TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

ume LVII, No. 4

April 2000

Janet Reno

Michael J. Fox

Muhammad Ali

Rev. Billy Graham

Don Quixote

Katharine Hepburn

Adolf Hitler

Gov. George Wallace

Pope John Paul

Although historians have found evidence of the disease as far back as 5,000 B.C.,

Parkinson's Disease

was first formally described by London physician James Parkinson in 1817.

It is a complex, devastating disease that ***destroys*** *all ability to control movement and comes with a broad spectrum of symptoms including dementia.*

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TOMA's 101st Annual Convention & Scientific Seminar

GENERAL INFORMATION and EARLY REGISTRATION FORM

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CALENDAR OF EVENTS

APRIL

15 – 16

"14th Annual Spring Update for Family Physicians"

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

Location: Dallas Southwest Medical Center
Dallas, Texas
CME: 12 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
Web site: http://CME.cjb.net

MAY

3 – 6

"92nd Annual Clinical Assembly & Scientific Seminar"

Sponsored by the Pennsylvania Osteopathic Medical Association

Location: Adam's Mark Hotel, Philadelphia, PA
CME: Over 40 hours category 1-A credits anticipated
Contact: Mario Lanni, POMA Executive Director
1330 Eisenhower Blvd., Harrisburg, PA 17111
717-939-9318; in PA 800-544-7662
FAX: 717-939-7225, E-mail: poma@poma.org

4 – 7

"103rd Annual Convention"

Sponsored by the Indiana Osteopathic Association

Location: Sheraton Hotel/Westin Suites, Indianapolis, IN
CME: 30 hours category 1-A credit anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

JUNE 8 – 11

"OMT With a View: Pain Management by the Sea"

Sponsored by the Osteopathic Physicians and Surgeons of California

Location: Marriott Laguna Cliffs Resort, Dana Point, CA
CME: 20 hours category 1-A credits
Contact: 916-561-0224, FAX: 916-561-0728

15 – 18

"TOMA's 101st Annual Convention & Scientific Seminar –The Century of Tomorrow Touching Our Communities Today"

Sponsored by the Texas Osteopathic Medical Association

Location: Bayfront Plaza Convention Center and
Bayfront Omni Hotel, Corpus Christi, Texas
CME: 27 hours category 1-A credits
Contact: Sherry Dalton, TOMA Conventions Coordinator
800-444-8662 or 512-708-8662
FAX: 512-708-1415
E-mail: sherry@txosteo.org

JUNE 28 – JULY 2

"20th Annual Primary Care Update"

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

Location: Radisson Resort, South Padre Island, TX
CME: 24 hours category 1-A credits
Contact: UNTHSC Office of Continuing Medical Education
817-735-2539 or 800-987-2CME
http://CME.cjb.net

JULY 27 – 30

"TxACOFP Annual Clinical Seminar"

Sponsored by the Texas Society of the American College of Osteopathic Family Physicians

Location: Arlington Hilton Hotel, Arlington, Texas
Contact: Janet Dunkle, TxACOFP Executive Director
888-892-2637

AUGUST 11 – 13

"25th Annual Convention"

Sponsored by the Pennsylvania Osteopathic Family Physicians Society

Location: Hotel Hershey, Hershey, PA
CME: 16 hours category 1-A credits
Contact: Mario Lanni, POFPS Executive Director
1330 Eisenhower Blvd., Harrisburg, PA 17111
717-939-9318; in PA 800-544-7662
FAX 717-939-7255; E-mail poma@poma.org

SEPTEMBER 22 – 24

"The Successful Osteopathic Practice: Wine Country Revelations"

Sponsored by the Osteopathic Physicians and Surgeons of California

Location: Embassy Suites, Napa Valley, CA
CME: 20 hours category 1-A credits
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ON THE WEB in April

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TOMA's 101st Annual Convention and Scientific Seminar Information Packet and EARLY Registration Form

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By Susan K. Blue, M.D.

Parkinson's Disease – Recognition and Current Management

"...one of the quickest and most accurate ways to diagnose Parkinson's Disease is to watch the patient as he or she stands, walks, turns, and listen as he or she talks."

As physicians, we are faced with pressures to see more patients in a shorter period time in an attempt to keep our practices solvent. It is easy to forget one of the basic aspe of patient evaluation: observation. How often do we walk into an exam room, talk hurriedly, address the issues of the moment, and then leave – often with the patient sitti just where he or she was when we entered. Yet one of the quickest and most accurate wa to diagnose Parkinson's disease is to watch the patient as he or she stands, walks, turns, a listen as he or she talks. For two years, I observed a very good friend walk with a progre sively slow gait, with a slowly stooping posture. His face became wrinkled and expre sionless. His voice was almost inaudible at times. He had cardinal features of Parkinso disease. Since he could afford to seek medical care anywhere in the country, I assumed th if he had Parkinson's, he must not be responsive to the medications. Then I learned that h had been treated for depression and anxiety for those two years (and indeed he appear depressed as we sat eye-level to each other). If his physician had watched him walk and t to stand up unassisted, it would have been apparent that depression was not the only iss – and perhaps not an issue at all – once appropriate medication for his Parkinson's disea was initiated. He returned to running his company full time, resumed his traveling fo pleasure, and his sexual life improved drastically.

Not all stories are so successful, since there is no "clinical pathway" that can real tell us how to treat Parkinson's disease in multiple patients. As with migraine patient each dose of each medication must be individualized for each patient for optimu management.

Diagnostic Sandtraps

Before we discuss management, there should be a few reminders about differenti diagnoses. Disorders that can easily be confused with Parkinson's disease include:

- Drug-induced extrapyramidal reaction: For example, metoclopramide, phenothiazine neuroleptics.
- Early Alzheimer's disease or other dementia: With adequate history or interview of th patient, memory loss or inappropriate affect might overshadow the physical symptom of tremor, depressed effect, and impaired mobility. The presence of dementia ofte seems readily apparent by briefly interviewing the patient alone without the presenc of the spouse or relative to supply the answers.
- Multiple sclerosis: Can present with tremor, difficulty with ambulation, and mil cognitive impairment.
- Cerebellar or frontal lobe tumor: Tremor, impaired mobility, change in personality.
- Pseudobulbar palsy: Numerous anti-Parkinson agents can be tried, often to no avail, a patient continues to become less mobile, more emotional, and more forgetful.

If a patient does not respond to treatment, remember these and other possibilities an suspect another diagnosis besides Parkinson's disease.

Goal of Treatment: Maximize the Norm

As medications are initiated, it is helpful to explain to the patient and the spouse tha many people have peaks and valleys in terms of their functional abilities. These patients more than with most other illnesses, have tremendous fluctuations in their symptoms. As medications are adjusted, the goal should be to maximize the "norm." An attempt to make the worst days good will result in over-treatment, and attempt to adjust medica tions based on the best days of functioning will result in under-treatment.

Current and Emerging Drug Therapies

Anticholinergic agents: The most difficult part of the symptomatic triad to treat is tremor. Benztropine mesylate, biperiden hydrochloride, or trihexiphenidyl hydrochloride may be helpful. Particularly in older patients, these drugs trigger or aggravate confusion, urinary retention, dry mouth, and other undesirable side effects before they lead to much

provement in the tremor. An essential or familial tremor might prove with propranolol, but such response should tend to clude the diagnosis of Parkinson's disease.

The bradykinesia and rigidity of the disease are much more ponsive to appropriate therapy. However, even with these nptoms – intervention of treatment at low doses with slow ation to higher doses will result in better tolerance of the gs, and more satisfactory long-term treatment. It is important the patient and the spouse to understand that treatment of kinson's disease is a long-term process. Education about atment, expectations with the drug, and potential adverse cts, allows the patient to participate in his medical manageent. The physician must understand the full spectrum of the ient's functional limitations, his anxieties and concerns about disease, and intolerance to medication. These goals can be ieved only by asking for regular input from the patient and m the relatives who observe him on a daily basis.

vodopa preparations: Striatal depletion of dopamine was first scribed in 1960, or forty years ago. However, the "gold standrd" of treatment for the rigidity and bradykinesia is still the odopa preparations.

Although many people, particularly the younger patient with usy career, do best with sustained release preparation (such as emet CR), the previously described fluctuations in symptoms often better controlled with the immediate release rbidopa/levodopa preparations. If sustained-release form is ed, then most patients also need a dose of the immediate ease form in the early morning. For example, if a patient takes emet CR 50/200 at 7:00 a.m. and 2:00 p.m., then a dose of mediate release carbidopa/levodopa 25/100 or 25/250 also en at 7:00 a.m., will improve his function from 7-9:00 a.m., til the CR "kicks in." It should be remembered that most stained-release preparations have a slower onset of action than ir counterpart preparations.

Many patients function well with a sustained-release medican taken three times a day at equal intervals. An older patient o doesn't attempt to do much until 9:00 or 10:00 a.m. might t need the boost of an additional dose of "plain/not-CR" vodopa in the early morning. Other patients who tend to be re active in the evenings might benefit from CR dosage twice ring the day (for example, 7:00 a.m. and 2:00 p.m.), and a dose immediate release form about 6:00 p.m. – with or without the rly a.m. immediate release form. Titration of the dose of vodopa up to 2 grams a day or perhaps 4 grams, is not unreanable. (Remember, with carbidopa/levodopa, the denominator the dose of levodopa.)

When therapy is initiated, it is often advisable to adjust the se optimally, and then try to convert the patient at least rtially to the sustained-release equivalent dose, if possible. ausea, confusion, dyskinesia, and hallucinations are often the niting side effects. If they appear, the patient should decrease e dose slightly, and then perhaps later increase it again slowly an attempt to find the best dose with the fewest side effects. ncourage the patient to call the physician if he develops side fects. If he stops the drug abruptly, then the prior days or weeks titration are negated.

Dopamine Agonists: Selegiline was introduced as a neuroprotective agent in the late 1980's, but current literature suggests that it might have no real effectiveness in this area. Personally, I have been impressed by the long-term stability of many patients who have taken selegiline since its introduction, but it will possibly fade from our treatment armamentarium in the near future. Particularly for patients who do not tolerate other agents, it can yield some symptomatic improvement.

Neuroprotective Agent: The dopamine agonists bromocriptine and pergolide have been available for many years. In recent years, pramipexole and ropinirole have proved effective in management of Parkinson's. The dopamine agonists work directly on postsynaptic dopamine receptors.

All of them are useful as monotherapy, particularly in younger patients who might want to avoid early initiation of levodopa, patients who do not tolerate levodopa, and those whose main symptom is tremor. These medications are levodopa sparing, and they may also have a neuroprotective effect. One disadvantage is expense, particularly since some of these agents need to be titrated to high doses (ropinirole 1.0 mg. t.i.d. to 5.0 t.i.d. or bromocriptine 2.5 t.i.d. to 7.5 t.i.d. for example). Orthostatic hypotension and other potential problems include cognitive impairment. Failure to respond to one dopamine agonist should not discourage trial of another one, since individual response varies greatly. A slow taper and transition to the next agent is desirable for essentially all anti-Parkinson agents. Sometimes all therapy must be minimized slowly, recognizing that there will be temporary exacerbation of symptoms, to determine whether confusion, hallucinations, or dyskinesias are secondary to the treatment, or to the disease process itself.

