor evaluation survey, which will be sent to randomly selected providers in Texas. 500 providers will have the opportunity to grade BC/BS of Texas on subjects such as their timeliness in paying claims, responding to appeals, accessibility for questions, etc.... In anticipation of this HCFA inspection, Blue Cross of Texas will probably join more than 20 other BC/BS carriers in conducting their own survey in Texas. Should you receive either one, please forward a copy to our office. I would be very interested in seeing the questions they ask.

After visiting a small rural clinic, I'm reminded that you know you're a native of Texas if:

- *You have a rag for a gas cap*
- *You help your richest relative remove wheels from their new house.*
- *Your car is the color of Bond-o*
- *Your family tree does not fork*
- *Directions to your house includes: "Turn off the paved road"*
- *You barbecue Spam on the grill*
- *You watch your Bug-Zapper more than you do television*

MENTAL HEALTH ICD9 - REDUCTIONS

As we've been warning for more than a year, Medicare has been cutting your reimbursement to 62.5 percent (instead of 80 percent) on mental psychoneurotic and personality disorder diagnostic codes, when services are rendered on an out-patient basis. HCFA recently clarified their instructions to Medicare, abolishing this reduction for Alzheimers disease.

The following services are subject to the out-pt mental health treatment reductions:

- Psychiatric Codes 90835 - 90899
- ICD9 Codes 290-319
- Testing Services evaluating a pt's progress during treatment

Notice that some common diagnoses, included in the above list are: Senile Dementia, Depression, Hysteria, and Anxiety.

Consequently, we recommend you try to avoid using these diagnoses as the primary diagnosis on your Medicare claims.

Those services that do **not** suffer the reductions are:

- Diagnostic services to establish or confirm pt's diagnosis, including psychological testing CPT codes 90801 - 90830.
- Code M0064 — brief O.V. for the sole purpose of monitoring or changing drug prescriptions for mental, psychoneurotic and personality disorders.

CHARGING FOR CASE MANAGEMENT

There's not a two week period that goes by that we do not receive a call from a Texas Physician or staff, asking if they can charge for phone calls to Medicare, Medicaid or commercial patients for phone consultations with the patient or a nurse in a nursing home, or a home health care nurse. This case management has been a sensitive subject in many offices, due to the fact that you must have a face-to-face patient encounter in order to charge for an evaluation and management service. Prescribing medication or treatment over the phone is a large part of case management, but does not qualify for an evaluation and management service procedure code.

HCFA has approached different physician groups in an attempt to determine which physicians should be compensated for the coordination of care in case management situations. They realize that non-payment for these services quite often results in the patient being admitted into the hospital, thereby costing HCFA big bucks. The AMA has presented two codes (99361 & 99362) for case management to HCFA, and hopefully, we will see this month whether Medicare will cover these in 1994, in the *Federal Register* with the 1994 changes. In the meantime, we highly encourage you to charge these codes on private pay and commercial accounts, when you have to manage the patient's care over the phone.

Since the evaluation and management service includes non-billable services, such as clinical lab interpretations, prescribing of medicine, telephone consults with the patients or responsible parties, you should document each service you give over the phone during the month. Then, when you make your nursing home or home visit to the patient, this documentation in the chart will substantiate the necessity for a higher level of service. As an example, you received two calls from a nursing home over the past month on Ann Richards and five days after your last visit, you received lab results from tests you ordered. When you make your next visit, make sure you take these services into account when choosing codes 99212 or 99213 for the visit.

The Ann Richards Statue Committee has finally decided where to place the statue of Ma Richards in the Hall of Fame in Washington, D.C. The spot chosen is next to Christopher Columbus, the greatest Democrat of all. He left home not knowing where he was going, and upon arriving, knew not where he was. He returned, not knowing where he had been, and did it all on borrowed money.

STAY OUT OF SUPPLY BUSINESS

We must receive three calls per week, every week, from office staff trying to get paid for orthopedic braces, shoes or other supplies, on Medicare patients. Due to the hassles involved in proper coding, documentation, and the fact that Medicare leaves almost NO profit in these areas, we generally recommend you write the patient a prescription, and let them get the supply at the pharmacy or orthopedic supply store. Since the advent of the Durable Medical Equipment Regional Carriers (DMERCs) and the additional forms, new filing codes, etc...., we suggest you just avoid it if possible. Even if you order a wheelchair or infusion pump for your patient, you will still have to fill out a one page Certificate of Medical Necessity (CMN), although the patient will not be buying or obtaining the supply from you. DMERCs have implemented 10 new CMNs, depending on which equipment or supply you are prescribing for your patient. Just be glad they're trying to **reduce** the amount of paperwork being generated. If they were trying to increase it, you wouldn't have time for anything other than paperwork.

2ND PROCEDURE NOT ALWAYS CUT

HCFA recently clarified to Blue Cross Texas that code 92996 is always billed in conjunction with code 92995, so code 92996's relative value units have already been reduced. In other words, the multiple procedure reduction rules do ▶

not apply to code 92996. This rule is effective on or after January 1 this year, so Cardiologists may want to check their EOMBs to see if Texas Medicare has been applying these reductions this year. If so, you should send the EOMBs to us, so we may appeal these claims for you. This is part of our retainer system, so we will not charge retainer clients for this service.

HOW LONG TO KEEP RECORDS?

This is another question commonly asked of us: "How long should I keep patient medical records?" Medicare's civil penalties law has a six year statute of limitations, and their criminal false claims law has a five year limitation. The A.M.A. has a policy of keeping records seven years. With this age of lawsuit-happy people and lawyers with little ethics, we recommend you keep your patient medical records forever. We also do not recommend you alter or "clarify" your notes or documentation in response to any allegations, without first consulting with an attorney who knows health care law. In a recent case, the alterations were construed as "obstruction of justice." Even though your first impulse is to clarify yourself, your next one should be not to do it. Hopefully, this will never come up in your practice.

MULTIPLE DIAGNOSTIC REDUCTIONS?

While Medicare pays 100 percent, 50 percent and 25 percent on multiple procedures (surgical - or what they consider surgical - services), HCFA has made a proposal to cut 1994 reimbursement for multiple echocardiography procedures done on the same day by the same physician, for the same patient. HCFA wants to keep the highest value code at 100 percent of the approved and reduce the remaining codes to 50 percent. This proposal has been met with comments from several state associations, and individual practices throughout the nation. We have not seen it challenged by the AMA or ASIM.

If HCFA is successful in this change it will be a very short step to applying the same rules to other diagnostic tests, such as EKG's, Spirometry, X-Rays, etc.... We will be watching the *Federal Register* when they publish the 1994 Medicare Fee Schedule and rules and let you know what's coming.

