TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association
November, 1996
LIII, No. 10

Join us in Dallas Valentine's Weekend for the 41st Annual MidWinter Conference & Legislative Symposium

February 14-16
The Fairmont Hotel

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Look for the MidWinter pre-registration form inside

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TEXAS D.O.

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

FEATURES

DEPARTMENTS

TEXAS D.O.
TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

November 1996

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Calendar of Events

DECEMBER 6-8

15th Annual Winter Update
Sponsored by Indiana Association of Osteopathic Physicians and Surgeons
Location: Westin Hotel, Indianapolis, IN
Contact: IAOPS, 800-942-0501 or 317-926-3009

7

TOMA Board of Trustees Meeting
Location: TOMA Headquarters, Austin, TX
Contact: TOMA, 800-444-8662

JANUARY, 1997
10-12

Annual Winter Convention of the Massachusetts Osteopathic Society/Rhode Island Society of Osteopathic Physicians and Surgeons
Location: Sturbridge Host Hotel, Sturbridge, MA
Contact: Northeast Osteopathic Consortium, 800-982-7247

FEBRUARY 7-11

Seventh Annual Update in Clinical Medicine for Primary Care Physicians
Sponsored by University of North Texas Health Science Center at Fort Worth
Location: Embassy Suites Resort, South Lake Tahoe, CA
Hours: 20 CME Hours
Contact: UNT Health Science Center, Office of Continuing Medical Education
817-735-2539

14-16

41st Annual MidWinter Conference & Legislative Symposium
Sponsored by Texas Osteopathic Medical Association
Location: Fairmont Hotel, Dallas, TX
Hours: 17.5 AOA Category 1-A CME Hours
Contact: TOMA, 800-444-8662; 512-708-8662; FAX 512-708-1415

23-28

Ski & CME Midwinter Conference
Sponsored by the Colorado Society of Osteopathic Medicine
Location: Keystone Lodge & Resort, 800-258-0437, Code DA2RSCO
Hours: 39 AOA Category 1-A CME Hours
Contact: Patricia Ellis, 303-322-1752 or 800-527-4578 FAX 303-322-1956

APRIL 9-12

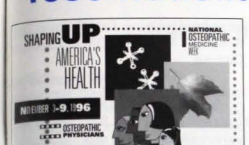
Atlantic Regional Osteopathic Convention - "Technology and Medicine"
Sponsored by New Jersey Association of Osteopathic Physicians & Surgeons
Location: Tropicana Casino and Resort, Atlantic City, NJ
Hours: 34 Category 1-A CME Hours plus Workshops
Contact: New Jersey Association of Osteopathic Physicians & Surgeons
908-940-9000

11-12

11th Annual Spring Update - A Day in the Life of a Primary Care Physician
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Dallas, TX
Contact: UNT Health Science Center, Office of Continuing Medical Education
817-735-2539

Articles in the *"TEXAS D.O."* that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the *"TEXAS D.O."* is required by that law: Terry R. Boucher, Executive Director, TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634.

1996 National Osteopathic Medicine Week



Once again the celebration of National Osteopathic Medicine Week has come and gone, paying tribute not only to the profession today but to all the pioneers in osteopathic medicine. NOM Week 1996, celebrated November 3-9, marked the 122nd year of osteopathic medicine.

It was in 1874 that Dr. Andrew Taylor Still, a Missouri physician, not satisfied with medical care as it was, first articulated his osteopathic principles which eventually revolutionized the field of medicine with his unique philosophy of treating the whole patient, not just the disease.

At the time of his death in 1917, he was able the see his new concept of healthcare become a reality. In 1917, there were 5,000 practicing D.O.s; today there are almost 40,000 D.O.s.

Arthur G. Hildreth, D.O., author of *The Lengthening Shadow of Dr. Andrew Taylor Still*, aptly noted, "Had the principles of osteopathy been enunciated by a man of less philosophic acumen, of less faith in the laws of nature and nature's God, of less courage, less force, less perseverance, less love and devotion to humanity than Dr. Still, it is extremely doubtful whether osteopathy would now or ever have reached the position which it occupies today..."

NOM Week 1996, celebrated November 3-9, focused on improving America's overall health with the theme, "The Sandwich Generation." Members of the Sandwich Generation are the people caring for children while at the same time caring for aging parents. They are "sandwiched" between two high-maintenance populations, which many times leads to neglect of their own health needs. The time commitments and responsibilities related to child care, elder care and to career make for hectic, stress-filled lifestyles for this generation.

According to Anthony J. Silvagi, Pharm.D., D.O., Dean of the University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri, "A holistic medical approach with emphasis on treating the entire family unit is the best answer to challenges facing the sandwich generation."

And, not only are osteopathic physicians responsible for treating the sandwich generation, many actually are members of this generation. U.S. Census data shows more than 64 million people aged 40 to 64 years, which defines the sandwich generation as making up 25.8 percent of the population.