Amantadine might improve akinesia and rigidity. It is often well tolerated but in some cases it can cause cognitive impairment, edema, and in rare instances, livido reticularis.

On-off effect of levodopa: There is reasonable concern about the "on-off" effect of levodopa preparations and the possibility of eventual ineffectiveness if the drug is used for many years. However, these possibilities can be minimized by:

- Titration of doses of levodopa only to the lowest doses needed for control of symptoms
- Education of the patient to recognize under-treatment versus over-treatment
- Realistic goals for treatment
- Use of other drugs as adjunctive therapy

Inhibitors of catehol-o-methyl transferase: Two newer agents, intacapone and tolcapone, enhance and prolong the benefit of the levodopa preparations. Although they can often be added abruptly to each dose of levodopa, many patients tolerate these agents much better if they are added to one dose at a time, and slowly introduced over a period of ten to fourteen days. Intacapone must be monitored closely with respect to liver function studies. The dosage of levodopa often needs to be reduced at the time of initiation of these agents.

continued on next page

Ancillary Therapy

Medication adjustment is a small part of management of Parkinson's disease. Many patients benefit from reassurance that it can often be managed very effectively for many years. Life span is not affected in all patients, and many patients die of unrelated causes, not because of the Parkinson's disease. Symptoms are often aggravated by anxiety, and a low-dose anti-anxiety agent is often helpful, even with prn use. Recognition and treatment of secondary depression improves function, as with all diseases. Cramping of leg muscles might respond to a prn or bedtime muscle relaxant. Urinary and bowel dysfunction can be improved with appropriate management. Sexual dysfunction is another issue that should be addressed in many patients.

The patient and his family should understand that adjusting the daily schedule to allow for more rest and less stress is often very beneficial. When needed, the patient should be encouraged to use oversized pens, eating utensils, adjustable height beds and chairs, trapeze bars, and ambulatory assistive devices. Water therapy or other low-impact exercise should be encouraged. Since weight loss is a major problem in Parkinson's disease, dietary supplements and adjustment of medication doses should be addressed.

In summary, once the diagnosis of Parkinson's disease is made, many patients will benefit most from combination of new and old therapies, the opportunity to understand his disease and treatment, and the attention to the many factors that affect his own functional abilities, including family dynamics and support.

On a personal note, Dr. Blue states, "I have been active in support of the local Parkinson's Disease Association. I see many patients with Parkinson's. I pursue other professional activities, but patient care is my first love."

Dr. Blue is the founder and president of Neurological Services of Texas, P.A., a multi-physician consultant practice with all neurological services. The office is located at 1001 Washington Avenue, Fort Worth. She is an active participant in research activities; an extensive lecturer; and the author/co-author of many publications.

Facts About Parkinson's Disease

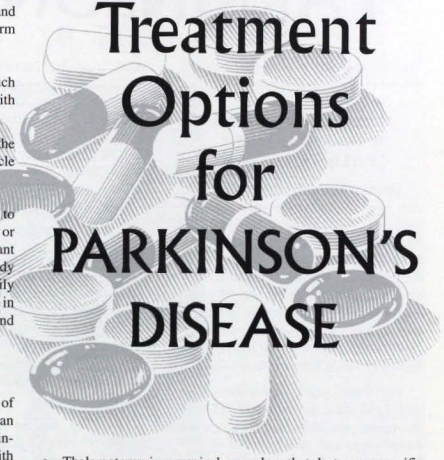
- Parkinson's disease is a common progressive neurological disorder that results from degeneration of nerve cells in a region of the brain that controls movement. This degeneration creates a shortage of the brain-signaling chemical (neurotransmitter) known as dopamine, causing impaired movement. The disease has no known cause. Most researchers feel that Parkinson's disease results from the interplay of multiple factors, both genetic and environmental.
- Although historians have found evidence of the disease as far back as 5,000 B.C., Parkinson's disease was first formally described by a London physician named James Parkinson in "An Essay on the Shaking Palsy," published in 1817. In this paper, he set forth the major symptoms of the disease that would later bear his name.
- Parkinson's disease is the second most prevalent degenerative brain disorder, with Alzheimer's the first.
- In the United States, as many as 1.5 million people are believed to suffer from Parkinson's disease, and about 50,000 new cases are reported every year. The disease usually affects people over the age of 50, with the average age of onset 60 years. However, some physicians have reportedly noticed more cases of "early-onset" Parkinson's disease in the past several years, and some have estimated that 5 to 10 percent of patients are under the age of 40. The early signs, especially in the young, are often vague and non-specific. In addition, it is frequently under-diagnosed, particularly in the elderly, who may be suffering other common medical conditions which limit their mobility.

Although Parkinson's disease does not affect everyone the same way, the major symptoms of the disease are as follows:

- Tremor – Tremor of a limb, especially when the body is at rest, may be one of the first symptoms of Parkinson's. Tremor usually begins in a hand, although sometimes a foot or the jaw is affected first. It is most obvious when the hand is at rest or when a person is under stress. In three out of four patients, the tremor may affect only one part or side of the body, especially during the early stages of the disease. Later, it may become more general. Tremor is rarely disabling and it usually disappears during sleep or improves with intentional movement.
- Rigidity – Rigidity, or a resistance to movement, affects most Parkinsonian patients. In Parkinson's disease, rigidity comes about when, in response to signals from the brain, the delicate balance of opposing muscles is disturbed. The muscles remain constantly tensed and contracted so that the person aches or feels stiff or weak. The rigidity becomes obvious when another person tries to move the patient's arm, which will move only in ratchet-like or short, jerky movements known as "cog-wheel" rigidity.
- Bradykinesia – Bradykinesia, or the slowing down and loss of spontaneous and automatic movements, is extremely frustrating because it is unpredictable. One moment the patient can move easily. The next moment he or she may need help. Activities once performed quickly and easily may take several hours.
- Postural instability – Postural instability, or impaired balance and coordination, causes patients to develop a forward or backward lean and to fall easily. When bumped from the front or when starting to walk, patients with a backward lean have a tendency to step backwards, which is known as retropulsion. Postural instability can cause patients to have a stooped posture in which the head is bowed and the shoulders are drooped.

Sources: Division of Intramural Research, National Human Genome Research Institute; "Parkinson's Disease: Hope through Research," by the National Institute of Neurological Disorders and Stroke, National Institutes of Health; Experimental Therapeutics Branch of the National Institute of Neurological Disorders and Stroke; and FDA Consumer Magazine (July-August 1998).

Drugs & Surgical Treatment Options for PARKINSON'S DISEASE



Recent Drug/Device Approvals

Tasmar was approved by the FDA on January 29, 1998. It is used together with the Parkinson's medication carbidopa/levodopa to treat Parkinson's disease. Tasmar appears to help make the medications work longer.

Comtan was approved last October as an adjunct to levodopa/carbidopa for patients with Parkinson's disease. The addition of Comtan to levodopa improves motor skills and extends the amount of time patients are able to perform common daily activities.

Mirapex was approved by the FDA in 1997. The drug, which mimics dopamine's role in the brain, benefits patients with tremor from Parkinson' disease and other types of tremor.

Requip, approved in 1997, also mimic dopamine's role in the brain and allows patients to regain some of their lost muscle control.

The Activa Tremor Control System was approved in 1997 to help control tremors in people with essential tremor or Parkinson's disease. The device, which is a brain implant device, controls hand and arm shaking on one side of the body enough to enable many patients to once again perform daily living activities. The device was approved for implantation in one side of the brain, to help control tremors in the hand and arm on the opposite side of the body.

Other Drugs Used

The drug levodopa is often called the "gold standard" of rapy because it is often the first-line treatment. Nerve cell can levodopa to make dopamine and replenish the brain's dwin- ng supply. Usually patients are given levodopa combined with bidopa.

Several others used are bromocriptine and pergolide, which nic the role of dopamine in the brain; selegiline, in which dies have shown that the drug delays the need for levodopa rapy by up to a year or more; and amantadine, which may help he release of dopamine.

Certain medications are directed specifically against tremor. veral of these include trihexyphenidyl, benztropine, diphenhy- mine, and biperiden.

Neurosurgical Approaches

Pallidotomy, in which a surgeon makes a tiny hole in the skull and uses a tiny electronic probe to destroy a small portion of the globus pallidus, which experts believe is overactive in Parkinson's patients. This procedure is most effective in relieving dyskinesias and tremor but also helps some of the other symptoms of advanced PD.

- Thalamotomy is a surgical procedure that destroys a specific group of cells in the thalamus and is aimed at Parkinson's patients with disabling tremor in the hand or arm.
- A new technique called deep brain stimulation involves the placement of electrodes into the brain, which are connected to a pacemaker device that is usually implanted in the chest. Tiny electrical impulses are sent to areas of the brain that affect Parkinsonian symptoms.
- Currently undergoing clinical trials, fetal transplantation involves the placement of fetal neural cells into the area of the brain where dopamine is deficient. A recent study has shown mixed results.

Sources: "Frequently Asked Questions About Parkinson's Disease," Experimental Therapeutics Branch of the National Institute of Neurological Disorders and Stroke"; "FDA Approves Implanted Brain Stimulator to Control Tremors," by the Department of Health and Human Services; Journal of the American Medical Association, Vol. 282, No. 21; and Food and Drug Administration.

RESEARCHING PARKINSON'S

The following are several highlights of notable research on Parkinson's disease.

Genetics Not Significant to Developing Typical Parkinson's Disease

Genetic factors do not play a significant role in causing the most common form of Parkinson's Disease (PD), according to a study published in the January 27, 1999 issue of the *Journal of the American Medical Association*. This epidemiological study, the largest of its kind to investigate the role of genetic or environmental causes of PD, examined 19,842 white male twins enrolled in a large registry of World War II veteran twins.

For many years, researchers have speculated about the causes of PD, with the prime considerations being genetic determinants and environmental factors. The current study suggests that typical PD – defined as PD diagnosed after age 50 – has no genetic component, while the opposite was observed in a small subset (six pairs) of identical and fraternal twins whose PD was diagnosed before age 51 in at least one twin. Investigators concluded that undetermined environmental factors, not genetics, are likely triggers of typical PD and they suggest that research concerning a genetic link to PD be directed toward subjects with earlier onset of the disease.

Twin studies have proven particularly useful in distinguishing the relative contribution of genetics and environment to the cause of various diseases. In the JAMA study, the investigators theorized that if PD had a genetic basis, both individuals in an identical twin pair would be expected to develop the disease (since they have the exact same genetic make-up). Instead, they found that PD most commonly occurred in only one member of a twin pair, whether the pair was identical or fraternal.

Fetal Cell Therapy Benefits Some Parkinson's Patients

Results from the first randomized, controlled clinical trial of fetal dopamine cell implants for Parkinson's disease show that the surgery helped a small number of Parkinson's patients, but not all who underwent the experimental therapy. These results raise important questions in the search for improved treatments for Parkinson's disease.

The study, funded by the National Institute of Neurological Disorders and Stroke, included 40 patients with advanced Parkinson's disease. Half the patients received the cell implants, while half had a placebo surgery which appeared very similar to the implant procedure.