ELECTRONIC CLAIMS FORMAT VALID?

Some providers are holding onto older software programs because of the cost involved in changing formats, which may cost them big bucks in the long run. More than 400 different formats exist for electronic claims, but legislation is currently being debated (to save administrative costs) to require the use of only one nationally recognized electronic claims format...National Standard Format. Medicare currently spends approximately $80 billion annually on administrative costs to process claims. Texas Medicare currently receives between 175,000 to 200,000 claims per day. As of August 1993, only 64 percent of all Part B claims were filed electronically, while 89 percent of all hospital Part A claims were filed electronically. Blue Cross Texas is setting a deadline for all Texas Medicare and Texas Blue Cross claims to be formatted with the National Standard Format. Currently, approximately 40 percent of the claims filed to Medicare in Texas are filed with the Texas Standard Format. If the computer software company you bought your program from is no longer in business, and you want to continue filing claims electronically, you will either have to align yourself with a clearing house (such as ourselves) or obtain a new software program, once Texas switches over. We recommend you start looking into this now, instead of waiting until the last minute.

KEEP HIC NUMBERS CONFIDENTIAL

You could do your Medicare patients, yourselves and Medicare a favor by advising the patients to keep their HIC numbers confidential. Especially caution them against giving their Medicare number to telemarketers, blood pressure screeners at the mall or any other stranger. Some firms are even getting the patients' numbers at self-help seminars (estate planning, stress reduction and depression) taught in community centers, hotels and churches.

Professional scammers are visiting nursing homes and identifying themselves as Medicare Part B representatives, obtaining patient numbers and then selling them to dishonest DME suppliers. These swindlers then file claims for supplies never ordered by physicians.

Sometimes, patients receive supplies and equipment they know nothing about and other times, the companies bill Medicare, bilking the system out of hundreds of thousands of (our) dollars.

NATIONAL PROVIDER NUMBERS

To reduce the costs of each state assigning individual provider numbers to each provider in their state, HCFA is looking at assigning National Provider numbers to each physician (does this sound like UPIN?) to use in processing claims. While this may sound like a good idea at first, and is for providers with only one billing location, there will be problems. Presently, a physician with two offices, located in different Medicare practice localities, has two provider numbers. Since each locality has a different reimbursement rate, the approved amount on the claim is determined by the locality, and ergo the provider number. It will be interesting to see how they get around this one.

CORRECTION TO SEPTEMBER S.T.A.T.

In the September issue of our newsletter, I incorrectly advised you to use observation visit code Z9073 on Medicaid patients. Unfortunately, we had not received Medicaid Bulletin No. 96, which stated this code was no longer valid for Medicaid, effective May 1, 1993. Doris Williamson at Dr. Smola's office was kind enough to alert us to this fact and send us a copy of the Bulletin. Therefore, we now recommend you use out-patient observation codes 99218, 99219 and 99220 on Medicaid patients. Medicaid will not pay for an office visit on the same day as these codes, but will pay for in-patient hospital care on the same day as observation. Our gratitude goes out to Doris on this one.

If you ever notice an error in one of our newsletters, please do not hesitate to call it to our attention. We need all the help we can get to stay on top of all of the changes.

THINK ON IT!

The trouble with self-made men is that they worship their creator!

NEW OMT CODES IN 1994 CPT

For years, the only code for OMT in the CPT book was classified as Physical Therapy, thereby causing confusion and problems with many private carriers who limit physical therapy services. While the A.O.A. has for years petitioned the A.M.A. for separate, physician-performed OMT codes, the 1994 edition now has them. Currently, you have Medicare OMT codes, commercial physical medicine codes and workers comp manipulation codes. Under the 1994 coding system, hopefully, all will accept the same coding, thereby simplifying your coding duties.

Who was the man that failed so much?
He later became President
His name was Abraham Lincoln.

■

Summary of the Proposed Medicare/Medicaid Fraud and Abuse Safe Harbor Regulations

Prepared by Kathleen K. di Bene
Fulbright & Jaworski L.L.P. • Health Law Group • Washington, D.C. Office

On Tuesday, September 21, 1993, the Office of Inspector General of the Department of Health and Human Services ("OIG") published seven safe harbor regulations that it proposes to add to the existing safe harbors specifying payment practices that will not violate the federal Medicare/Medicaid fraud and abuse statute, 42 U.S.C. §1320a-7b(b). *See* "Health Care Programs: Fraud and Abuse; Additional Safe Harbor Provisions Under the OIG Anti-Kickback Statute," Proposed Rule, OIG, 58 Fed. Reg. 49008 (September 21, 1993).

These proposed safe harbors address several significant issues, including physician recruitment and physician investments in health care providers. Predictably, the safe harbors, as proposed, are exceedingly narrow. For example, the safe harbor for physician recruitment is limited to providers located in rural areas. Notably, rural areas are afforded special treatment in several of the proposed safe harbors.

Proposed Safe Harbors

1. ***Investment Interests In Rural Areas.*** This safe harbor would protect physician investment in entities located in "rural areas." For purposes of determining whether an entity is located in a rural area, the OIG proposes to defer to the definition developed by the Office of Management and Budget and used by the Bureau of the Census. The OIG invites comments on whether a more appropriate definition would be the "rural area" criteria used by Medicare for purposes of determining a hospital's inpatient reimbursement rate. In addition to being located in a "rural area," the entity must demonstrate that at least 85% of its business in the previous year is derived from the service of individuals residing in a rural area. The investment arrangement also must meet six other criteria, including that the opportunity for investment be made in a good faith, nondiscriminatory manner to any individuals or entities who are potential sources of capital, and not just to those in a position to refer business to the entity.

2. ***Investment Interests In Ambulatory Surgical Centers.*** Investments by surgeons in a Medicare-certified ambulatory surgical center ("ASC") would be protected if all the investors in the ASC are surgeons who perform the services on the patients they refer to the ASC. The arrangement must meet five additional criteria, including that the surgeon-investors agree to treat Medicare and Medicaid patients.

The safe harbor would not protect ASC joint ventures between hospitals and treating surgeons. Nor would the safe harbor protect an ASC located on the premises of a hospital when the ASC shares its operating or recovery room space with the hospital for treatment of the hospital's inpatients or outpatients. The OIG requested comments on entities other than ASCs that should fall in this safe harbor, because they can similarly be viewed as extensions of physicians' practices. The OIG suggests that only those facilities where the technical component of the fee is far less than the professional component would be appropriate for safe harbor protection.