The Centers for Disease Control and Prevention note the leading causes of death of people in this generation as follows:

- Cancer - 32 percent
- Heart disease - 30 percent
- Accidents - 6 percent
- Stroke - 4 percent
- Lung disease - 3 percent

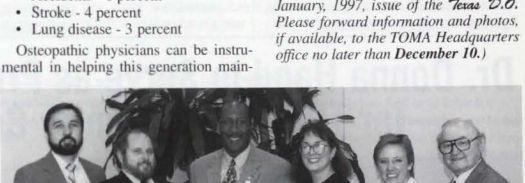
Osteopathic physicians can be instrumental in helping this generation maintain good health during the highly stressful sandwich years.

During the week of November 3-9, osteopathic physicians and facilities across the nation joined together in a variety of activities in their local communities.

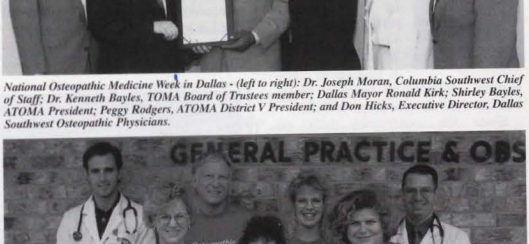
Closer to home, TOMA Board of Trustees member Kenneth Bayles, D.O., was instrumental in obtaining a proclamation from Dallas Mayor Ronald Kirk, proclaiming National Osteopathic Medicine Week in that city.

Al E. Faigin, D.O., of Fort Worth, and his office staff wore ATOMA "Osteopathic Medicine" T-shirts to call attention to the special week.

(Editors note: TOMA would like to feature your NOM Week activities in the January, 1997, issue of the Texas D.O. Please forward information and photos, if available, to the TOMA Headquarters office no later than ***December 10.****)*



National Osteopathic Medicine Week in Dallas - (left to right): Dr. Joseph Moran, Columbia Southwest Chief of Staff; Dr. Kenneth Bayles, TOMA Board of Trustees member; Dallas Mayor Ronald Kirk; Shirley Bayles, ATOMA President; Peggy Rodgers, ATOMA District V President; and Don Hicks, Executive Director, Dallas Southwest Osteopathic Physicians.



Striking a pose during NOM Week - (Left to right, back row): Student Doctor Niska, Dr. Al Faigin, Nancy Neuwine and Student Doctor Todd Grey. (Left to right, front row): Melinda Thomas, Diana Brevo and Lauren Elson.

1997 TOMA Dues Statements Mailed

Invoices for 1997 dues were mailed to all Texas Osteopathic Medical Association members in October. TOMA dues have not increased since 1982 and the Board of Trustees is attempting to keep dues the same, even with the added expenses of the new TOMA building and additional member services.

"Without a doubt, a TOMA member receives services many times the value of the dues paid," said Dr. Jim Speece, President of the Texas Osteopathic Medical Association and Chairman of the Board of Trustees.

With the Texas Legislature convening in January, TOMA will provide leadership to influence health care legislation addressing Medicaid managed care and funding; tort reform; insurance/managed care reform; fraud and abuse issues; technical corrections to the Medical Practice Act and amendments to the non-certified radiologic technician law. While state activities will be a priority in 1997, TOMA will also be working with the AOA at the federal level on issues such as Medicare/Medicaid funding, initiatives facilitating the development of physician-sponsored organizations and direct contracting and recognition of AOA board-certification by Medicaid. TOMA will continue to provide members with timely information; low-cost/high quality continuing medical education programs and valuable networking opportunities.

"Dr. Speece's theme for the year, 'Unity and Shared Knowledge,' underscores the importance of collaboration. Membership in TOMA creates partnerships among the state's osteopathic physicians which will allow us to achieve mutual goals and create/maintain a marketplace with fair competition on a level playing field," noted Terr Boucher, M.P.H., TOMA Executiv Director.

"The TOMA Board of Trustee requests that dues, which are payabl October 1, be remitted as soon a possible," said Dr. Speece. "Board an staff decisions on our budget, o necessity, are based upon dues receipt and when payments are delayed program decisions are implemente based on revenue estimates. During th 1996 fiscal year, some physician delayed payment of their dues to th point that revenue estimates wer merely guesses. The TOMA Boar hopes to have a clear picture of fisc 1997 revenue before the first quarter o the year, so that it can make solid informed decisions. Your cooperation i greatly appreciated."

Dr. Donna Hand to Serve as Program Chairman for TOMA's MidWinter Conference

Donna M. Hand, D.O., of Lindale, will be serving as Program Chairman for the educational portion of TOMA's 41st Annual Mid-Winter Conference & Legislative Symposium, scheduled for February 14-16, 1997, at the Fairmont Hotel in Dallas.

Since the conference falls on Valentine's Day weekend, Dr. Hand stresses the fact that "this will afford physicians and their spouses the opportunity to partake of a romantic getaway/CME weekend at the fabulous Fairmont Hotel." With that thought in mind, Dr. Hand says, "I made an effort to choose clinically relevant topics that might also appeal to the non-physician spouse, such as the new diet pills, etc."