The 40 patients in this study were randomly selected to receive either the cell therapy or the placebo. Patients in the implant group received injections of dopamine-producing cell into the putamen, the area of the brain in which progressive loss of dopamine production triggers the symptoms of Parkinson's disease. Patients given placebo surgery received four small cosmetic holes in the skull that looked like those made for the implant therapy but which did not penetrate the brain or its dura. The patients were evaluated periodically for one year after the procedure before they learn whether or not they had received the implant therapy.

After one year, the treated patients under age 60 (9 of the total patients in trial) showed significant improvements movement. Patients over age 60 w received implants, as well as those who the placebo surgery, showed no significa improvement in any of their symptoms. another important measure, the stu showed that patients did not perceive benefit from the therapy in terms of th normal daily activities.

PET brain scans showed that mo than half of the patients who received t implants had a greater than 20 perce increase in dopamine activity in t putamen, regardless of age. There were significant surgical complications duri this clinical trial, confirming that both t implant and the placebo surgery are sa when performed by an experienc surgeon. While there were significant more severe adverse experiences durin the one-year follow-up period in patien who received the implants than in tho who received placebo, these seve adverse experiences showed no consiste or logical pattern that could be associate with the surgery or the implants.

While the study results indicate th fetal cell implants can help some patien younger than age 60, they also rais important questions, including why th treatment did not benefit older patient Furthermore, the implants did not reduc the need for any drugs that patients in th study were taking for Parkinson's disease The next steps will be to determin whether the benefits last over time whether other therapies are more benefi cial, and whether there might be differen forms of Parkinson's disease dependen on the age of the patient. More analysis o the results from this trial and additiona years of patient follow-up are needed t answer these questions. A second NINDS funded clinical trial of 36 patients is unde way and may yield additional informa tion. However, the results of that study ar not expected until 2001.

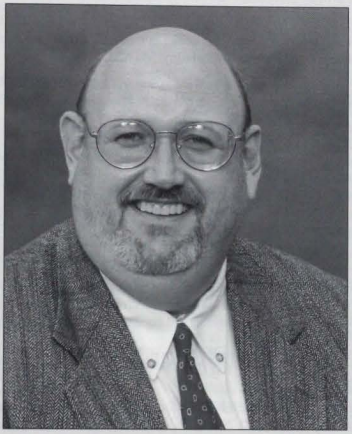
Texas Osteopathic Medical Association

101st Annual Convention & Scientific Seminar

Bayfront Plaza Convention Center and Omni Bayfront Hotel

Corpus Christi, Texas

June 15 - 18, 2000



Ray Morrison, D.O., Program Chair

Whether you serve in osteopathic, allopathic or integrated communities as a physician, physician's assistant, nurse or other healthcare provider, you will benefit from this educational and networking opportunity. The program includes general sessions on a wide variety of health topics, each on the leading edge of medical knowledge and technology, along with specialty breakout workshops. Plus, visit with over 90 exhibitors, enjoy great social events and soak up all the surf, sun and coastal cuisine that Corpus Christi has to offer.

Turn the page for

Annual Convention Information

&

EARLY Registration Form

Texas Osteopathic Medical Association

101st Annual Convention & Scientific Seminar

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June 15 - 18, 2000

Hotel Information

The host hotel for the 101st Annual Convention is the Omni Bayfront Hotel
900 North Shoreline Blvd., Corpus Christi, Texas 78401

Please call the hotel directly to make your room reservations at 800-843-6664 or 361-887-1600. Be sure to say that you are with ***"Tex Osteopathic Medical Association"*** (not TOMA) to receive the group rate of $102.00 single, double or triple per night.

Reservations must be made no later than Tuesday, May 23, 2000, to receive the discounted rate.

The Omni Bayfront Hotel provides a complimentary shuttle service to and from the Corpus Christi International Airport, 12 miles fr the hotel. TOMA will provide scheduled shuttle service to and from the Bayfront Plaza Convention Center, during the convention, fr the Omni Bayfront Hotel only.

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The Physician's Registration Fee includes admission to all CME lecture sessions, workshops and the exhibit hall, plus **27 availab hours of category 1-A credits, including 2 hours of ethics education.** Also included are all lecture handouts, Wednesday Night Gra Opening Reception, breakfast Thursday through Sunday, and one admission ticket for each of the following: Thursday Keyn Luncheon, Friday Lunch with Exhibitors, Saturday AOA Luncheon and Saturday Night President's Reception and Banquet. For ad tional tickets, please see registration form.

Spouse Registration

The Spouse Registration Fee includes exhibit hall admission and one admission ticket for each of the following: Wednesday Nig Grand Opening Reception, Thursday Keynote Luncheon, Friday Lunch with Exhibitors, Saturday AOA Luncheon, ATOMA President Installation Breakfast and Saturday Night President's Reception and Banquet. For additional tickets, please see registration form.

Just For You

Refund/Cancellation Policy

To receive a registration refund, less 25% for administrative handling, all registration and special event refund requests must be I WRITING and postmarked no later than June 1st, 2000. ***No refunds will be given to requests postmarked after June 1, 2000.***

Special Requests

To help make your convention experience everything you want it to be, if you have any special requests (such as vegetarian meal please contact Sherry Dalton, TOMA Conventions Coordinator, ***prior to June 1st***, at 800-444-8662 or 512-708-8662. All TOM Annual Convention functions, including off-site activities and bus transportation, are ADA compliant.

Optional Activities

Aside from our planned Family Day, Sustainers Party and the Annual ATOMA Golf Tournament, TOMA will provide information o other optional activities for the entire family such the bayfront promenade, an arts & museum district across the street from th Convention Center, casual waterfront restaurants that serve the freshest seafood in Texas, within walking distance of the Omni Bayfron Hotel, Heritage Park Historic Homes walking tours and charter boat fishing, just to name a few. Look for flyers in your registratio packet and a special "Corpus Christi Information Table" near the Registration Area at the Convention Center.

Convention Attire and Gear

All convention functions are "Business Casual to Vacation Casual"; the only way to dress in Corpus in June.* It will be sunny and ho with moderate to strong breezes; perfect weather for cotton shirts, walking shorts, comfortable walking shoes, sun hats and shades Don't forget to bring the sunscreen if you plan to take advantage of the miles and miles of beautiful beaches, go fishing or play in th ATOMA Golf Tournament.

***The President's Banquet, Saturday night, June 17, at the Omni Bayfront Hotel, is black tie optional.**

? ? QUESTIONS ?? Call Sherry Dalton, Conventions Coordinator, at 800-444-8662 or 512-708-8662

Preliminary Schedule

– 27 CME hours category 1-A available –

EDNESDAY, JUNE 14, 2000 – CONVENTION CENTER

0pm – 7:00pm	Early Registration Open
0pm – 7:00pm	Exhibit Hall Open
0pm – 6:30pm	**Convention Grand Opening Reception with Exhibitors**
0pm	Registration and Exhibit Hall Close

HURSDAY, JUNE 15, 2000 – CONVENTION CENTER

0am – 5:00pm	Registration Open
0am – 5:00pm	Exhibit Hall Open
0am – Noon	ATOMA House of Delegates Meeting
0am – 9:00am	Breakfast Lecture – *The Benefits of Wine for Your Health*
0am – 10:00am	*South Texas Osteopathic Manipulative Protocol Trial*
:00am – 10:30am	Pharmaceutical Update with Exhibitors
:30am – 11:30am	*Hepatitis C: A National Epidemic* – Sponsored by Schering
:30am – Noon	Q & A Session
on – 1:30pm	Keynote Luncheon – Sponsored by Pfizer
0pm – 2:30pm	*Managing Migraines* – Sponsored by Merck
0pm – 3:30pm	Pharmaceutical Update with Magic Show
0pm – 4:30pm	*Obesity and Liposuction*
0pm – 5:00pm	**Spouse/Family Optional "On Your Own"Activities** • **Charter Boat/Pier Fishing** • **Heritage Park Historical Homes Tour** • **Asian Culture Museum** • **World of Discovery Museum** • **Art Museum of South Texas** • **Beach Combing**
0pm – 5:00pm	TCOM Alumni Board Meeting
0pm – 6:00pm	**MOPPS Reception**
0pm – 6:00pm	**POPPS Reception**
0pm – 6:30pm	**KCOM Alumni Reception**
0pm – 7:00pm	**TCOM Alumni Reception**
0pm – 10:00pm	**Sustainers Party – USS Lexington**

FRIDAY, JUNE 16, 2000 – CONVENTION CENTER

0am – 1:45pm	Registration Open
0am – 10:00am	ATOMA President's Installations Breakfast
0am – 8:15am	Breakfast Lecture – *What Do Ear Infections, Sinus Infections, Asthma and Allergies Have in Common?*
0am – 3:00pm	Exhibit Hall Open
5am – 9:00am	*Treating Irritable Bowl Syndrome* – Sponsored by Glaxo Wellcome
00am – 9:45am	*Developments in Treatment for Upper Gastrointestinal Track* – Sponsored by Wyeth-Ayerst
5am – 10:30am	*OMT Application*
:30am – 11:00am	Pharmaceutical Update
11:00am – 1:00am	CONCURRENT BREAKOUT WORKSHOPS
Workshop I	*OMT – Touching, Caring*
Workshop II	*CLIA Waived Tests and Other Advanced Office Procedures* – Sponsored by Physicians Sales and Services
* Workshop III . . .	*How to Avoid Exposure to Fraudulent Medical Claims* *A Physician's Checklist for Working with Managed Care Organizations*

* This course has been designated by the Texas Osteopathic Medical Association for two (2) hours of education in medical ethics and/or professional responsibility.

1:00pm – 2:00pm	Pharmaceutical Update and Lunch with Exhibitors
2:00pm – 6:00pm	**Family Day – Texas State Aquarium and USS Lexington**
6:00pm – 8:00pm	**Family Day continued – Poolside Swim & Buffet Omni Bayfront Hotel**
2:00pm – 8:00pm	**ATOMA Annual Golf Tournament North Shore Golf Course**
3:00pm	Exhibit Hall Closes
5:00pm – 7:00pm	TCOM Board Post Convention Meeting

SATURDAY, JUNE 17, 2000 –OMNI BAYFRONT HOTEL

7:00am – 4:00pm	Registration Open
7:30am – 8:15am	*Osteoarthritis 2000* – Sponsored by Proctor and Gamble
8:00am – 9:00am	TxACOFP Breakfast
8:15am – 9:00am	*A New Look at Pelvic Pain*
9:00am – Noon	TxACOFP Board Meeting
9:00am – 9:45am	*New Non-Invasive Treatment for Herniated Disks*
9:45am – 10:30am	*OMT Application* – Sponsored by Searle
10:30am – 11:00am	Q & A Session
11:00am – Noon	*Functional Medicine for the New Millennium* – Sponsored by Great Smokey Diagnostic Center
Noon – 1:30pm	AOA Luncheon – AOA Update
1:30pm – 3:30pm	CONCURRENT BREAKOUT WORKSHOPS Repeat from Friday, 11:00am – 1:00pm
1:00pm – 4:00pm	**Mary Kay Makeovers**
3:30pm – 3:45pm	Break
3:45pm – 4:45pm	*Acute and Chronic Pain Management* – Sponsored by Merck
4:00pm	Registration Closes
6:00pm – 7:00pm	**President's Reception**
7:00pm – Midnight	**President's Banquet**

SUNDAY, JUNE 18, 2000 – OMNI BAYFRONT HOTEL

7:30am – 9:30am	Registration Open
7:30am – 8:00am	Continental Breakfast
8:00am – 1:15pm	*Risk Management Program* – Sponsored by Dean, Jacobson Financial Services

Wednesday, June 14

5:30pm – 6:30pm
Convention Grand Opening Reception with Exhibitors
"Celebrate the Century – TOMA's 100 Year Anniversary"
The attire is "Business Casual". This is a No Charge Event open to all registrants, their families (all children must be accompanied by an adult) and registered convention exhibitors.