3. ***Investment Interests In Group Practices.*** This safe harbor would protect profit distributions from entities owned exclusively by members of a group practice. Each investor must either be responsible for the day-to-day management of the entity and also be a bona fide general partner, or agree in writing to assume liability for the entity's actions. There are three additional criteria relating to the initial contributions by and distributions to the physician-investors.

The OIG proposes to reply on the relatively narrow definition of "group practice" found in the Stark clinical laboratory prohibition, 42 U.S.C.§1395nn, i.e., the physician members of the group must provide substantially the full range of their services through the shared use of space; the physician members must provide substantially all of their services through the group; and overhead and income are distributed in accordance with a predetermined formula.

The OIG invited comments on whether they should be a safe harbor for entities owned by physicians and other entities, such as hospitals or DME suppliers, so long as all investors assume personal liability for the entity's activities and are involved in the day-to-day operations of the entity.

4. ***Practitioner Recruitment.*** Payments and benefits offered by rural hospitals to recruit physicians would be protected under this proposed safe harbor if seven criteria are met. Once again, the OIG defers to the "rural area" classification used by the Office of Management and Budget.

To be protected, the benefits would have to be offered to 1) a physician practicing within his or her current specialty for less than one year or 2) to any other practitioner so long as the physical location of the new practice is no less than 100 miles from the practitioner's old practice and at least 85% of the revenues of the new practice must be generated from new patients not previously seen by the practitioner at the old practice. Obviously, this 85% criteria will be difficult for a hospital to verify.

The benefits could not last for more than three years unless the new place of practice is a health professional shortage area for the physician's specialty category during the entire duration of the benefit period. Also, the physician must agree to treat Medicare and Medicaid patients.

The OIG invited comments on whether to protect payments designed to retain physicians already practicing in health professional shortage areas. ▸

5. ***Obstetrical Malpractice Insurance Subsidies.*** This safe harbor would protect payments for malpractice insurance premiums for a practitioner engaging in obstetrical practice (including a certified nurse-midwife) under the following narrow circumstances: 1) the practitioner must practice in a health professional shortage area; 2) at least 85% of the practitioner's obstetrical patients treated under the coverage of the malpractice insurance must either reside in an area designated by Medicare as having a shortage of primary medical care manpower or be part of a population group designated by Medicare as having a shortage of primary medical care manpower; and 3) the insurance must be provided by an entity regulated as an insurer by State law. Additionally, the practitioner would have to agree to treat Medicare and Medicaid obstetrical patients.

The OIG asked for comments on whether to expand this safe harbor to include areas other than health professional shortage areas and whether to include malpractice insurance programs operated directly by providers.

6. ***Referral Agreements For Specialty Services.*** This safe harbor protects arrangements between practitioners where one practitioner refers a patient to the other for a specialized service in return for an agreement that the second practitioner will refer the patient back at a mutually agreed upon time or circumstance.

7. ***Cooperative Hospital Service Organizations.*** Certain payments between a cooperative hospital organization, organized under section 501(e) of the Internal Revenue Code, and its patron-hospitals would be protected under this safe harbor if the organization is wholly owned by two or more patron-hospitals.

Opportunity for Comments

The OIG accepted comments on these proposed regulations until November 22, 1993. As identified above, the OIG requested comments on a number of specific issues. We believe this was an excellent opportunity for providers, suppliers and physicians to submit views they believe merit consideration by the OIG. ■

Blood Bank Briefs for Physicians

Cytomegalovirus — Negative Blood Request

Margie B. Peschel, M.D., Medical Director
Carter Blood Center, Fort Worth, Texas

Human Cytomegalovirus (CMV) is a member of the herpes family of viruses which also includes Epstein-Barr virus (EBV), Varicella and Herpes Simplex (HSV). Features of CMV which are important in understanding CMV and transfusion associated infections include:

1. The incidence of CMV infections as determined by the sero-prevalence of lgG to the virus is highly dependent on geographic locations; socioeconomic settings and degree of crowding influence rate at which individuals become infected;

2. CMV infections usually cause minimal if any morbidity and mortality among immuno-competent individuals. Because most CMV infections are asymptomatic, diagnosing disease requires not only viral and/or serological evidence of CMV disease, but also signs and symptoms compatible with CMV infections. These include fever, pneumonitis, hepatitis, GI symptoms or hematological problems; and a tissue biopsy exhibiting inflamed tissue with replicating virus and dense inclusion cells within disease tissues and finally the absence of other pathogens.

Patients at risk for CMV disease include newborns and fetuses. Premature seronegative infants are immunocompromised and CMV is difficult to prove, but mortality has been accessed. The 15th edition of the American Association of Blood Banks Standards for Blood Banks and Transfusion Services state "where transfusion-associated cytomegalovirus (CMV) disease is a problem, cellular components should be selected or processed to reduce the risk to infant recipients weighing less than 1200 grams at birth, when either the infant or mother is CMV-antibody-negative or that information is unknown."

Additional patients at risk are CMV-antibody-negative bone marrow transplant recipients or organ transplant recipients.

The purpose of this bulletin is to call to the physician requesting blood other patients at risk. In view of the significant risk of congenital mental retardation associated with CMV primary infection during pregnancy, a CMV-antibody-negative pregnant woman should receive CMV-seronegative blood components.

Another group of patients at risk are CMV-antibody-negative HIV infected individuals. Although most HIV infected gay males are already seropositive for CMV, approximately half of HIV infected hemophilia patients are not and there is the risk of a high likelihood of developing CMV retinitis in HIV infected individuals. Therefore, prevention of CMV transmission to these patients seems reasonable in view of the high probability of CMV disease during the course of HIV infection. ■

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Jackson JB, Erice A, Englund JA, et al. Prevalence of cytomegalovirus antibody in hemophiliacs and hemosexuals infected with human immunodeficiency virus type I. Transfusion. 1988;28:187-189.

Widman F. Standards for Blood Banks and Transfusion Services 15th ed. American Association of Blood Banks. 1993:27.

Texas ACOFP Update

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

1994 will be known as the year of health care reform in the U.S.A. The challenges to physicians will be how much influence we, as a profession, can exert to bring about positive changes in health care reform.

If you had to design a system of health care that would maintain its quality, while becoming more affordable, where would you start?

Some folks believe that the answer lies in rationing health care and placing caps on health care expenditures, because the American public has an insatiable appetite for health care services which physicians are more than happy to supply.

Out-of-pocket expenses, such as deductibles and co-payments, help slow down the demand for health care services; however, health care costs keep escalating. Why?