Dr. Hand reminds physicians that the conference will offer 17.5 Category 1-A CME hours.

"I hope to see you all there for a fun-filled and informative weekend."

A 1985 Cum Laude graduate of Texas College of Osteopathic Medicine, Dr. Hand subsequently interned at Hillcrest Osteopathic Hospital in Oklahoma City, Oklahoma. In 1986, she returned to Texas to marry a fellow TCOM graduate, Dr. Wendell Hand. They proceeded to set up a family practice together in his hometown of Lindale.

Board certified in Family Practice in 1995, they have continued in private practice in Lindale. Both are involved i their church and community.

Dr. Hand served several years a Secretary of TOMA District III befor being appointed to the TOMA Convention Committee in 1995. She i also serving on the Board of Governor of the Texas Society of the ACOFP.

A D.O. serving tray, a gift from Dr. and Mrs. T. Eugene Zachary to TOMA, was presented by Dr. Zachary (right) to TOMA Executive Director Terry Boucher, M.P.H.(left), and TOMA President Arthur J. Speece, III, D.O., during the September 7, 1996, TOMA Board of Trustees meeting.

1st MidWinter Conference and Legislative Symposium

Donna Hand, D.O., Program Chair

SCHEDULE OF EVENTS - 17.5 AOA Category 1-A Hours Available

day, February 14

4:30 pm	-	8:30 pm	Registration
5:00 pm	-	6:00 pm	Reception with Exhibitors
5:00 pm	-	8:30 pm	Exhibit Hall Open
6:00 pm	-	6:45 pm	Common Foot Problems - Tom Abigail, D.P.M.
6:45 pm	-	7:30 pm	Rotation Deformities of the Lower Extremities - Christine Quatro, D.O.
7:30 pm	-	8:00 pm	Exhibit Hall Break
8:00 pm	-	8:45 pm	Topic TBA - Laurence Cunningham, D.O.

turday, February 15

7:30 am	-	8:00 am	Breakfast with Exhibitors
7:30 am	-	4:00 pm	Exhibit Hall Open
7:30 am	-	5:15 pm	Registration
8:00 am	-	9:00 am	New Strategies for Risk Management in Obesity - Craig Spellman, D.O. Sponsored by Wyeth-Ayerst Laboratories
9:00 am	-	10:00 am	Hirsutism: Evaluation & Treatment - Steve Buchanan, D.O.
10:00 am	-	10:45 am	Exhibit Hall Break
10:45 am	-	11:30 am	Repairing Photodamage - Norman Guziek, M.D. Sponsored by Ortho Pharmaceutical Corporation
11:30 am	-	12:15 pm	H. Pylori Update - David James, D.O. Sponsored by Astra Merck
12:15 pm	-	1:30 pm	Legislative Luncheon Sponsored by Astra Merck
1:30 pm	-	2:15 pm	Impotence: Update on Treatment Options - Wayne Hey, D.O. Sponsored by Merck & Co., Inc.
2:15 pm	-	3:00 pm	Obsessive Compulsive Disorder - David Baron, D.O. Sponsored by Pharmacia & Upjohn, Inc.
3:00 pm	-	3:45 pm	Exhibit Hall Break
3:45 pm	-	4:30 pm	Lupus: Diagnosis & Treatment - Nancy Brown, D.O.
4:30 pm	-	5:15 pm	How to Treat Varicose Veins - Alvin Mathe', D.O.

Sunday, February 16

7:30 am	-	8:00 am	Continental Breakfast
7:30 am	-	1:15 pm	Registration
8:00 am	-	10:30 am	Malpractice Loss Prevention for the Osteopathic Physician - Ed Kelsey, J.D.
10:30 am	-	10:45 am	Refreshment Break
10:45 am	-	1:15 pm	Malpractice Loss Prevention for the Osteopathic Physician (con't) - Ed Kelsey, J.D.

HOTEL INFORMATION

This year's conference will be held at the Fairmont Hotel in the Dallas Arts District, 1717 N. Akard Street, Dallas, Texas 75201. Reservations must be made no later than Tuesday, January 14, 1997, in order to receive the discounted group rate of $89 single or double. Call the Fairmont Hotel directly at 800/527-4727 or 214/720-2020 for reservations and be sure mention you are with TOMA.

VALENTINE'S DAY - make reservations at the Pyramid Restaurant, which is one of Dallas' finest dining spots, when calling the Fairmont Hotel.

Registration Form

_____ Nickname for badge _____

_____

_____ State _____ Zip _____

(_____) _____ Fax (_____) _____

_____ College _____ Grad. Year _____

	Registration Postmarked On or Before 1/14/97	Registration Postmarked After 1/14/97
TOMA Member	$175	$250
Non-Member	$275	$350

Please reserve me _____ extra ticket(s) to the Legislative Luncheon on Saturday for $25 each. (One ticket is included in the registration fee.)