Kick back and join us as we kick off TOMA's 101st Annual Convention and Scientific Seminar in the Exhibit Hall. An hour of mixing and mingling with exhibitors and colleagues plus door prizes and lots of food and beverages.

Thursday, June 15

6:30pm – 10:00pm
Sustainers "South Pacific" Party
USS Lexington Museum on the Bay
The dress for the evening is "Tropical Island Casual". This is a No Charge Event for sustaining members and one guest only.

Imagine a glistening sunset on a beautiful south pacific beach, waves lapping on the shore, seagulls drifting overhead. Then think about sipping tropical drinks while touring one of World War II's most celebrated warships complete with vintage aircraft. For the brave of heart, why not pilot the Lexington's Flight Simulator for a thrill of a lifetime? Interested? There's more. How about a delicious island dinner served on the Hanger Bay of the ship? Finally, hold on to your drink umbrella as the South Pacific Islanders entertain with authentic island instruments and music, whirling machetes, swirling grass skirts, fire dances and some fun surprises for the audience. Open to sustaining members and one guest only.

Friday, June 16

2:00pm – 8:00pm
Family Day
The dress for Family Day is "Summertime Cool"; walking shorts, T-shirts and, of course, comfortable walking shoes are a must! This is a Ticketed Event. $15 per person.

START: Discover the magical and mysterious underwater world of seahorses and jellyfish at the Texas State Aquarium during the first part of our Family Day. With over 400,000 gallons of water and 3,000 animals, all sorts of adventures await you in every area of the Aquarium. From playful rivers otters, hand fed pelicans, and giant anglefish to dive and feeding shows starring sharks, barracudas, eels and numerous other wondrous creatures of the deep.

NEXT: We step back in time as we visit the USS Lexington Museum on the Bay for a self guided tour of one of the most decorated carriers in Naval history. Roam the Flight Deck, the Foc'sle, Captain's Quarters, Sick Bay and Engine Room. Explo vintage aircraft, enjoy the spectacular ocean view, browse t specialty gift shop.

FINISH: We head back to the Omni Bayfront Hotel for a sun splash in the pool complete with a poolside buffet dinner.

Friday, June 16

2:00pm – 8:00pm
ATOMA's Annual Golf Tournament
The dress is "Whatever You Wear to Play Golf on a H Summer Afternoon". This is a Ticketed Event open to everyon over the age of 18. $75 per person.

Once again, ATOMA is hosting the Annual Golf Tournamen sponsored by Dean, Jacobson Financial Services. This annu fund raiser helps support TCOM student scholarships as well a other areas of the osteopathic community. North Shore Gol Course, set on the ocean's edge, is the place to be if you like you team mates fun, your golf game competitive and the scener beautiful. After the tournament, relax and enjoy dinner at the clu house while tall tales and tournament trophies are shared.

Saturday, June 17

1:00pm – 4:30pm
MaryKay Makeovers
Back by popular demand, ATOMA members, who are also MaryKay Cosmetics representatives, will be offering FREE makeovers by appointment only. Look for the MaryKay Makeovers Sign Up Board in the Registration Area.

Saturday, June 17

6:00pm – 7:00pm
President's Reception
7:00pm – Midnight
President's Banquet
The attire for this special occasion is "Elegant Evening" with Black Tie optional. Your registration fee includes one ticket. Additional tickets are $50 per person.

The Grand Foyer on the 3rd floor of the Omni Bayfront Hotel is the location for this year's President's Reception. Enjoy cool drinks, lively conversation, and a spectacular view of the setting sun over the Gulf of Mexico.

The reception will be followed by dinner in the beautiful Corpus Christi Ballroom. TOMA President, Dr. Rodney Wiseman will pass the gavel to Dr. Bill Way and TOMA award presentations will be made.

Then dance the night away as Blue Moon Entertainment provides a popular, local DJ playing all our favorite "Oldies Toons" from the 40's, 50's, 60's, 70's and 80's.

? ? QUESTIONS ?? Call Sherry Dalton, Conventions Coordinator, at 800-444-8662 or 512-708-8662

TOMA's 101st Annual Convention & Scientific Seminar • June 15 - 18, 2000
Bayfront Plaza Convention Center and Omni Bayfront Hotel • Corpus Christi
REGISTRATION

PRINT CLEARLY or TYPE

Name_____

First Name for Name Badge (if different from above)_____

Mailing Address_____

City_____ State_____ Zip_____-_____

Phone ( )_____ FAX ( )_____ E-mail_____

M.D. College_____ Year Graduated_____ AOA#_____

Specialty_____ TOMA District_____

Spouse or Guest (if Name Badge is requested)_____

A local, private Sitter Service can be available during the convention. Do you anticipate using this service (for events such as the Sustainers Party or President's Banquet)? NO___ YES___ Number of children___ Age Range_____

REGISTRATION FEES - *See Page 12 for Descriptions*

	EARLY Registration (Postmarked by 5/25)	Registration (Postmarked after 5/25)	
TOMA Members*	$375	$475	$_____
1st or 2nd Year in Practice	$225	$325	$_____
Retired/Life Member, Guests, Associate	$175	$275	$_____
Other Healthcare Professionals (such as P.A.'s, Nurses)	$275	$375	$_____
Students/Interns/Residents**	$0	$0	$ 0
Non-Members	$625	$725	$_____

*Includes members of other state associations.
**Registration does NOT include tickets to any meal function. Tickets may be purchased separately or on-site.

REGISTRATION FEES SUBTOTAL $_____

SPECIAL EVENTS - *See Page 15 for Descriptions*

Family Day . . . . . $15 x # _____ tickets $_____
YES __I/We will ride the TOMA bus. # of riders in your group____
NO __I/We will NOT ride the TOMA bus.

Golf Tournament . . . . . $75 x # _____ tickets $_____
Name: Player #1_____ Handicap_____
Player #2_____ Handicap_____
YES __I/We will ride the TOMA bus. # of riders in your group____
NO __I/We will NOT ride the TOMA bus.

Sustainers Party (*Open to Sustaining Members Only*)
Number of tickets (circle one) 1 2 N/C
YES __I/We will ride the TOMA bus. # of riders____
NO __I/We will NOT ride the TOMA bus.

SPECIAL EVENTS SUBTOTAL $_____

ADDITIONAL TICKETS

TOMA President's Banquet . . . . $50 x # _____ tickets $_____

TOMA President's Installation Breakfast
. . . . . $25 x #_____ tickets $_____

ADDITIONAL TICKETS SUBTOTAL $_____

PAYMENT SUMMARY

Convention Registration Fee(s)	$_____
Special Events	$_____
Additional Tickets	$_____
TOTAL	$_____

FORM OF PAYMENT

☐ Check in the amount of $_____

Credit Card

☐ Visa ☐ MasterCard
☐ AmExpress ☐ Discover

Please TYPE or PRINT name as it appears on the card:

_____

Card Number

_____

Expiration Date_____

Authorized Signature

_____

MAIL THE COMPLETED FORM WITH CHECK PAYABLE TO
TOMA
1415 Lavaca Street, Austin, TX 78701
OR
***ONLY* if paying by credit card**
FAX: 512-708-1415

FOR OFFICE USE ONLY
Date Received_____
Amount $_____
Check Number_____

Independent Investor

Dean, Jacobson Financial Services, LLC — A Registered Investment Advis

Securities Sold Through Linsco/Private Ledger · Member NASD/SIPC

Tax-Deferred, Tax-Free Investments Help Ease the "Price of a Civilized Society"

Supreme Court Justice Oliver Wendell Holmes, Jr. famously remarked in 1904 that taxes are the price Americans pay to live in a civilized society. That seems fair enough, but unfortunately the cost of a civilized society has risen dramatically.

According to research by the Tax Foundation, a nonpartisan, nonprofit organization that monitors fiscal policy, citizens in 1904 paid $340 per year in federal, state and local taxes (in inflation-adjusted 1999 dollars). Today the privilege of civilized living costs every man, woman and child $10,298 in total taxes.

While this comparison demonstrates how the tax bite Americans pay each year has grown, it also reinforces the need for effective tax-free investing and smart money-saving moves.

We all have an obligation to pay our fair share of taxes, but why pay even a dollar more than necessary?

There are several potentially beneficial tax-free and tax-deferred investments; you may be able to grow your money while keeping more of what you earn. The following are some techniques to try to ease the pain of tax time come April 17.

04/00

First, take advantage of your company's tax-deferred retirement plan. Most organizations offer a 401(k), or for non-profit groups, a 403(b) plan. These plans allow for pre-tax contributions to be made to a retirement account. Let's look at how a worker making $120,000 per year can benefit. If she contributes the maximum allowable, she'll add 10,500 to her plan, lowering her taxable income to $109,500. Our hypothetical worker gains a tax benefit of almost $3255 at a 31% marginal tax rate from investing the maximum in her 401(k) plan. If her company matches any of her contributions to her 401(k), the benefit can be even larger. [1]

Another investment vehicle that can potentially save you tax dollars is the Roth IRA. This retirement account features many options for investors seeking tax-free growth of earnings and withdrawals. [2] The guidelines for making contributions, which are made with after-tax funds, are similar to the traditional IRA, but there are significant differences affecting deductions, distributions and withdrawals. A married couple investing $4,000 per year into individual Roth IRAs would have a combined total of $657,976 available tax-free after 30 years. [3] This money can even be left for children if desired, unlike with the traditional IRA.

Other investments include tax-free municipal bonds4 and tax-deferred annuities. For information or advice on these and other investment vehicles, consult your financial representative.

While most Americans are willing exchange their taxes for members in a civilized society, nobody wan overpay for this privilege. Tax-advantaged investing is one way yo can decrease the "membership du you pay in mid-April of every year

This article is not intended to provi specific advice or recommendation for any individual. Consult us, you LPL financial advisers, or your attorney, accountant or tax advise with questions.

[1] Taxes are due upon withdrawal. Additionally, penalties may also apply to withdrawals prior to age 5

[2] Restrictions, penalties and taxes ma apply.

[3] Assuming a 10 percent annual retur This hypothetical example is for illustrative purposes only and is no indicative of any particular investme Assuming the account has been held least 5 years, funds are available tax free at age 59 ½.