Could it be that we need to get back to the basics? When we first started our clinical rotations in medical school and began to learn the proper mechanics of performing a history and physical examination, we all sought that elusive entity known as the chief complaint — the **one** reason why the patient had decided to see the physician on that particular day for health care. We were taught to be both inquisitive and tenacious in our search for the chief complaint.

If a chief complaint could not be elicited, the patient probably did not require the immediate services of a physician. In the past, the patient's key to health care services was the chief complaint. Without the chief complaint, the health care door was not widely opened.

The third party payor system has changed the traditional system of treating the chief complaint to one of treating multiple symptoms. The American public has been conditioned to voice every symptom, no matter how small, with the expectation that a physician will address each and every symptom with an equal intensity of medical services.

On top of this patient demand to find the definitive etiology for all of their many symptoms, there is the ever-looming threat of litigation if physicians fail to meet the high expectations of their patients.

The treatment of multiple symptoms has led to polypharmacy with the danger of multiple drug interactions. It is not uncommon for physicians to prescribe medication for drug-related symptoms when the appropriate treatment would be to withdraw all offending drugs.

In days gone by, physicians would admit patients to hospitals to safely monitor the cessation of all medications in a controlled environment. Once the medications were out of the patient's system, the physician would then place the patient on one medication at a time, based on the chief complaint. The rule of thumb was that maintenance medications would be limited to no more than three. However, this method of treating polypharmacy was expensive and a lot of third party payors are reluctant to reimburse for this service now, plus there is always the threat of litigation from unhappy patients and their relatives.

Physicians are taught that minor illnesses are self-limiting and will resolve with time. Therefore, physicians tend to focus their attention on major illnesses which require medical or surgical intervention in order for the patient to improve. Yet, most patients cannot distinguish between major and minor illnesses. They just want to get well quick.

The tincture of time used to be an acceptable form of treatment for minor illnesses in the good old days. Time used to be a physician's ally, but time has changed!

Failure to diagnose a disease or injury that later develops into a life-threatening situation is the number **one** reason patients now sue their physicians.

The Medical Services Division of St. Paul Fire and Marine Insurance Company, in 1990 and 1991, listed "failure to diagnose" as the top category of malpractice claims against the physicians they insured. It accounted for 28 percent of claims and more than 35 percent of overall costs. "Improper treatment" was the second-place malpractice category at the St. Paul Company, generating 26 percent of claims and 30 percent of costs.

If it was left up to me, I would reform the patient-doctor relationship in the following ways. First, I would initiate tort reform to limit physician liability to only the chief complaint. There would be "no fault liability" for all other complaints. If no chief complaint was obtainable from the patient, there would be "no fault liability." Second, I would limit physician liability when prescribing maintenance medication to the three most important pharmaceuticals, as noted in the patient's medical record. If more than three maintenance medications were requested by the patient or a family member, any adverse drug reaction related to polypharmacy would come under the category of "no fault liability." Medications for acute care would not be subjected to any liability limitations.

You have probably noticed that my suggestions on how to preserve quality health care, while making that care more affordable, centers around tort reform. You will also have noticed by this time that President Clinton's health care plan came up short on tort reform. Without significant tort reform. health care expenditures will not decrease, but the quality of that care will decrease.

At the recent MCAC meeting in Austin, Texas, on 11-10-93, there was a federally mandated agenda item that Texas physicians should find interesting. "The Omnibus Budget Reconciliation Act of 1993, Sec. 13605, expands coverage of Certified Nurse Midwife services to require coverage of services outside the maternity cycle. Such services must be within their scope of practice and consistent with the rules and regulations promulgated by the Board of Nurse Examiners for the State of Texas or other appropriate licensing authority."

The amendments expand coverage of Nurse Midwife services to include primary health care.

President Clinton's health care plan calls for expanded use of nurses to provide primary care. He has plans for the federal government to knock down state barriers that prevent nurses from providing primary care. The new battle cry of the American Nurses Association (ANA) is that "in the future your 'family doctor' may be a nurse!"

The ANA has the ear of Mrs. Clinton and the President. It will be our job as Texas physicians to gain the ears of our congressional representatives to make sure that nurses will not be family doctors. Our patients deserve the best possible health care.

Let us all resolve to be a positive force for health care changes in 1994 rather than passive victims of a national campaign for health care political correctness.

On behalf of the Texas AOFP officers, trustees and ex-officio members, I would like to wish everyone a Happy and Healthy New Year. ■

CHAMPUS News

CHAMPUS EXPANDS PARTIAL HOSPITALIZATION TO INCLUDE MENTAL HEALTH TREATMENT

CHAMPUS has broadened its coverage of partial hospitalization beyond alcoholism rehabilitation, to include other psychiatric disorders.

The expanded benefit will be effective for care provided in CHAMPUS-authorized partial hospitalization programs on or after September 29, 1993. It will be limited to 60 days of treatment per government fiscal year (October 1 through September 30), with waivers available for unusual cases. Each partial day counts as one day toward the 60-day limit.

The partial hospitalization benefit for alcoholism rehab will remain at its previous limit of 21 days per 365-day period.

Pre-admission and continued-stay authorizations are required for all admissions to a partial hospitalization program (including alcoholism rehab). In most parts of the country, CHAMPUS' mental health contractor, Health Management Strategies International, Inc. (HMSI), will review and authorize all partial hospitalization care before admission, and will also review the care while it is being provided. In certain areas, such as in California and Hawaii; New Orleans; the Norfolk, Virginia, area; and several additional sites in Texas and Louisiana, the CHAMPUS contractor for those areas will handle advance authorization. Contact the Health Benefits Advisor at the nearest military medical facility for information and assistance.

Facilities wishing to treat patients under CHAMPUS may be free-standing or hospital-based. They must comply fully with CHAMPUS standards, must be certified by HMSI as institutional providers for partial hospitalization programs, and must enter into a participation agreement before admitting CHAMPUS patients.

Claims for care must be submitted on the UB-82 or UB-92 claim forms, and the claim must identify the number of hours of care actually provided. Providers may not bill CHAMPUS patients for charges in excess of the cost-share, for days the patient is absent, or for services that CHAMPUS won't pay for because the provider didn't comply with requirements for pre-authorization or concurrent care review.

CHAMPUS will reimburse psychiatric partial hospitalization programs based on fixed regional per diem rates. Reimbursement is all-inclusive; it covers patient assessment, psychological testing and assessment, treatment services, board, ancillary services, etc.

The only services that may be billed separately are individual or family psychotherapy (up to five sessions per week) provided by a CHAMPUS-authorized professional provider who is not employed by, or under contract with, the partial hospitalization program, and non-mental-health-related services not normally included in the evaluation and assessment of a partial hospitalization patient.