Registration Fee $ _____

Luncheon Ticket(s) $ _____

TOTAL ENCLOSED $ _____

Return this form with your payment in full to TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634. All refund requests must be received in writing. Requests postmarked on or before 1/14/97, will receive a refund minus a 25% handling charge. No refunds will be given after January 14, 1997.

New Interns and Residents Continued

Continuing from last month, interns and residents training for the 1996-97 year are as follows:

TRI-CITY HOSPITAL
(Dallas)

Kathie Boyd, D.O.
OSU-COM
OB/GYN Resident

Dharma DeFrese, D.O.
COMP
Intern

Christopher DeLoache, D.O.
OSU-COM
Orthopedics Resident

Elizabeth Hill, D.O.
UHS-COM
Family Medicine Resident

Gerald Rana, Jr., D.O.
OSU-COM
Intern

Patricia Roberts, D.O.
UNTHSC/TCOM
Interns

Denise Steiner, D.O.
KCOM
Family Medicine Resident

Steve Vacalis, D.O.
UOMHS/COMS
Intern

Camille Ziomek, D.O.
COMP
Intern

BAYLOR COLLEGE OF MEDICINE
(Houston)

James E. Andrews, Jr., D.O.
UOMHS/COMS
Physical Medicine and Rehabilitation Resident

Insurance Inflation Continues to Decline

Largely attributed to HMOs, health insurance inflation for medium and large employers has continued a seven-year decline this year, according to a new survey by the management consultant KPMG. The annual survey is based on interviews with 1,151 companies employing 200 or more people.

Health insurance premiums rose 0.5 percent between the spring of 1995 and spring of 1996. These figures compare with a 2.1 percent increase in 1995 and 4.8 percent in 1994. The study noted that this is the second consecutive year in which health insurance premium inflation was less than the overall rate of inflation of 2.9 percent. In the early 1980s, health care inflation was close to 20 percent.

The survey also revealed that, for the first time, HMO-enrolled employees outnumbered employees with other kinds of insurance. Approximately 33 percent of employees were in HMOs; 41 percent were in managed health care networks which were less defined (doctor or hospital choices are not limited); and 26 percent held conventional health insurance.

Although the survey is good news for workers, it may not last, according to another recent survey by Sherlock Company, which indicates HMO executives expect to increase rates next year by an average of 2.6 percent. ■

Rural Health Factline

• In 1993, heart disease, stroke, COPD, diabetes, pneumonia, and influenza accounted for 75 percent of all deaths in the Untied States.[1]

• In 1993, 2,268,553 deaths were registered in the U.S. - the highest number ever. That same year, life expectancy at birth declined for the first time since 1980.[2]

• The five Texas counties with the largest percent population increase from July 1, 1994 to July 1, 1995 are: Blanco (28.11 percent); Bandera (27.65 percent); Lampasas (22.82 percent); Burnet (20.20 percent); and Hudspeth (9.57 percent).[3]

• The number of doctors practicing in the U.S. has more than doubled in 25 years, nearing the 700,000 mark, and the proportion who are female has jumped from 7.6 percent to 19.5 percent. Of those 700,000 physicians, 34 percent are primary care physicians. Women and black physicians are more likely to be primary care physicians, with 46.1 percent and 43-68 percent, respectively, choosing primary care.[4]

1, 2. Centers for Disease Control, National Center for Health Statistics, Division of Vital Statistics, Mortality Statistics Bureau, 1995.
3. U.S. Census Bureau, cited in "Austin American-Statesman," March 12, 1996.
4. "American Medical News," February 26, 1996, cited in "Healthcare Leadership Review," April 1996. ■

Sixth in a Series: *Better by Association*

Community by Association

Is America missing something? A lot of cultural observers say we are. They say we've lost a sense of community, a sense that we're all in this together, a sense that by joining hands we can build a brighter, more successful future.

How can America reclaim the common ground we've lost? The answer is by uniting in affiliation and common purpose, something associations have helped Americans do since revolutionary times. Associations provide Americans with an opportunity that is all too rare today—the opportunity to come together and decide what to do, both individually and collectively, to achieve goals we share for ourselves, our businesses, our children and our country.

How are we building community by association in America today?

We're helping to build healthy communities.

We're developing strategies for affirming diversity in the workplace. Filling gaps in social services by renovating old homes for use as child care and family counseling facilities. Expanding access to the capital to start small businesses. Convening community leaders to focus on race relations and build trust and communication. Mobilizing businesses and communities to promote flextime, job sharing and other family friendly workplace practices.

We're bringing people together to envision the future.

We're helping to build a free and open information society by promoting public participation in decision making on the nation's technology future. Creating opportunities for professionals in environmental management, public transit, engineering, computer sciences and other fields to share information and strategies for success. Using the internet to facilitate dialogue between medical professionals and elected leaders about health policy priorities for the next century.

We're helping Americans show compassion and community spirit.

We're creating opportunities for volunteers to provide free medical care and treatment to children. Organizing retired police officers to provide special assistance in missing and exploited child cases. Mobilizing our members to provide counseling, food, aid and shelter to victims of disasters from earthquakes and floods to the Oklahoma City bombing.