4 May be subject to other taxes such a alternative minimum tax, state or lo taxes.

FT WORTH 817-335-32

DALLAS 972-445-55

TOLL FREE 800-321-02

Dean, Jacobson Financial Services, LLC is locat 3112 W. 4th Street, Ft. Worth, TX 76107.

HEALTH NOTES

sk of Drug Interactions with John's Wort and Indinavir

Health professionals are notified of the possibility of drug interactions between St. John's Wort (hypericum peratum), an herbal product sold as a dietary supplement, and indinavir, a protease inhibitor used to treat HIV infection. A study conducted by the National Institutes of Health showed that a significant drug interaction substantially decreased indinavir plasma concentrations, potentially due to induction of the cytochrome P450 metabolic pathway. For advisory by the Public Health Advisory see <www.fda.gov/cder/drug/advisory/stjw> or <www.fda.gov/cder/drug/advisory/stjwort.htm>.

rning about Herbal Products

The California Department of Health Services issued a warning about 5 herbal products that were found to have 2 prescription drugs. For a copy of the California DHS announcement go to <www.fda.gov/medwatch/safety/2000/ca_dhs.htm>.

Recall Notice

The Clinipad Corporation is voluntarily recalling all Povidone Iodine, Tincture of Iodine, Benzoin Tincture, Acetone Alcohol and Alcohol Antiseptic products, as well as, Cliniguard Protective Dressing labeled as "sterile," that were manufactured over the last three years. The letter can be found at: <http://www.fda.gov/medwatch/safety/2000/clinip.htm>, and the list of products at: <http://www.fda.gov/medwatch/safety/2000/clinip1.htm>.

Web Site for Clinical Trials Debuts

A new database to help patients ferret out who are conducting clinical trials has been created by the government. Congress ordered the comprehensive registry of all clinical trials for serious illnesses, with consumer-friendly explanations of how the experiments work and what questions patients should ask to ensure they understand the risks. Each study lists a phone number to reach researchers.

"This is a single place you can go where the most important information, we hope, will be available to everybody," said Dr. Donald Lindberg of the National Library of Medicine, which opened the Internet-based registry on February 29. The site address is <http://clinical trials.gov>.

Aetna U.S. Healthcare is Dropping Coverage of Bone Marrow Transplants

Aetna reversed its ten-year policy of covering the procedure after learning that data had been falsified in a South African study that supported the treatment's effectiveness. Four other independent studies maintain that the transplant treatment is no more effective than standard treatment for breast cancer. Aetna will continue to cover women who undergo bone marrow transplantation as part of federally sponsored clinical trials, and will continue to cover the procedure for patients with other illnesses, such as leukemia, for which studies prove its effectiveness.

(New York Times, 2-16-2000)

Cardiologists and Internists Results Similar for Congestive Heart Failure Patients

A study of 1,298 congestive heart failure patients between 1989 and 1994 treated by cardiologists and internists found no difference in their mortality rate for the first 30 days, while cardiologists used more invasive procedures and had 42.9 percent higher hospital costs. Patients treated by cardiologists had a better survival rate starting one year after hospital discharge, but were also more likely to be younger, male, non-black and have private insurance.

(Medical Tribune, 2-1-2000)

Geographic, Racial and Ethnic Disparities in U.S. Women's Heart Disease Death Rates

A woman's risk of dying from heart disease depends in part on where she lives, according to new maps of heart disease rates among U.S. women 35 and older. Women and Heart Disease: *An Atlas of Racial and Ethnic Disparities in Mortality*, has been released by the Centers for Disease Control and Prevention and West Virginia University.

"Contrary to what many people believe, heart disease is the leading cause of death for women," said David Satcher, M.D., Ph.D., U.S. Surgeon General. "This atlas provides a valuable sense of perspective about the threat that heart disease poses to our mother, our wives, and our sisters." Approximately 370,000 American women of all races and ethnic groups die from heart disease each year.

Maps in the atlas show that women who live in parts of the rural South, including the Mississippi Delta and Appalachian regions, have dramatically higher rates of heart disease death than women living in most parts of the western United States and upper Midwest. Women in most major cities had low to moderate heart disease death rates, except for New York City, Chicago, Detroit, and New Orleans. Women living in those cities had high heart disease death rates compared with most of the rest of the country.

Counties with the lowest death rates for women were in the Pacific Northwest, the Rocky Mountain areas of Colorado and New Mexico, and parts of Wisconsin, North Dakota and South Dakota.

EQUALIZING the Playing Field Between Physician and Hospital

Making the "Fair Hearing" Procedure *FAIR*

By Roland F. Chalifoux, Jr., D.O.

As a board certified physician who recently had a Fair Hearing procedure at a Texas hospital, I would like to bring to the profession's attention several sections in hospital bylaws that are extremely unfair to the practicing physician, and make one's attempt at defending oneself extremely difficult and almost impossible.

First and foremost, most doctors have not read their hospital's bylaws. I strongly recommend that this be done. In essence, when a physician applies and is given privileges at a hospital, that is in fact what they are receiving – the privilege, not the right, to practice medicine. When reviewing bylaws, several aspects will appear if you study them closely. Staying on staff at a particular facility, in almost all situations, rests with the Medical Executive Committee (MEC). This Committee is usually made up of the chairman and co-chairman of each department within the hospital. Essentially, if an adverse evaluation is made of a physician within a certain department, it is reviewed at this level first. The practitioner then has the right to either accept the recommendation of the Committee or proceed to a Fair Hearing. Unfortunately, in most cases, the MEC rubber stamps decisions made by the chairman and co-chairman of the physician in "their department." Most of the other professionals on the MEC do not have the expertise to question the reasoning behind a decision made by a specific chair or co-chair of a specific department. In essence, a physician's direct competitor(s) can stop him/her from practicing at a facility and the information supporting that decision is protected or privileged. This is especially true of hospitals that require "proctoring" prior to receiving "active staff" status. When one is "proctored" for several cases (usually required of surgeons, but other departments may require it), this is usually done by your same specialty competitor(s) who, after the required cases are submitted, will submit his/her report. This report is protected and privileged and if your competitor(s) wants you out, their negative report will go to the MEC which will recommend you be removed from the hospital staff. How convenient! This is what happed to me.

After the MEC completes its review and recommendation, a "Fair Hearing" is held. Unfortunately, the Fair Hearing panel is composed of additional "peers" who have no idea as to what type of practice this particular medical specialist has. This is because "peer review" is supposed to be made up of noncompeting professionals and, obviously, this means not of the same specialty. It is up to the physician who is the subject of the adverse recommendation to explain his course of treatment to the hearing panel in attempt to educate and then convince them that the adverse recommendation is inappropriate. Interestingly enough, even though the hearing panel can side with the physician, the hearing panel has jurisdiction over the ultimate outcome. In fact, a favorable decision for the physician can be overturned at the MEC level as well as the Board of Trustees, since either has the final say in the matter.

In reviewing the Fair Hearing procedure, it becomes very evident that the process can become extremely political to the point where it makes no difference as to whether the physician subject to the adverse recommendation is medically competent or not. This is because the overall decision rests with the MEC that has already recommended that the practitioner no longer be part of the hospital. How is this a fair situation? One of the ways of addressing this, and at the same time ending any potential political power plays at a hospital, would be to require that when a physician is being questioned about his/her specialty or expertise, the questionable case(s) be sent to independent external reviewers who practice in the same specialty. Once again, in order to make this a fair situation, they must be independent and have no ties to the facilities. Otherwise, it could become political and, subsequently, an unfair situation.

Most administrators do not have a clue as to whether or not a physician is competent. In order to stay out of the "medical" practices of these physicians, they rely on the hospital's MEC and department heads to ensure that their facility has quality physicians. Unfortunately, most administrators only hear from department heads regarding specific practitioners, and are unaware of whether the information they are receiving is true, unbiased, or being fabricated for political gain. One of the best ways of letting administrators know exactly how competent the physicians are at their facility is to require, not request, that any adverse recommendation, excluding substance abuse and/or significant drug use, be sent to outside practitioners for an unbiased evaluation. Then, if the determination by these outside physicians is in agreement with the department head and/or MEC, it is up to the Fair Hearing panel to at least have this information made available to them when the physician with the adverse recommendation is being heard. Unfortunately, the burden of proof is always with the physician having the adverse recommendation. Even if he or she has all the appropriate information at the hearing, this can still be overturned by the MEC as well as the Board of Trustees without having any factual knowledge of where the truth lies.

I strongly recommend that every physician in Texas review their hospital bylaws and force administration and the medical staff to review their own bylaws and change them to make them more "physician friendly." The federal government, in its infinite wisdom, feels that hospitals and doctors can police themselves and have given you the "Fair Hearing" procedure as your equivalent to a trial. As you can see, the odds are now stacked against the practitioner and the playing field is no longer fair.

Unfortunately, we are living in harder economic times and "turf battles" are occurring every day to each and every one of us. It is unfair, however, that your future may be curtailed due to political motivations over which you have no control. This happened to me, and I pray it does not happen to you.

The President's FY 2001 Budget

By Heidi Ann Ecker
Director of Grassroots and Washington Communications, American Osteopathic Association

In mid-February, the President released fiscal year 2001 budget plan for iety of health programs-including rts addressing fraud & abuse, health fessions, Indian health, Internet drug s, medical errors, research, rural health women's health. Over the next two nths, Congress will digest the adminis- ion's request and interview leading lth experts defending the administra- n's request (Congressional hearings e started and will continue through the of March). If anyone has any questions ut this outline or programs not ntioned, just let me know (I have the IS budget in my office).

The following are key excerpts from Administration's proposal:

Fraud and Abuse

The Office of Inspector General (OIG), ked with improving HHS programs and tect them against waste, fraud and se, would receive between $130-$140 lion from the Health Care Fraud and use Control Account for Medicare ated fraud and abuse activities. Public lth investigations address grant and tract fraud, research fraud and all other gations of wrongdoing.

Health Professions

The administration's plan would uce funding for "other health profes- ns program" by $94 million and rease funding for children's hospitals duate medical education by $40 lion and training diversity by $10 lion. The agency believes the increases l raise the level of GME support for ost 60 children's hospitals and recruit mising racial and ethnic minority dents in health professions training ough the Centers for Excellence and Health Careers Opportunity program. eductions will be taken in broad-based egorical programs that address anding the supply of primary care and cialty disciplines," says the draft plan.

Indian Health

The administration requested $229 million over FY 2000 funding levels for the Indian Health Service (IHS) to support the 49 hospitals, 209 health centers and 285 other health sites providing medical and dental care to 1.5 million American Indians and Alaska Natives. The draft plan would allocate $41 million to the Contract Health Services program which purchases care from the private sector. Additionally, the new dollars would extend coverage from serious injuries/illnesses treatments to other conditions. The IHS estimates funds will support an additional 1,460 hospital days and 57,200 additional visits to doctor and dentists.

The plan also requests funds specific to tribal communities: (1) Diabetes, cancer, heart and infectious diseases ($7 million); (2) domestic community violence prevention, elder and maternal & child health ($7 million); (3) emergency medical services and injury prevention ($6 million); (4) Mental health and substance abuse prevention/treatment; (5) dental health ($3 million) and (6) preventative health activities ($6 million).