Professional providers who bill separately for individual or family psychotherapy must state on the claim form that the psychotherapy is related to a partial hospitalization stay. Otherwise, the claim will be denied, since outpatient psychotherapy is not authorized during the time a patient is participating in a partial hospitalization program.

CHAMPUS cost-shares partial hospitalization on an inpatient basis, which means there's no annual deductible for patients to meet. The inpatient cost-share applies both to the institutional per diem rate and to associated psychotherapy billed separately by an individual professional provider.

Partial hospitalization services may be provided on a full-day (six hours or more) or half-day (three to six hours) basis. CHAMPUS won't pay for partial hospitalization services of less than three hours per day.

Inquiries about the program, or applications for facility approval throughout most of the country may be obtained from:

Health Management Strategies International, Inc.
CHAMP-MH
P.O. Box 26307
Alexandria, VA 22313

HMS may also be contacted on this toll-free telephone number:

1-800-242-6764.

CHAMPUS CLAIM FILING RULES WILL CHANGE SOON

Beginning January 1, 1994, all CHAMPUS claims must be filed with the appropriate CHAMPUS contractor no later than one year after the services are provided — *or*, in the case of inpatient care, the claim must be filed within one year of the date the patient is discharged from the inpatient facility. Here are two examples:

(1) For professional or outpatient facility services, if the service was provided on January 1, 1994, the claim must be postmarked no later than January 1, 1995.

(2) For services received from inpatient facilities, if the date of the patient's discharge from the hospital is January 1, 1994, the claim must be postmarked no later than January 1, 1995.

The old rules still apply to services provided before the end of 1993. Claims for these services must be in the hands of the proper CHAMPUS contractor by December 31 of the year *after* the year in which the services were provided. In other words, for treatment or services provided any time during 1993, you must get the claim to the CHAMPUS contractor by the end of 1994. And the deadline for claims for 1992 services is the end of 1993. ■

FYI

PLANT MAY CONQUER CRAVING FOR ALCOHOL

A study by researchers at Harvard Medical School found that an imported weed called kudzu may curb the craving for alcohol. To test its effect, researchers used Syrian golden hamsters, unique in that they have a huge appetite for alcohol, preferring it to water. After injections of a compound called daidzin, which is the active ingredient in Kudzu, the animals voluntarily gave up their preference for alcohol.

The kudzu plant has been used as a treatment for alcoholism in Asia since about 200 A.D. Japan and China sell kudzu in pill form over the counter

CLINTON'S UNIVERSAL HEALTH PLAN PUSHED BACK TO JANUARY 1998

In late October, President Clinton finally delivered his universal health care package - 1,342 pages - to Capitol Hill. He has stated that he is open to compromise on virtually any aspect of the plan but one - comprehensive health care security must be achieved for all Americans when legislation is enacted. The plan's implementation date has been pushed back to January 1998. Additionally, the estimate of insured people who will probably be socked with higher insurance premiums has been raised to 40 percent.

SMALL COLA RISE FOR 1994

Social Security and Supplemental Security Income benefits are scheduled to rise 2.6 percent in 1994. The increase is based on the Consumer Price Index and is the second smallest increase since automatic cost-of-living adjustments were added in 1975.

THE DINOSAURS' DEMISE — ANOTHER THEORY

Geologists are suggesting that a lowering of oxygen in the atmosphere (from 35 percent to 28 percent over a period of 500,000 years) may have caused the death of dinosaurs in that they were unable to adapt to such a change. This possibility was revealed by analyzing gas bubbles trapped in amber.

FREE HEALTH INSURANCE FOR IBM WORKERS ENDS

Following the lead of thousands of other U.S. businesses, IBM has ended free health care coverage for its U.S. employees. New plans and options will be presented and the minimum annual deductible for major medical and surgical expenses will be increased from $150 to $250. This move is expected to save IBM approximately $280 million annually. Free health care coverage had been provided as a benefit for 79 years.

NIH RECOMMENDS MORE AGRESSIVE TREATMENT, LONGER DIALYSIS SESSIONS FOR KIDNEY PATIENTS

A report by the National Institutes of health says that even though the U.S. spends about $7 billion annually on dialysis treatment, kidney-failure patients either have a high mortality rate or live a miserable life, causing some to choose death over dialysis. The report urges earlier and more aggressive treatment of the medical conditions that lead to kidney failure, as well as longer sessions on kidney machines when therapy is necessary. Currently, there are approximately 195,000 Americans with kidney failure.

DR. HARVEY MICKLIN RECEIVES FELLOW STATUS, IS ELECTED OFFICER

Harvey G. Micklin, D.O., was elevated to Fellow in the American College of Neuropsychiatrists at their annual meeting held in Boston on October 11, 1993. In addition to this honor, Dr. Micklin was elected Vice President of the American College of Neuropsychiatrists.

Dr. Micklin is a 1960 graduate of the University of Osteopathic Medicine and Health Sciences in Des Moines, Iowa, and did his psychiatry residency at Mt. Sinai Hospital in New York. He is certified by the American Osteopathic Board of Neurology and Psychiatry and by the American Board of Psychiatry and Neurology.

He is currently Associate Professor and Chairman of the Department of Psychiatry and Human Behavior at the University of North Texas Health Science Center at Fort Worth.

Congratulations to Dr. Micklin from TOMA!

GOOD NEWS FOR COFFEE CRAVERS

Coffee acts as an anti-depressant and thus, has the potential to prevent suicide and depression, suggests a report by Dr. Arthur Klatsky of Kaiser Permanente Medical Care Program in California.

The study followed 128,000 people for 10 years and found that death by suicide lowered as more coffee was consumed. Additionally, tea was found to have similar but weaker effects.

Dr. Klatsky warns physicians, however, not to prescribe coffee, tea or pure caffeine for depression before patient trials are conducted. ■

Attorney General Opinions

• An opinion was requested concerning sharing of "co-management fees" between optometrists and ophthalmologists.

Summary of opinion: *"An ophthalmologist does not violate section 161.091 of the Health and Safety Code merely by co-managing a patient with an optometrist and thereby consenting to have Medicare pay a fee to the optometrist. To violate this provision, the ophthalmologist would also have to intentionally or knowingly offer to pay remuneration to 'any person, firm, association of persons, partnership, or corporation for securing or soliciting patients or patronage.'"*

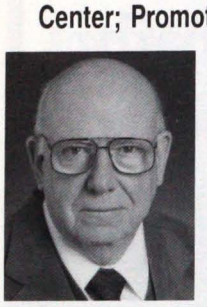
• An opinion was requested concerning whether the practice of reflexology falls within the definition of "massage therapy" in article 4521k, V.T.C.S., and related questions.