America's associations always have operated on the principle that we're in this together. And together, we can make America a better community.

Advancing America.

Creating Knowledge.

Innovating.

Learning.

Ensuring Excellence.

Bringing People Together.

Associations Advance America

Texas Medicaid Drug Use Review
Oral Prescription Medications and Black Box Warnings

By Curtis Burch

Black box warnings have been created to alert and inform health professionals of potentially severe, life-threatening adverse events associated with a particular medication. Additionally, black box warnings impart important safety information as well as revised prescribing instructions. Several prescription medications have been recently assigned a black box warning due to reports of potentially life-threatening adverse effects.

Ketorolac (Toradol®), a nonsteroidal anti-inflammatory agent, is indicated for use in short-term management of moderately severe acute pain requiring opioid analgesia. A black box warning was developed for Toradol in December, 1994, limiting the total duration of therapy, parenteral and oral combined, to five days due to an increased risk of serious adverse events with prolonged use, including peptic ulcers, gastrointestinal bleeding, gastric perforation, increased bleeding risks, and renal toxicity.

Cisapride (Propulsid®) is a gastrointestinal prokinetic agent indicated for management of nocturnal heartburn associated with gastroesophageal reflux disease. Propulsid is metabolized by cytochrome P-450 3A4, a major isoenzyme in the cytochrome P-450 enzymesystem. Agents that inhibit cytochrome P-450 enzymes, including ketoconazole (Nizoral®), itraconazole (Sporanox®), miconazole (Monistat®), fluconazole (Diflucan®), erythromycin, troleandomycin, and clarithromycin (Biaxin®), may limit Propulsid metabolism with a resultant increase in Propulsid bioavailability and reduction in Propulsid clearance. Life-threatening cardiac arrhythmias, including ventricular tachycardia, ventricular fibrillation, and torsades depointes with associated QT interval prolongation, have been observed in patients receiving Propulsid concomitantly with those agents that inhibit the cytochrome P-450 3A4 isoenzyme. A black box warning has been included in the Propulsid package insert alerting health professionals and patients to this drug interaction as unexpected fatalities have occurred following the combined use of Propulsid and agents that impede the cytochrome P-450 enzyme system.

Terfenadine (Seladane®) and Astemizole (Hismina®) have also had reported cases of serious cardiac events including QT interval prolongation/ventricular arrhythmias when used in combination with ketoconazole, itraconazole, erythromycin, clarithromycin or troleandomycin.

(See Chart on following page) ➤

THANK YOU!

TOMA would like to thank the following "Texas Stars" who have contributed above the $1,000 donation level:

Richard Anderson, D.O.
Auxiliary to the Texas Osteopathic Medical Association
Mark Baker, D.O.
Dr. and Mrs. John Bowling
Dr. and Mrs. Frank Bradley
Mary Burnett, D.O.
George Cole, D.O.
Nelda Cunniff-Isenberg, D.O.
Jim Czewski, D.O.
William Dean
Drs. Cynthia and Gregory Dott
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Al E. Faigin, D.O.
D. Dean Gafford, D.O.
Samuel B. Ganz, D.O.
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Bill V. Way, D.O.
Dr. and Mrs. Rodney Wiseman
Dr. and Mrs. T. Eugene Zachary

Other medications assigned a black box warning include:

Medication	*Potential Adverse Event*
altretamine (Hexalen®)	myelosuppression; neurotoxicity
amphetamines	high abuse potential
angiotensin converting enzyme inhibitors	contraindicated in pregnancy due to potential fetal abnormalities/fetal death if used during second and third trimesters
astemizole (Hismanal®)	QT interval prolongation/ventricular arrhythmias when used in combination with ketoconazole, itraconazole, erythromycin, troleandomycin and clarithromicin
azathioprine (Imuran®)	increased neoplasia risk
bumetanide (Bumex®)	excessive use may lead to profound fluid/electrolyte depletion
busulfan (Myleran®)	bone marrow suppression
carbamazepine (Tegretol®)	aplastic anemia; agranulocytosis
chlorambucil (Leukeran®)	bone marrow suppression; carcinogenic; potentially teratogenic, mutagenic
clindamycin (Cleocin®)	potentially fatal colitis
clozapine (Clozaril®)	agranulocytosis; seizures; orthostatic hypotension
cyclosporine (Sandimmune®)	adrenal suppression
dantrolene (Dantrium®)	hepatotoxicity
didanosine (Videx®)	potentially fatal pancreatitis
disulfiram (Antabuse®)	should not be administered to patients with alcohol intoxication
estrogens	increased risk of endometrial cancer in postmenopausal women; avoid using in pregnancy
etretinate (Tegison®)	contraindicated in pregnancy due to potential development of fetal abnormalities
felbamate (Felbatol®)	aplastic anemia; hepatic failure
fentanyl transumcosal system (Fentanyl Oralet®)	life-threatening hypoventilation
flucytosine (Ancobon®)	use with extreme caution in patients with impaired renal function
ganciclovir (Cytovene®)	granulocytopenia, anemia, thrombocytopenia; carcinogenic and teratogenic in animal studies
isoniazid	potentially fatal hepatitis
isotretinoin (Accutane®)	contraindicated in pregnancy due to potential development of fetal abnormalities
itraconazole (Sporanox®)	combined use with terfenadine, astemizole may result in serious cardiovascular events; combination is contraindicated
ketoconazole (Nizoral®)	potentially fatal hepatotoxicity; significant drug interaction with astemizole, terfenadine causing potential QT interval prolongation
levomethadyl (ORLAAM®)	to be dispensed only by treatment programs approved by FDA, DEA, and state authority for treatment of narcotic addiction
lincomycin (Lincocin®)	potentially fatal colitis
lithium	lithium toxicity
lomustine (CeeNU®)	bone marrow suppression
melphalan (Alkeran®)	bone marrow suppression; leukemogenic; potentially mutagenic
methotrexate	fetal death; congenital abnormalities; bone marrow suppression; hepatotoxicity
methoxsalen (Oxsoralen-Ultra®)	ocular damage; aging of skin; skin cancer
methysergide (Sansert®)	retroperitoneal fibrosis; pleuropulmonary fibrosis; fibrotic thickening of cardiac valves
metronidazole (Flagyl®)	carcinogenic in rats, mice
minoxidil (Loniten®)	pericardial tamponade; angina exacerbation
misoprostol (Cytotec®	contraindicated in pregnancy due to abortifacient properties
mitotane (Lysodren®)	adrenal suppression
mycophenolate (Cellcept®)	increased susceptibility to infection; potential development of lymphoma
procainamide	prolonged administration may result in positive ANA titer
progestins	contraindicated in pregnancy due to potential development of fetal abnormalities
ritonavir (Norvir®)	potentially lie-threatening adverse events when co-administered with certain nonsedating antihistamines, sedative hypnotics, or anti-arrhythmics
spironolactone (Aldactone®)	carcinogenic in rats
stavudine (Zerit®)	peripheral neuropathy; limited clinical indications
tacrolimus (Prograf®)	increased susceptibility to infection; potential development of lymphoma
terfenadine (Seldane®)	QT interval prolongation/ventricular arrhythmias when used in combination with ketoconazole, itraconazole, erythromycin, troleandomycin and clarithromycin
tocainide (Tonocard®)	blood dyscrasias
valproic acid (Depakene®, Depakote®)	potentially fatal hepatic failure
zalcitabine (Hivid)	peripheral neuropathy; pancreatitis; lactic acidosis
zidovudine (Retrovir)	granulocytopenia; anemia; myopathy; lactic acidosis

Prepared by: Drug Information Service, The University of Texas Health Science Center at San Antonio, and the College of Pharmacy, The University of Texas at Austin, under contract with the Texas Medicaid Drug Utilization Review Board.

References:

1. Duffy MA, Schumacher MM, Dowd AK, eds. *Physician's Desk Reference.* 50th ed. Montvale, NJ: Medical Economics Data Production Co., 1996.
2. Olin BR, Hebel SK, Dombek CE, eds. *Facts and Comparisons Looseleaf Drug Information Service.* St. Louis, MO: Facts and Comparisons, Inc., 1996.

AOA Washington Update

Health Insurance Reform Bill Signed by President Clinton

Following many years of partisan battles over the scope of health care reform legislation, Congress recently enacted a package of health insurance reforms. The Health Coverage Availability and Affordability Act of 1996 was passed by the House of Representatives by a vote of 421-2, and by the Senate by a vote of 98-0. Despite some serious concerns regarding the range of these reforms, President Clinton signed the bill into law on August 21, 1996.

Generally, the bill guarantees that workers who lose or leave their jobs can maintain health insurance coverage. The bill will limit to 12 months the period in which an insurer can deny coverage of a new enrollee for a health condition that was treated or diagnosed in the six-month period before enrollment. Newborns, adopted children and pregnancies will be exempt from this 12-month pre-existing condition exclusion. Insurers will also be prohibited from denying coverage to enrollees based on the enrollees' health status or medical claims experi-ence, and from refusing to renew policies (except in the cases of fraud and non-payment of premiums).

Persons who wish to purchase individual coverage also fare well under the bill. Insurers will now be required to offer coverage to individuals who: 1) maintained group coverage for at least 18 months; 2) are not eligible for coverage under any group plan; and, 3) have exhausted their COBRA coverage. The pre-existing condition exclusions and denial of coverage based on health status provisions in group policies will also be applicable to individual policies.

While Congressional negotiations over these provisions were not without controversy, heated battles over four specific issues kept the bill in limbo for months – medical savings accounts, mental health parity, medical liability reform, and fraud and abuse.

Medical Savings Accounts

Congressional negotiators sparred for months over the medical savings account (MSA) provision in the House version of the bill. The original provision would have allowed individuals to make tax-deductible contributions to special accounts for routine medical expenses, that would be linked with catastrophic health insurance policies. Individuals would be able to save the money they did not use.