IHS also requests increases to improve tribes with the lowest health service levels ($8 million), technology like telecommunications equipment ($64 million), contract support costs associated with operating local health programs ($40 million) and health facility construction ($20 million)

Internet Drug Sales

The Food and Drug Administration (FDA), the lead agency responsible for assuring the safety of food and medical products, requests a $138 million increase over FY 2000 funds, including dollars for a new initiative to address Internet drug sales ($10 million). Recognizing the large numbers of people purchasing medical products on the Internet, the FDA plans to spend $10 million to protect consumers from illegitimate Internet pharmacies that inappropriately prescribe medications, increase the risk of dangerous drug reactions, or sell potentially counterfeited or contaminated drugs. Funds will reduce illicit Internet sales by half through public education campaigns, new civil penalties for illegal Internet sale of drugs without valid prescription, and new procedures for rapid FDA investigation.

What's ahead: FDA wants to convince Congress to grant the agency authority to protect Internet consumers.

Medical Errors

The administration requested $16 million for a new FDA initiative to address medical errors ($16 million) as outlined in the Institute of Medicine report "To Err Is Human". The agency plans to spend funds to improve its Adverse Event Reporting System, the leading system tracking and evaluating the 300,000 event reports filed annually. Funding will initiate the development of an integrated, fully electronic adverse reporting system in each program area. The agency believes electronic monitoring and surveillance of these reports will improve its ability to detect patterns in reports and follow-up rapidly to protect the American public. Meanwhile, the Agency for Healthcare Research and Quality (AHRQ), an agency that studies costs of services with academic institutions/medical societies/health payers, requests $20 million to research the reduction of medical errors with the focus of information technologies and computerized support systems.

What's ahead: The FDA will expand medical error partnerships with medical and patient safety organizations.

Research

Under the proposal, the National Institutes of Health (NIH) would receive $1 billion additional dollars to maintain and improve health through medical science. The agency estimates 82 percent of its funding is directed to research facilities in the 50 states and ten percent support NIH-based clinical research. In

the case of FY 2001, NIH requests research project grants receive a 6 percent increase to fund 237 new grantees. The plan also earmarks $37 million new dollars over last year to support the Biomedical Information Science and Technology Initiative, a new "trans-agency" dedicated to medical research related to clinical trials, population genetics and statistics. An additional $105 million will sponsor intervention research targeting at-risk populations like women and minorities.

What's ahead: Every Institute and Center will help prepare the agencies new Strategic Plan for Research on Health Disparities.

Rural Health

Under the draft budget, telehealth funding would be reduced by $18 million. To offset program reductions, HRSA will focus $6.8 million of its total request ($75 million) to support a Mississippi Delta initiative for 219 counties. According to the agency the focus will enhance health care in a region where the poverty rate is 175 percent of the national average. The National Health Service Corps is level funded at FY 2000 levels of $117 million.

Women's Health

The Health Resources and Services Administration (HRSA) would utilize $145 million over FY 2000 levels to continue its efforts to ensure access to health care through a wide range of programs for those who are uninsured, live in medically underserved areas or have special health care needs. HRSA intends to direct $1.2 billion to strengthen the infrastructure of the health care safety-net. Nearly $50 million would create an additional 22 Community Health Centers.

The administration also requests $35 million additional dollars over FY 2000 levels for clinics providing access to reproductive health care and preventative services under the Title X Family Planning program. Increases will provide family planning services to an additional 500,000 women, increase HIV/AIDS prevention (24% of all new AIDS cases are women), and expand its efforts to reach hard to reach populations. The nation's lead agency for disease prevention, the Centers for Disease Control and Prevention (CDC), would receive an additional $40 million for HIV/AIDS prevention and $15 million for a National Syphilis Elimination Initiative over FY 2000 funding levels. Women are disproportionately infected with syphilis and HIV/AIDS.

What's ahead: In FY 2001, the Ry White Care Act reauthorization expir and the program will focus on identifyi new methods of bringing and providi medical services and therapies to tho outside the care system.

The CDC's National Breast an Cervical Cancer Early Detection Progra would receive $5 million over last year funding to expand screening, diagnostic and case management services to wome at risk. Under the plan, an additional $ million would also boost the efforts of th department's Violence Against Wome (VAW) Initiative. The CDC intends to us the VAW monies to craft a scientifi approach to evaluate services and bring i partners to improve service delivery an prevention opportunities.

The administration's proposal also allows states to create a new Medicai eligibility option to cover uninsure women diagnosed with conditions unde the CDC's Breast and Cervical Cance early detection program.

Under the Departmental Managemen portion of the budget, the administratio requests $16 million for the Office o Women's Health to advance women' health programs through the promotion coordination of research, service delivery and education throughout HHS agencies and other professional groups.

Good News! One Chart Pull for MMC Focused Studies

By Beverly Koops, M.D.

For physicians who participate in Medicaid Managed Care MC), the yearly requirement for participation in random chart ews has been an intrusion. It has frequently resulted in tiple managed care organizations (MCOs) coming into the e physician's office for chart abstraction or copying on tiple occasions.

The Texas Department of Health (TDH), in consultation with Texas Health Quality Alliance (THQA), has made a signifi- change in methodology for the focused studies in order to be intrusive to providers. First, the number of charts needed has greatly reduced. Second, the requirement for various Os to copy or abstract from the same charts has been elimi- d. The new methodology will mean that the quality of care uations will reflect MMC service delivery areas instead of ecting individual MCOs.

The result is that physicians may choose to have some relief n the intrusion of MCOs in their offices. Physicians will be the patients' names of the charts to be pulled, and the names ach patient's MCO.

The new studies requiring chart information will begin in ch 2000. Physicians can copy their charts and immediately rn the copies to TDH/THQA, as instructed. If physicians or r office staff desire help from the MCOs, they may ask for stance with copying, abstracting, and/or sending the charts. harts have not been received within one month after the TDH uest, then the MCOs will contact physicians to obtain the ired charts.

This is GOOD NEWS! Physicians have been heard by TDH! metimes good things happen.

ATOMA News

Names of Delegates and Alternates Needed

It is time to elect delegates and alternates for the ATOMA House of Delegates meeting, to be held June 15th in Corpus Christi. Additional district members and potential members are welcome to attend this meeting.

Each district is allowed three delegates and three alternates. This also includes unorganized districts. ATOMA state officers and board members are automatic delegates, so please elect six other members. The names need to be sent to the Credentials Chair by April 30th, so that they may be included in the Annual Report.

"All delegates shall be active paid members of the State Auxiliary and be registered at the State Convention" – Article VIII, Section 2, ATOMA Constitution and Bylaws.

Please encourage attendance for this important meeting so we can all continue to support osteopathic medicine. Thank you.

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News

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

Health Science Center Receives Scholarship Gift

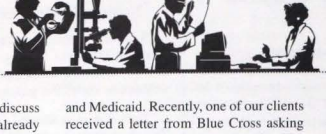
The Wayne O. Stockseth Endowed Scholarship was established with a seed gift of $100,000 to the University of North Texas Health S nce Center/Texas College of Osteopathic Medicine Foundation by Mr. and Mrs. Wayne Stockseth.

The endowed scholarship is for medical students of the Texas College of Osteopathic Medicine, the medical school component of t UNT Health Science Center at Fort Worth. The scholarship will be enhanced through solicitation of additional gifts from TCOM a nni who have received Stockseth scholarships in the past.

The endowed scholarship continues a two-decade tradition of giving to the UNT Health Science Center by Stockseth and his wife, Na ma Lee. The Stocksteths have shown their support of the UNT Health Science Center in previous years through an annual scholar- gift of $1,000 to a UNT Health Science Center medical student and the gift of a Rolex watch to a graduating senior who has shown o tanding achievement in osteopathic manipulative medicine.

"As a member of the UNT Health Science Center's Board of Trustees in the 1970s and as chairman of the University of North Texas B rd of Regents in the 1980s, Wayne Stockseth has made significant contributions of leadership to the health science center," said Dr. B jamin Cohen, interim president of the UNT Health Science Center. "His generous offering will create continuous opportunities for g medical students."

Self's Tips & Tidings



By Don Se

This month, we are going to discuss several issues that are either already affecting your practice, or they will in the very near future.

First, let me clarify something. Some offices tell me they get my monthly newsletter when they call with a question when, in fact, they are getting this monthly column which is quite different. This column is only two pages long, while my newsletter is 8 to 12 pages of different material than I post in my monthly column. Consequently, if you are interested in trying a subscription to my monthly newsletter, give us a call at 800-256-7045.

Blue Cross Not Allowing Consults Before Surgery

In what may be seen as a trend among Blue Cross carriers across the country, some carriers are no longer paying for a consult if a surgery is performed within 30 days of the consult by the same physician. This is contrary to every other carrier, Medicare, Medicaid and common sense. If your Blue Cross carrier starts this, then it is past time to not only withdraw from Blue Cross (in our opinion), but it's also time to educate every other physician you know as to this policy. So far, Pennsylvania has adopted this policy and Maryland has adopted a 10-day prior to surgery policy. Keep your eye on your claims and if they start denying the consults, you have a problem. In Pennsylvania, they paid for the consults, later paid for the surgery and then months later, they recouped the payment for the consultation, referencing a 1995 written policy that Blue Cross presented.

When Private Carriers Audit You

Yes, doctor, since the HIPAA (Health Insurance Portability and Accountability Act) was passed back in 1996, private carriers can audit you as can Medicare and Medicaid. Recently, one of our clients received a letter from Blue Cross asking for 32 patient encounter records. The office manager called the carrier and told them that 32 was quite a bit and would cost quite a bit of money. If the carrier were willing to pay the practice for the expense of copying and mailing, they would comply, but they would not charge the carrier for sending 10 records of the carrier's choice. The carrier went for it and that saved the practice a heck of a lot of time and money.

Are the Medicare Prepayment Audits Working?

HCFA recently released some figures for the first half of 1999. Remember - the pre-payment audit is where Medicare sends you a request for documentation of the E&M service prior to their paying the claim. HCFA reports they have saved Medicare $1.1 billion from all Part B claims through the audits. With that kind of success, don't look for Medicare to drop the audits in the near future. If you still haven't ordered an E&M documentation sliderule to make sure your documentation will stand up to a Medicare audit, give us a call today. They are only $10.50 each, plus shipping and handling.

How to Bill for Assisted Living Facility Visits

The way you bill, (procedure code and place of service code) depends on the type of living arrangement the patients have. Some facilities provide a full apartment with a kitchen and bath while some just provide a private room for the patient with common eating areas. Use the following to help determine which codes to use:

Use Rest Home codes (99321-99333) if the patients do not have full apartments, but they have their own room and eat in common areas, with limited come-and-go privileges.

Use Home Visit codes (99341-9935 if the patients have their own apartmen with kitchen and baths; the patients c come and go as they please; and if you s the patient in their residence and not in separate room the facility provides.

Use Out-patient Visit codes (9920 99215) if the patients live in their ow apartments and the patients come and g as they wish, but the facility provides ye a separate room in which to see patient

Read this Sentence Once

Finished files are the result of years o scientific study, combined with the exper ence of years.