Summary of opinion: *"Whether reflexology techniques constitute 'massage therapy' as defined in article 4521k, V.T.C.S., is a question of fact and therefore is not an appropriate subject for an opinion from this office. The Advisory Council on Massage Therapy ('advisory council') does not have authority to promulgate a rule establishing that reflexology is 'massage therapy.' A determination by the advisory council that reflexology is 'massage therapy' does not affect the duties of the Texas Department of Health to administer article 4512k and investigate possible violations of that statute.*

"A person convicted of practicing 'massage therapy' without a registration must wait five years to be registered and must complete the educational and experiential requirements and pass the state examination in order to obtain a registration certificate. The Department of Health has discretion to refuse to register, for a period of no more than five years, an applicant who admits to, but has not been convicted of, practicing 'massage therapy' without a registration in violation of article 4512k." ■

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

NIH Researchers Visit Health Science Center; Promote Aging Research



Internationally recognized researchers Earl and Thressa Stadtman visited the University of North Texas Health Science Center October 27-28.

The Stadtmans are regarded as the world's top authorities on aging and nutrition. They lead the biochemistry division of the National Heart, Lung and Blood Institute, one of the National Institutes of Health in Bethesda, Maryland. Among Earl Stadtman's many significant honors are the National Medal of Science and the 1991 Robert A. Welch Award in Chemistry (the monetary equivalent of the Nobel Prize). Both researchers are members of the National Academy of Science, an elite group of America's top scientists elected to membership by their peers.

Since 1992, when they presented inaugural lectures at the opening of the Texas Institute for Research and Education on Aging — the collaborative program of the health science center and the University of North Texas — the Stadtmans have taken an interest in helping develop the institute.

Robert Gracy, Ph.D., associate dean for basic science and research, hosted the Stadtmans' visit. The Stadtmans said they have known of Gracy's work for almost 15 years, and have come to know him personally in the past several years. Much of their research is closely related, said Earl Stadtman.

The Stadtmans lead a team of about 30 researchers and 20 more post-doctoral fellows at the NIH. The focus of their work, according to Thressa Stadtman, is on improving the quality of life. She said that they not only look at finding cures for the diseases related to aging, such as Alzheimers and arthritis, but also study how the things people do throughout their lives affects how they age.

"I think people are interested in improving the quality of life, overall," she said. "This can be done on a lot of levels — nutrition, what you do early in childhood and what you do with medicine to remove some of the known barriers to good health. We are now finding that so much of what we suffer from can be prevented by changes in lifestyle, a better environment and improvements in medicine. We can't avoid aging, as far as we know, but we can age more gracefully."

On October 27, the Stadtmans were guests at the home of former UNT regent Billie Parker for an evening reception with Fort Worth civic and business leaders and other guests.

Health Science Center Offers Patient Care Analysis Service

The University of North Texas Health Science Center at Fort Worth opened a new office in the Department of Public Health/Preventive Medicine on September 1 that helps gather and analyze medical-related data important to clinics, hospitals, businesses and insurance companies.

The Office of Clinical Outcomes Research, Epidemiology and Statistics is directed by John Licciardone, D.O., associate professor, and will serve both the health science center and the public.

The office's first major project is for the health science center's clinics. Licciardone will gather very basic background information on patients and combine that information with their medical history, both before visiting the clinic and following treatments, to create an assessment of how their health improves after becoming a patient at the clinics.

Externally, the new section will be available to hospitals, businesses and insurance companies to conduct studies that will provide information needed to improve their services. Statistical data can help organizations save money, improve patient care and qualify for funding or accreditation, Licciardone said.

The department will also continue its research on drug abuse prevention in colleges for the United States Department of Education.

UNT Health Science Center Researchers Are Awarded $353,000 In State Grants

Four faculty members at the University of North Texas Health Science Center at Fort Worth have been awarded three research grants totaling $353,630 from the Advanced Research Program/Advanced Technology Program of the Texas Higher Education Coordinating Board.

Receiving funding for their projects were H. Fred Downey, Ph.D., and Robert T. Mallet, Ph.D., both of biochemistry; Rafael Alvarez-Gonzalez, Ph.D., microbiology and immunology; and Robert W. Gracy, Ph.D., associate dean for basic science and research.

The ARP/ATP project is a peer review, competitive, state-wide research program created by the Texas Legislature in 1987. It has become the nation's largest competitive state-supported research grant program. More than 3,000 project proposals in 24 research fields were submitted for the current two-year funding cycle.

Downey and Mallet were awarded a $98,005 grant from the Advanced Research Program for research on "Modulation of Myocardial Oxygen Demand When Oxygen Supply is Limited."

Alvarez-Gonzalez also received an ARP grant. His award of $83,600 will fund his research project titled "Structure and Function of DNA-binding Proteins; Molecular Anatomy of Poly (ADP-Ribose) Polymerase."

Gracy was selected to receive a $172,025 grant from the Advanced Technology Program for a research project on "Validation and Automation of Human Tissue Equivalents as *In Vitro* Animal Alternatives for New Products." Gracy received a $180,000 ATP grant in 1991 for research into human skin ▸

equivalents on which new drugs can be tested and evaluated more rapidly and with a higher degree of safety and control than animal systems. The latest ATP grant is for continuation of the research project.

The Advanced Research Program is designed for basic research while the Advanced Technology Program is intended for applied research.

Student Wins AOAA Writing Competition

Linda Odom, a D.O./Ph.D. student at the University of North Texas Health Science Center at Fort Worth, won first place for a paper she submitted to the American Osteopathic Academy of Addictionology's writing competition. Her award included a trip to Boston to the American Osteopathic Association Convention, a $1,000 stipend and the opportunity to present her paper to physicians at the AOA seminar sponsored by the academy.

Odom's paper, titled "The State of The Art in Addiction Medicine in the 1990s," was selected out of all the entries from the 16 osteopathic medical schools. The AOAA plans to submit her paper to a journal targeted to student doctors. Roger Kendrick, D.O., chairman of undergraduate education for the academy, described Odom's paper and presentation as first rate. "It was an outstanding paper," he said. "She is going to be an outstanding physician."

Odom, a 1987 graduate of the University of Texas at Austin, worked as a research assistant at the University of Texas Marine Science Institution in Port Aransas after graduating from college.

"I had originally planned to become a researcher, but I developed rheumatoid arthritis to such a degree that it was difficult to use my hands," Odom said. "I had lost hope that doing research was an option for me."