Republicans argued that such a plan would "put consumers in the driver's seat," by offering them the incentive to shop more wisely for their health care service needs. Democrats maintain that the option would attract only affluent and healthy individuals. The Senate version of the bill did not include the MSA provision.

Ultimately, a deal was struck between Congressional leaders on the MSA provision. The MSA's will now become available, through a demonstration-type project, to a limited population of approximately 750,000 for four years, beginning January 1, 1997. Following the four year demonstration, Congress will have to vote on whether to expand this option nationwide. Individuals eligible to participate in this demonstration would include employees of companies with 50 or fewer employees, self-employed workers, and the uninsured. Funds withdrawn from these accounts used to cover medical expenses will not have a tax penalty assessed. Withdrawals made for other purposes will be taxable and subject to additional penalties.

AOA Action: No position.

Mental Health Parity

The Senate version of the bill included a provision which would have required health plans to offer coverage for the treatment of mental illnesses on par with the coverage for physical illnesses, provided that the treatment was "medically necessary." The House version, however, did not include this provision. Despite a national campaign led by dozens of mental health provider and consumer advocacy organizations to retain this provision in the final bill, the provision was ultimately dropped. Congressional leaders expressed concern over the potential costs of such a provision, and the conflicting cost data presented by both the mental health and business communities. Efforts are already underway to address the mental health coverage issue in other legislative vehicles.

AOA Action: No position.

Medical Liability Reform

The original House version of the bill included comprehensive medical liability reform provisions, including a $250,000 cap on non-economic damage. The Senate version, however, did not include these provisions. Recognizing that the Senate has historically thwarted any legislation which includes medical liability reform language, House negotiators thought it best not to run the risk of jeopardizing the whole bill by fighting to retain the medical liability provision. The provision was ultimately dropped.

AOA Action: The AOA worked diligently with a coalition of pro-reform groups to retain the reform provisions. The coalition is already identifying other legislative vehicles to carry this position. Through one of its Legislative Alerts, the AOA also enlisted the support of D.O.s practicing in the Congressional districts represented by Congressional negotiators in an effort to retain these provisions.

Fraud and Abuse

Both the House and Senate versions of the bill defined federal health care fraud and abuse offenses. However, the versions of the bill differed in the extent to which these offenses would be prosecuted (imposition of fines, prison time, or both). The final bill includes language that will make it more difficult to prosecute a provider who has allegedly committed a federal health care fraud offense. For example, the House version of the bill would have required prosecution to demonstrate that a provider acted "knowingly" in defrauding the health care system. The Senate version, however, would have required prosecution to demonstrate that a provider acted "knowingly and willfully." This Senate language was retained.

AOA Action: The AOA worked in concert with the AMA to ensure that the final fraud and abuse provision was acceptable to the physician community. Because a number of the original fraud and abuse provisions could have been construed as unnecessarily penalizing a physician for unintentional acts (mistakes in coding, etc.), the AOA signed onto a letter to Congress requesting amendments to the provision to ensure that physicians, generally, would not be subject to such onerous penalties.

Generally, the provisions in the Health Coverage Availability and Affordability Act of 1996 will become effective in July of 1997.

For a more detailed summary of the Health Coverage Availability and Affordability Act of 1996, please contact the AOA Washington, D.C. Office at 800-962-9008. ■

In Memoriam

Oliver H. Jones, D.O.

Dr. Oliver H. Jones of Lubbock passed away on February 29, 1996. He was 77 years of age. Services were held at St. Christopher's Episcopal Church with burial in Resthaven Memorial Park.

Dr. Jones earned his D.O. degree in 1941 from Kirksville College of Osteopathic Medicine. He practiced family medicine in Olton and relocated to Lubbock in 1972, where he practiced until 1982.

Dr. Jones was a life member of the Texas Osteopathic Medical Association and the American Osteopathic Association, a past president of TOMA District X, and a past officer of the Lubbock Osteopathic Foundation. In addition, he had served as chief of staff at the Community Hospital in Lubbock.

Dr. Jones was also a member of St. Christopher's Episcopal Church and a former member of the Lions Club.

Survivors include two daughters, Kathleen Jones of Lubbock and Cindy Ahrens of Hale Center; three sisters, Florence Bounds of Fairhope, Alabama, and Helen Sears and Clara Redmond, both of St. Louis, Missouri, and four grandchildren.

USMLE Step 2 Minimum Passing Score Increased to 170

The USMLE Step 2 Committee reviewed the results of the investigation of the appropriateness of the pass/fail standard currently used for Step 2. Based upon this review, the Step 2 Committee increased the Step 2 pass/fail standard to 170. If the standard had been 170 instead of 167 in August, 1995, the failure rate would have been 7.9 percent instead of 6 percent for first-time examinees from U.S. schools.