Now count the F's in that sentence Count only once, don't go back a secon time. You will see something that ma surprise you, later in this column.

Don't Let the Patients Convinc You to Change Diagnoses

This should be a completely unneces sary subject, but unfortunately it is not Patients will repeatedly ask you to change the diagnosis on the claim so that their insurance will pay for it. A Medicare patient may ask you to change the ICD-9 code so that Medicare pays for the B-12 shot. A mother may ask you to change the diagnosis code on her son's claim so the private carrier will pay for it. If you do this, you are guilty of FRAUD. You will be caught. You will either pay a fine or go to jail for this, as it is illegal. Please do not take this lightly. If you wish to see a list of doctors that have not believed this to be fraud, visit the Federal Prison in Texarkana. Ex-physicians are rapidly becoming the majority of inmates.

Even if you do not end up in prison, some of the fines are as high as $4 million, as one OB/GYN in New York City just found out.

continued on next page

Legal Depositions – How Do You Charge?

We were recently asked by a new ician how he should charge for depo- ns requested by attorneys. Your time oney and you collect that money UP- NT. You notify the attorney that you be more than happy to give a deposi- but you will be charging them by the , in advance, at $600 per hour. If it over an hour, you will be paid an tional $150 per every 15 minute incre- t or part thereof. So, if you spend an and 5 minutes, your fee is $750.00. want a deposit of two hours and, upon pletion, you will return any unused ion. You may say to yourself at this t, "There's no way they'll pay it". If want you, they have to pay and payment must be received at least 7 days prior to the deposition. If cancellation occurs within 48 hours of the scheduled deposition, then 50% of the fee will be kept as a cancellation fee and you refund the rest. If cancellation is less than 24 hours, then your full fee is paid.

Medicare Secondary Payer

It has recently come to our attention that Medicare, HCFA and the OIG are prosecuting physicians and clinics (fines and penalties) for filing Medicare as primary when Medicare should be the secondary payer (MSP). For this reason, we have taken a patient questionnaire that some states are requiring all physicians to complete on all Medicare patients (Texas doesn't require the form yet), and placed it on our Web site at <www.donself.com> for you to download. We recommend that you download and use this form to make sure your patients do not have another carrier as primary insurance, as Medicare is putting the responsibility for knowing on you! That Web site also has new patient forms, documentation guidelines, waivers, insurance letters and more. All of it is free and you're welcome to use it.

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TEXAS FYI

TDH to Award Grants Focusing on Children, Public Health

The Texas Department of Health (TDH) is making available approximately $8.4 million in grants for up to 30 innovative projects targeting children and public health. Grant requirements were released in a formal request for proposals Friday, Feb. 18. Deadline to submit proposals is April 18 with contracts expected to begin around July 1. Funding from the state's General Revenue will be awarded in three areas:

- For developing and demonstrating cost-effective prevention and intervention strategies for improving public health outcomes;
- To local communities to address disparities in health in minority populations; and
- To local communities for essential public health services.

The TDH Innovation Grants were created last year by the 76th Texas Legislature in House Bill 1676 that established the Permanent Fund for Children and Public Health using tobacco settlement money. "We want to see improvement in health, especially among children and minorities, beginning at the community level," said Texas Commissioner of Health William R. Archer III, M.D. "We are looking for innovative projects that can be replicated throughout Texas and, as much as possible, show health improvements that can be demonstrated or measured." No funds will be used for direct health care. A single grantee may receive multiple contracts up to $1 million for the 14-month budget period. While most grants will be for general projects, a few, such as to address problems of childhood obesity, will be in specific categories. Information and a copy of the request for proposals are available by writing Gyl Kovalik, Office of Policy and Planning, Texas Department of Health, 1100 W. 49th St., Austin 78756, by faxing 512-458-7344 or by e-mail togyl.kovalik@tdh.state.tx.us. The request for proposals also is available at <www.tdh.state.tx.us/innovation> on the TDH Web site.

The Texas Board of Pharmacy Rejected Limits on Generic Drug Substitution

The board's unanimous decision is expected to produce millions of dollars in annual health care cost savings to consumers, according to Barr Laboratories, Inc., which was part of a coalition that pushed for unrestricted consumer access to FDA-approved generic pharmaceuticals. Since 1997, the Texas Board of Pharmacy has been considering how to promulgate regulations resulting from a state law that required the Board to consider generic drug restrictions.
(Barr Laboratories, Inc., 2-15-2000)

Texas Children's Hospital is Launching an HMO for Uninsured Children

The health plan will cover without copayment routine physical exams, well-child care, immunizations, vision and hearing screenings, routine lab tests and X-rays, diabetic services and durable medical equipment; and will also include coverage for prescriptions, outpatient services, home health care and emergency room visits. The plan will be available in Harris and surrounding counties, as well as Austin, Colorado, Matagorda and Wharton counties.
(Houston Chronicle, 2-2-2000)

UT System Board of Regents Approved $80 Million Allocation

The allocation includes $50 million to expand San Antonio Health Science Center's children's care program and $2 million for a regional academic center in Harlingen. Officials hope the academic center will encourage physicians to stay and serve rural areas after they have completed training there.
(Dallas Morning News, 2-11-2000)

MacGregor Medical Association's Management Company Taken Over by Methodist Health Care System

Methodist is renaming the company Texas Medical Management, while MacGregor's 170 physicians in the Houston locations will remain independent from Methodist. Methodist will have access to MacGregor physicians, over 100 of whom are in primary care, through their 34-year contract with the management company.
(Houston Business Journal, 2-7-2000)

Temple-Based Nonprofit Health Care Company Plans Merge of HMO, Hospital and Clinic Operations into Single Management Structure

Scott & White made the announcement in light of decreased reimbursements and increasing quality of care expectations, the American-Statesman reported, citing the company's CEO Alfred Knight, Jr., M. D. The company operates a 468-bed hospital in Temple and 19 regional clinics in areas including Taylor, Georgetown, Round Rock, Florence and Cedar Park.
(Austin American-Statesman, 2-2-2000)

Dallas-Fort Worth Business Group on Health Drafts Standardized Physician Credentialing Form

The group, composed of 140 corporations, which purchases health coverage for their employees, is also using claims data from several members to develop an

tive to track and improve outcomes for ovascular disease care. The group is surveying physicians about area health performance and hopes to create an net-based system to allow physicians staff to check patients' health plan lment and eligibility online.

las Business Journal, 2-7-2000)

Texas State Agency Awards Research Contract for Workers' Compensation Medical Studies

The Research and Oversight Council Workers' Compensation (ROC) has unced the award of a research contract edFx, a national medical consulting to conduct four separate studies d to the Texas workers' compensation m. Three studies will focus on cal cost and quality issues, and one will examine workplace return-to- issues. The studies are scheduled for letion in November 2000 to provide l data prior to the next legislative ion in the Spring of 2001.

The research is legislatively mandated. e Bill 3697, passed by the 76th Texas slature, directs the ROC and the Texas kers' Compensation Insurance Fund (a r writer of workers' compensation ance in Texas) to conduct specific es to determine why the cost of ng injured workers in Texas is higher other states, and to examine the rela- hip between cost of medical care and ty of medical care. Available data that the medical portion of a ers' compensation claim in Texas is significantly higher than that seen in other states, and rising at a faster rate. It is not clear, however, what impact cost may have on the quality of medical care. Higher claim costs translate into higher premium costs for employers, which in turn may lead to some employers choosing to opt out of the workers' compensation system. Data also show that a significant number of injured workers have difficulty returning to work after an injury.

MedFx began work on the four studies in February in an effort to identify problem areas and possible options for improvement. One study will compare the medical cost of a workers' compensation claim in Texas with medical costs in other state workers' compensation systems. A second study will compare Texas workers' compensation medical costs with medical costs in other types of Texas health care systems such as group health coverage and managed care organizations. A third study will focus on quality of medical care by examining medical provider treatment patterns and insurance carrier utilization review practices in Texas. A fourth study will examine return-to-work issues by reviewing available disability guidelines and exploring ways to identify injured workers who need additional assistance in getting back to productive employment.

MedFx is a firm specializing in improving clinical and business results by implementing best practices through consulting and software solutions in the workers' compensation, automobile, occupational health, and group health markets. Based in Mill Valley, California, the principals of the firm have experience in clinical care, quality improvement, strategic planning and public policy, and process redesign. The company also has statistical profiling capabilities to support provider network development, provider performance profiling and process improvements. In addition, the research team also includes health care providers and experts in workers' compensation regulation in Texas.

TDH Makes Tobacco Settlement Money Available for Local Projects

The Texas Department of Health (TDH) will award almost $500,000 in tobacco settlement money to schools and community groups throughout the state to pay for projects to prevent or reduce tobacco use or protect the public from secondhand smoke. Individuals, community groups, schools, non-profit organizations and coalitions are eligible to apply for the grants. TDH expects to award 100 grants through a competitive selection process. The maximum amount of each grant will be $4,999. The money must be used to motivate youth or adults to cease tobacco use, protect the public from involuntary exposure to secondhand tobacco smoke, reduce tobacco use in special population groups or prevent youth tobacco use.

The application deadline was March 29. The $500,000 to be awarded is part of $10 million in endowment earnings from a permanent fund for tobacco education and enforcement established by the Texas Legislature.

IN BRIEF

Aetna U.S. Healthcare Successful in Securing Injunction

Superior Court of New Jersey prevented Atlantic Health System's Morristown Memorial Hospital and Mountainside Hospital in Montclair from attempting to end their Aetna contracts in order to protect the patient access to health care at these hospitals, and called for an expedited hearing to resolve their dispute with Aetna. Atlantic Health maintained that it is losing money on Aetna's reimbursement, which it said includes a 20 percent claims denial rate.
(Aetna U.S. Healthcare, 2-11-2000)

Passage of U.S. House's Bipartisan Managed Care Improvement Act to Raise Employers' Health Care Premium Costs

The bill, sponsored by Reps. Charles Norwood (R-GA) and John Dingell (D-MI), would allow lawsuits against managed care health plans and could boost premiums more than three times higher than would a Senate version of a Patient's Bill of Rights, which is projected to raise employer premium costs by only 1.3 percent because it does not call for expanded liability. *(Business Insurance.com, 2-14-2000)*

Complexity of Medicaid's Re-Enrollment Process Significant Barrier to Parents

A Kaiser Commission on Medicaid and the Uninsured survey of 1,335 parents in families with incomes less than 133 percent of the poverty level found that fewer than half were successful in attempts to enroll their children in Medicaid, while the vast majority said they would like to do so. Another 31 percent said they never attempted to enroll because they didn't know how or thought their child would not qualify. Nearly five million uninsured children in the U.S. are believed to be eligible for Medicaid.
(American Medical News, 2-14-2000).

UOMHS Changes Name

The University of Osteopathic Medicine and Health Sciences has changed its name to Des Moines University – Osteopathic Medical Center. The announcement was made in mid-September.