Odom looked into medical school and was interested in the D.O./Ph.D. program offered by the Texas College of Osteopathic Medicine. "When I came here, I found that I was not limited by my hands and I could explore not only medicine but also research in areas that really interest me."

Her goal is to specialize in psychiatry, focusing on teaching, research and working with patients. ■

Nova University and Southeastern University Of The Health Sciences To Merge

The presidents of Nova University and Southwestern University of the Health Sciences recently announced that Southeastern will be merged into Nova on January 1, 1994, pending approval from the Commission on Colleges of the Southern Association of Colleges and Schools. The university will then be renamed Nova Southeastern University (NSU), with Southeastern's programs forming NSU's Health Professions Division.

The merger will add colleges of osteopathic medicine, pharmacy, optometry and allied health to Nova University, the second largest independent university in the state of Florida. Southeastern is one of the largest and most successful independent universities to be acquired in recent history.

Once combined, the Health Professions Division will relocate into a 250,000 square-foot facility to be constructed on Nova's 200-acre campus in Davie, Florida.

Nova Southeastern University will have annual revenues of $135 million, nearly 1,800 employees, and more than 13,300 students. Nova University President Stephen Feldman, Ph.D., will become president and C.E.O. of NSU, and Southeastern President Morton Terry, D.O., will serve as chancellor of the Health Sciences Division.

"The merger will allow our students to receive the benefits of being a part of a large university setting, including participating in Nova's student activities and using its vast facilities, while continuing to receive individualized education in our health fields," said Dr. Terry.

"The health profession is the fastest, growing field in the country. The addition of a medical school to Nova University — a first for Broward County — will enable Nova Southeastern University to become a major force in health education, fulfilling the need for qualified professionals," said Dr. Feldman.

Southeastern University of the Health Sciences, founded in 1979, is located in North Miami Beach, Florida. It has the only college of optometry in Florida, the only college of pharmacy in South Florida and the only college of osteopathic medicine in the southeastern U.S. The university has annual revenues of $25 million, employs nearly 400 individuals, has more than 1,100 alumni and currently enrolls 1,226 students.

Founded in 1964, Nova University offers bachelor's, master's, and doctoral degrees in such areas as law, education, business, psychology, computer science, oceanography, social and systemic studies, and hospitality. More than 12,000 students attend classes on Nova's main campus and in 21 states and three foreign countries. The university has annual revenues of $110 million, 1,400 employees and more than 36,000 alumni. ■

Newsbrief

PATIENT COUNT INCREASES UNDER EXPANDED AIDS DEFINITION

The broader definition of AIDS, which went into effect in January 1993, has added 48,915 Americans this year to the total of diagnosed cases, according to the Centers for Disease Control and Prevention's AIDS surveillance. In Texas, the total was increased by 19 percent, or 967 people, under the new definition.

Virginia Campbell Scott Authors "*The Dream Horse*"

Virginia Campbell Scott of Houston, has written a book entitled, *The Dream Horse*, published in June 1993. The book was a HarperPaperbacks Young Adult 1991 Golden Heart Finalist.

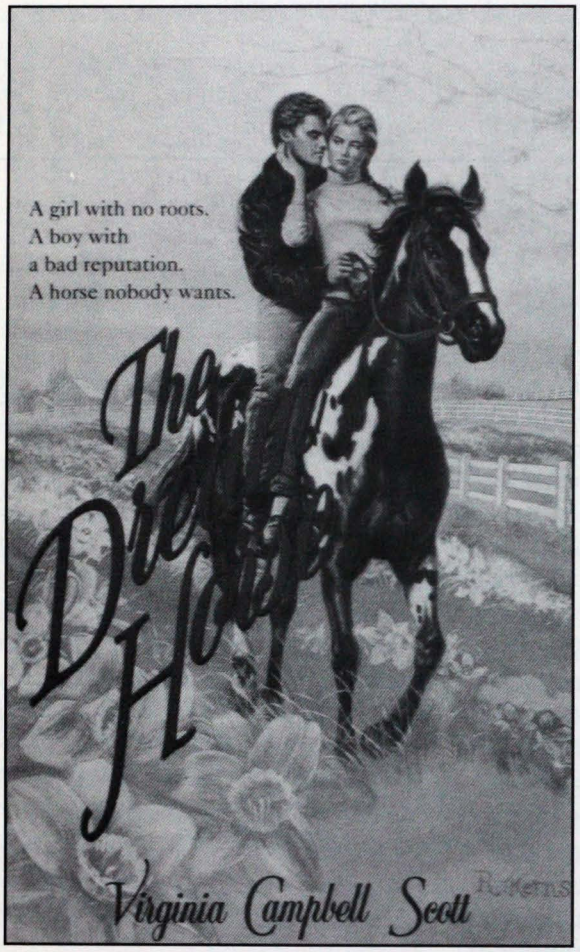
She is the daughter of Deweese Y. Campbell, D.O., and Lois K. Campbell, former ATOMA president. Additionally, she is the sister of Mary Campbell-Fox, D.O., Robert Bruce Campbell, D.O., and Cara Campbell, D.V.M., all of Houston.

In a letter to TOMA, Lois stated, "Our family is very proud of Virginia and the book...Our church is using autographed copies as a youth money-making project."

TOMA and ATOMA members may be interested in purchasing autographed copies of the book as Christmas gifts. The cost is $5.00 per book, which includes mailing charges. Lois notes that Virginia will include a personalized message, as requested, when autographing.

To order, send name and message desired, your name and address, and a check to: Virginia Campbell Scott, 1043 Sagecanyon, Houston, Texas 77089 phone (713) 481-9330.

Our sincere congratulations are extended to Virginia on the release of her first book.



Virginia Campbell Scott

is proud to announce
the release of her first YA romance

The Dream Horse

First Printing June 1993
HarperPaperbacks
ISBN 0-06-106149-2

Miranda McDonald and Graham Walker had nothing in common — except their belief that a clumsy piebald gelding named Different Drummer could be a champion show-jumper.

When she's not writing, Ms. Scott is riding. Her TB/Clydesdale cross horses are well known at dressage and combined training competitions in the southwest. She lives in Houston with her husband and two children, and all the horses, of course.