Providers of Naturopathic Therapies in Maine Must be Licensed

Licensure will set educational and ethical standards for the budding profession, whose practitioners can order certain diagnostic tests and prescribe certain medications after earning an N.D. degree through four years of graduate training and passing professional board exams. Maine's licensed N. D.s are also required in the first year of their practice to meet four times with a conventional physician to review their prescriptions. Maine is among 11 states that require licensure for naturopathic health care providers, including Connecticut, Vermont, New Hampshire, Washington, Oregon, Utah, Montana, Arizona, Hawaii and Alaska.
(Associated Press, 2-7-2000)

Clinton's Federal Budget Proposal Includes Over $5 Million for Programs to Red the Rate of Medical Errors

The budget would allocate $20 mil next year to the Agency for Health Research and Quality, up from this ye $4 million; $12.8 million in new fun to the FDA to hire 25 full-time employ for its adverse event reporting syste monitor errors involving drugs medical devices; and a $19.7 mill increase in funding to the Departmen Veterans Affairs for its patient saf program.
(Philadelphia Inquirer, 2-9-2000)

The Nation's Two Largest Consumer Health Care Web Sites are Joining

Healtheon/WebMD Corp. agreed acquire OnHealth Network Co. for $3 million, subject to regulatory approval, the end of the second quarter of the ye Healtheon/WebMD hopes to use increased consumer base to attract phy cians, hospitals, insurers, HMOs a other health care industry entities to mo their paperwork online.
(Associated Press, 2-16-2000)

White House Proposes Placing Fraud-Fighting Staff in the Office of Every Medicare Contractor Nationwide

President Clinton's fiscal 2001 budg sets aside $48 million to fund over 1 such staff members and to develo computer systems to track claims an payments. Recent federal reports state that Medicare fraud prosecutions nette the federal government $490 million i fiscal 1999 and prevented billions dollars of inappropriate Medica payments to providers.
(American Medical News, 2-7-2000)

mptions for the Anthrax Vaccination Program

By Staff Sgt. Kathleen T. Rhem, USA
American Forces Press Service

oD officials are in the process of approving a policy that stan-zes exemptions to the anthrax vaccination program. But, they they provided exemptions because it's "good medicine," not ise of any concerns about the vaccine's safety or efficacy.

he new exemptions fall into two categories, administrative and al, said Marine Maj. Gen. Randy L. West, special adviser to ecretary of defense for anthrax and bio-defense affairs.

he administrative exemption refers mainly to service bers who are within 180 days of separation and are not likely deployed to one of the key anthrax-threat areas — Korea and iwest Asia. The six-shot anthrax vaccination series takes 18 hs to complete.

f a person is within 180 days of discharge and not likely to be oyed to a high-threat area, it doesn't make sense to start a am that takes 18 months to complete," West said. "We dn't be able to complete the series while the person was on e duty.

However," he continued, "if a person is within 180 days of ation and is in a hostile area or is unexpectedly deployed to a e area, we will vaccinate them and give them as much protec-is we can under the approved FDA protocol."

he general said the services were looking at the issue of ptions for separating personnel differently, with recommen-ns ranging from 90 to 180 days. DoD officials decided to set tandard.

Medically speaking, certain individuals shouldn't receive any inizations, including anthrax. "Anthrax is a mandatory nation, but we want it to be given just like every other ne," West said. "If a person has a medical reason not to take accine or to be temporarily exempt from taking it, we want o happen."

edical exemptions fall into several categories

dverse reaction to a previous anthrax immunization. West id a person who has a suspected severe reaction after a shot ould be temporarily exempt until the cause can be definitely termined. If the vaccine is the cause, the individual would e exempt from further doses.

egnancy. "There's no history that would cause us to believe e anthrax vaccine would be harmful. However, there haven't en any tests done to prove that," West said. "Since we know at a woman's body goes through a lot of changes and a lot challenges during pregnancy, we would just like to avoid adding to those challenges by requiring her to take the anthrax vaccine."

- Currently taking corticosteroids or other immunosuppressant drugs. Vaccinations are commonly deferred for individuals taking drugs that suppress the immune system because the drugs reduce the effectiveness of the vaccine, not because there would be an adverse reaction to the combination.

"The purpose of vaccines is to build antibodies in your body," said Army Lt. Col. Gaston M. Randolph Jr., director of the Anthrax Vaccine Immunization Program. "When you're taking immunosuppressant drugs, your body doesn't build antibodies. It's sort of a waste to take the vaccine."

- Recent illness or surgery. "If individuals had recently been ill or had recently had surgery we wouldn't want them to take a shot until they were fully recovered," West said.

West said these measures address "common-sense medical situations," but said he felt the exemptions provide clarification because of the public controversy surrounding the vaccine.

Randolph explained that medical exemptions have always been covered in the healthcare providers' briefing, but until now have not been spelled out in a single clear, concise guideline to service members.

Stress Reaction Treatment to be Emphasized

By Staff Sgt. Kathleen T. Rhem, USA
American Forces Press Service

DoD is aiming to ensure that the services treat people for stress reactions from combat and other traumatic events.

"Many things beside combat can cause a combat stress reaction," said Army Dr. (Lt. Col.) E. Cameron Ritchie, director of Mental Health Policy and Women's Health for the Office of the Assistant Secretary of Defense for Health Affairs. "We may have less combat action today, but we still have danger and sleep deprivation, in training exercises and deployments."

Ritchie said service members today have to deal with the sight and smell of dead bodies on peacekeeping missions, accidental deaths of unit members, and "working in an environment where people you came to help are shooting at you, as in Somalia." Any of these things can cause a combat stress reaction, she said.

"Some people are very critical of the term 'combat stress control,' because we're seeing a lot of situations other than combat," she said. "We're seeing 'operational stress.' That's really the term I prefer."

continued on next page

Commanders should be aware that home-front stresses often cause difficulties. "A person may be doing great where he is, but it's the news that his wife is divorcing him, or his kid is having problems in school, or he needs to figure out what to do with his elderly parents that becomes a precipitating factor", Ritchie said.

Two aspects differentiate a "perfectly normal" reaction to trauma and a more severe reaction that requires professional treatment — how long the reaction lasts and its severity.

"It depends on the symptom," Ritchie said. "Nightmares might go on for weeks, but uncontrollable shaking shouldn't last more than a few hours. If someone becomes suicidal or even homicidal it becomes a medical issue. The chain of command should work closely with their medical team to provide the service member immediate help."

DoD mental health experts are trying to emphasize to the services the importance of combat stress control to the overall health and fitness of the force, Ritchie said. DoD Directive 6490.5, signed Feb. 23, 1999, attempts to implement combat stress control policies throughout the department.

The Army has devoted dedicated resources to combat stress control with active and reserve combat stress control units. "The chaplain is a good resource when medical personnel aren't immediately available. Corpsmen and medics should also be trained in the basic ideas of combat stress control,"Ritchie said.

"Initial treatment is simple," Ritchie said. "We use the phrase 'three hots and a cot.' I personally think it should be 'three hots, a cot and a warm shower. My mental health goes down drastically after a couple days without a shower."

She said soldiers need to know that psychological reactions to traumatic events are normal. Ritchie explained it's also important to treat combat stress casualties as close to the front or to their units as possible and with the understanding they will return to duty. "We've found that if you ship people out of their units, most never go back, and they don't recover as well," she said. "There's quite a bit of stigma attached to being removed from a unit, and some of these people develop chronic psychiatric conditions."

But, Ritchie explained, this policy is also for the unit's benefit. "One of the things we explain to the commands is that 80 to 90 percent of these people can be returned to duty usually within three days," she said. "If you start evacuating large numbers of soldiers, you're going to have an epidemic, especially if you get into a situation where there's real combat".

10 Years Ago in the *Texas D.O.*

- D. Dean Gafford, D.O., was named interim medical director for the U.S. Department of Energy's Super Conducting Super Collider, which was being built in Ellis County, around the Waxahachie area. As interim medical director, his duties were to help write a policy and procedures manual as well as institute a wellness program for the current 700 employees.

- Physicians were notified that by September 1, 1990, all physicians, regardless of their participation status, would be required to file Medicare claims for their patients. This little-known provision came out of the Omnibus Budget Reconciliation Act of 1989 (OBRA 89). Additionally, physicians were instructed not to charge their patients for this service.

- The start-up date for the National Practitioner Data Bank, which was supposed to have been April 1990, was postponed until fall. The data bank was mandated by the Health Care Quality Improvement Act of 1986.

- The Texas Department of Health stated that TB cases among Texans had increased in 1988 and 1989, especially among the black population. In 1989, 529 blacks contracted TB, compared with 479 in 1988. Reports also showed increased TB cases among Hispanics and persons infected with HIV. Until recently, TB had been declining nationwide. The federal Centers for Disease Control's "Strategic Plan for the Elimination of Tuberculosis in the United States" had a goal of 99 percent reduction in TB by 2010.

Compass 21 Implementation Update

Compass 21 Provider Advisory Council met on January 12. ır information, main points raised during this meeting are as

Compass 21 Update

npass 21 will replace the current National Heritage Insurance ay (NHIC) claims and encounters processing system on May). Educational workshops regarding Compass 21 began in cities throughout Texas in March, and invitations to work- ere mailed to all Medicaid providers in February. Information d on the EDS/NHIC Web site at <www.eds-nhic.com>. In to the workshops, the field based provider relations repre- es have also been conducting Compass 21 workshops in their es. Information regarding Compass 21 appeared in the April 2000 Medicaid bulletin. There will be a special bulletin to all providers indicating the changes to the 2000 Texas d Provider Procedures Manual as a result of the May 1, 2000 ntation of Compass 21.

Texas Provider Identifier (TPI)

y Medicaid provider has been assigned a TPI, which replaces his ırrent Medicaid provider number. Letters indicating providers' mailed to the provider's accounting address in March.

TDHconnect Software

Connect software was deployed in March via CD-ROM. All s who were using the TDHconnect software received the CD- tomatically. Providers are encouraged to load the software n familiarizing themselves with the changes, however, they be able to use the software to submit claims until May 1.

Pilot Tester Installations

irst pilot tester install was conducted on January 7, 2000, at e of Dr. William Steinhauer. Dr. Steinhauer gave a report zing the results of the installation. The pilot testers who sting the software February 1 were also present at the Their responsibilities are to test the software and find any defects that need to be corrected. By having the software tested in numerous pilot tester offices, the potential of determining defects increases. If any defects are discovered during the course of testing, pilot testers were educated on the procedure to follow in documenting and submitting information to NHIC.

Electronic Specifications

The specifications for claims submission are complete, and have been finalized since July, 1999. They can be downloaded from the TexMedNet Web site at <www.texmednet.com>. Vendors must make the specification changes and test their formats prior to May 1, 2000. If vendors fail to test their file formats prior to May 1, they will not receive user IDs and passwords for production on and after May 1. Without new IDs and passwords, all files will reject, which will ultimately affect the cash flow of the provider for which they bill.

Family Planning Claim Form

The family planning claim form 2017 to be used with the implementation of Compass 21 will be available in the Compass 21 special bulletin and the March/April Medicaid bulletin. If providers do not receive this bulletin, a request may be faxed to 512-514-4229. If there are any questions related to this form, contact the Texas Department of Health Family Planning Program at 512-458-7444.

The next meeting of the Provider Advisory Committee is scheduled for April 17.

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