***The Dream Horse* was a 1991 Golden Heart finalist.**

Opportunities Unlimited

PHYSICIANS WANTED

PHYSICIAN-OWNED EMERGENCY GROUP — is seeking Full or Part-time D.O. or M.D. emergency physicians who practice quality emergency medicine. BC/BE encouraged, but not required. Flexible schedules, competitive salary with malpractice provided. Send CV to Glenn Calabrese, D.O., FACEP, OPEM Associates, P.A., 4916 Camp Bowie Blvd., Suite 208, Fort Worth, 76107. 817/731-8776. FAX 817/731-9590. (16)

BUSY, PROGRESSIVE — Fort Worth private practice seeks 2nd BC/BE OB/GYN physician. Great location, all practice amenities, partnership potential. Contact in confidence. Send CV to: Vernon J. Hayes, D.O., 2600 Montgomery & I-30, Fort Worth, 76107; 817/731-3936; fax 817/782-0206. (26)

PRACTICE AVAILABLE — loyal family practice available in resort community with mixed staff hospital near metroplex. Physician desiring to travel. Inquire 800/437-7112. (42)

DALLAS AREA GP CLINIC needs associate doctor on locum tenens. 6-50 hours per week. Call 214/941-9200 (02)

PRACTICE FOR SALE — Southeast Dallas Family Practice Clinic. Physician retiring. 2,250 sq. ft. Established in 1960. Excellent location and visibility. 5 exam rooms, lab, 3 offices. Includes all equipment. Leave message at 214/388-9438. (21)

HIGH INCOME — successful GP clinic in Dallas area for sale. Will consider lease with option to buy and/or will finance to individual practitioner. Call 214/941-9200. (18)

FORT WORTH — Immediate opening for BE/BC physician to work full or part time in family practice/minor emergency clinic. No OB, week-ends or call. Potential for future partnership if desired. Contact Robert Hames, D.O., 817/237-3333. (25)

OZONA — The town of Ozona, Texas, located in West Texas' Crockett County is seeking a Texas Licensed Family Practitioner. Salary Guarantee Negotiable. Sign on bonus. Moving expenses paid. No start up costs, and staff supplied. Two practicing physicians currently. Inquire Crockett County Hospital, P.O. Box 640, Ozona, Texas 76943 and/or call Gerard Phillips at 915/392-2671. (56)

HOUSTON AREA — The town of Anahuac needs a family practice physician. New office and reasonable guarantee awaits. We are on the bay in Chambers County. Contact: John Luff, Bayside Community Hospital, Anahuac, Texas 77514 or call 409/267-3143. (31)

PART TIME/FULL TIME opportunities for doctors in walk-in clinics, rural health clinics, single and multispecialty clinics. For further information contact Jerry Lewis of The Lewis Group, 800/666-1377. (64)

MODERN MINOR EMERGENCY/AMBULATORY care centers seeking well-rounded practitioner for expansion in Central Texas. Generous modified fee-for-service income package with superior professional liability insurance included. Must have good experience in family medicine. Industrial medicine experience helpful. Send CV or call Keith Williams, M.D., 3305 N. 3rd, Ste. 304, Abilene, TX 79603, 915/676-3023. (37)

NEEDED — Busy D.O. in General Practice in need of partner. Great hunting and fishing in East Texas community of 35,000 near Sam Rayburn Lake. $120,000, malpractice, incentive and partnership. Send CV or contact Family Medical Clinic, 1702 E. Denman, Lufkin, Texas 75901; 409/639-1224. (68)

FAMILY PRACTICE PHYSICIANS needed for smaller communities throughout Texas. Many of these towns, with populations ranging from 5,000 to 100,000, are located within an hour of large metro areas. Excellent guarantees and all expenses paid. If you are interested in providing your family with the serenity and security of a smaller community, plese call us for details. Bennett & Associates, 915-550-9096. (08)

OB/GYN needed for a beautiful, "Picturesque" community, within 90 miles from DFW area. All the simplicity, security, and serenity of this smaller town, yet within 1½ hours of all the conveniences of the metro area. Lakes, hills, trees, lots of antique stores and friendly people. Excellent guarantee and all expenses paid. For this excellent opportunity call Bennett & Associates, 915-550-9096. (30)

OB/GYN'S needed for smaller communities throughout Texas. Many of these towns, with populations ranging from 5,000 to 100,000, are located within an hour of large metro areas. Excellent guarantees and all expenses paid. If you are interested in providing your family with the serenity and security of a smaller community, please call us for details. Bennett & Associates, 915-550-9096. (32)

WANTED — Associate with ultimate goal to take over established family practice in Denton. Contact: TOMA, Box 4, One Financial Center, 1717 IH-35, Suite 100, Round Rock, TX 78664-2901. (04)

POSITIONS DESIRED

LOCUM TENEN SERVICE — for the Dallas/Fort Worth Metroplex. Experienced physician in family practice and emergency medicine offering dependable quality care for your patients at competitive rates. Contact: Doyle F. Gallman, Jr., D.O., 817/473-3119. (24)

BOARD CERTIFIED GENERAL PRACTITIONER — working as independent contractor. Ten years experience. Available by appointment. $100 per hour plus expenses. Will furnish liability insurance. No obstetrics, please. Contact: TOMA, Box 27, One Financial Center, 1717 IH 35, Suite 100, Round Rock, TX 78664-2901. (27)

OFFICE SPACE AVAILABLE

FOR LEASE — 1,250 sq. ft. medical office in hospital district between Rosedale and Magnolia; also, will build to suit up to 3,000 sq. ft. medical building on Hulen between Vickery and West Fwy., Fort Worth. (817) 338-4444 (12)

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

FOR RENT — Medical office in Grand Prairie. Approximately 3,000 sq. ft. office presently occupied by general surgeon. Share space and overhead expenses. Across street from D/FW Medical Center. Call 214/660-3188. (22)

MISCELLANEOUS

RECONDITIONED EQUIPMENT FOR SALE — Examination tables, electrocardiographs, sterilizers, centrifuges, whirlpools, medical laboratory equipment, view boxes, weight scales, IV stands and much more. 40-70 percent savings. All guaranteed. Mediquip-Scientific, Dallas, 214/630-1660. (14)

FOR SALE — Late model X-ray equipment and accessories; complete ob/gyn tables; waiting room chairs; hydraulic stretcher; transport stretchers; culture counter and diluter; storage cabinets; office desks; treatment tables; wheelchairs; and assorted other items — very good condition. Contact: Dr. Glen Dow or Office Manager, 817/485-4711. (48)

EXCELLENT CONDITION, late model QBC Reference with QBC Centrifuge and supplies — $7500.00 or best offer. Also, available, Clinitek 10, Quantitative Urine Intepreter, $150.00 or best offer. Contact Dorian @ 817/498-1679. (65) ■

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION
One Financial Center
1717 IH 35, Suite 100
Round Rock, Texas 78664-2901

ADDRESS CORRECTION AND FORWARDING REQUESTED

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