Source: The Federal of State Medical Boards of the United States, September, 1996, NewsLine. ■

Nasal Flu Vaccine Undergoing Final Testing

Final tests of what may become the country's first nasal vaccine to fight influenza are currently underway in 10 medical centers nationwide.

Aviron Inc., of Mountain View, California, has developed a nasal vaccine which uses a live but weakened flu virus, rather than the killed virus in currently available shots. Approximately 1,000 children, ages one to six, will be involved in the final testing. Half will receive the Aviron vaccine while the other half will receive a placebo. If the spray proves effective, the company hopes to have Food and Drug Administration approval to sell it for the 1999 flu season.

A smaller, earlier study of adults showed the nasal vaccine to be 85 percent effective at preventing flu. ■

THE INDEPENDENT
INVESTOR

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Investment Opportunities Abound Internationally

Go west, young man, go west.

Over 100 years ago, this was the sage advice offered to those seeking to earn their fortunes. Today, a modified version of that statement might just as appropriately be offered to the same audience: go west...and east...and north...and south.

In the ongoing search for investing opportunities, international markets are holding increasing appeal and are attracting a steadily increasing amount of investment capital. It's not that the domestic market has lost any luster. One would be hard pressed to top the returns provided by the Dow's continuing bull market that has produced a string of new highs over the last 48 months and is up more than 14 percent in 1996 alone.*

It's simply a matter of reason that with the outbreak of capitalism in so many countries around the globe, the resulting opportunities for investors have increased proportionately.

It should be noted early in this commentary that there are risks associated with investing in markets outside the U.S. that don't exist here. Two of the most compelling are currency risk: that the value of your investment as measured in local currency will decline if the value of that currency declines against the dollar. And political risk: that a government implementing a free-market economy for the first time could be less stable than one with over 200 years of practice.

Having said that, we nevertheless believe that international exposure is a worthwhile component of a diversified investment portfolio.

There are many reasons for this viewpoint and they fall into two basic categories: logical conclusions about events taking place in the global economy today and statistical information that points to the present as an excellent time to take advantage of opportunities presenting themselves worldwide.

In the former category are these conclusions:

- At no time in our history has business been easier to conduct on a global basis. New technologies are shaping and changing the way individuals and corporations conduct business almost every day. Communication is easier, travel is more convenient and exposure to varying cultures is more prevalent than ever before. Our world has truly become a global village.

- The embracing of capitalism and free markets has never been so widespread. Although many transitions have, no doubt, been painful, the ones which take root should, no doubt, be fruitful.

- More American businesses than ever are focusing on expansion through international markets. As U.S. markets for goods and services continue to mature, corporations that have for years generated most or all of their revenue in the U.S. will look abroad for the right opportunities.

And in the latter category are these points:

- Low (from historical levels) world-wide inflation and low interest rates.

- An improving world economic climate - mainly attributable to the outbreak of free markets in so many locations.

• Economies abroad-especially in emerging markets - that have an abundance of raw materials but are lacking in capital. Finding the right opportunities in these locales can be a promising place to start for patient investors.

If so many opportunities exist, what is the most effective way to find them and how does an investor reduce the risks associated with investing abroad? Following a few simple guidelines will help.

They include beginning with a game plan that examines the right mix of international exposure to one's overall portfolio. One of the benefits of investing in markets outside the U.S. are their long-term lack of correlation to U.S. markets. This simply means that, over time, the performance of the Dow Jones Industrial Average has differed from that of market averages in the Pacific Rim, Latin America or Northern Europe. This type of diversification is an extremely important component of your overall investment plan.

The next is to remember that opportunities abroad are more varied than those in the U.S.- not only from one market to the next but from individual companies in the same market. This simply boils down to exercising extreme caution when making investment decisions.

Finally, remember not to overexpose yourself to markets outside the U.S. The risks we discussed at the outset are real and even the most aggressive portfolios should contain at least an equal mix of domestic and international exposure.

Our expertise lies in measuring our clients' investment goals against their willingness to assume risk in achieving those goals. We continue to believe in investment opportunities outside the U.S. and can help those who want to take advantage of them to find just the right mix. That may well include going west, east, north and south.

If you would like to know more about international investment opportunities, please give us a call.

***Indexes such as the do Jones Industrial Average are unmanaged and cannot be directly invested into**

All performance is historical and is no guarantee of future performance.

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The Cost of Caring: Who Heals the Healer?

By Peter A. Setness, M.D.
Editor-in-Chief, "Postgraduate Medicine"

The cost of medicine. We hear about it constantly, usually in connection with terms such as "sky-rocketing," "spiraling," and "out of control." But at a 25-year reunion of a family practice residency program I attended recently, the discussion centered on a different type of medical cost - the personal cost of being a primary care physician.

A large group of current faculty and residents, as well as returning graduates, spent a Saturday morning listening to a panel discussion and then, in smaller groups, sharing some of their own stories. These physicians, from rural solo practices, urban multispecialty group practices, and everything in between, talked not only of their great satisfaction in sharing in the personal and family events in the lives of their patients, but also of the loneliness in dealing with medical crises and other problems faced by patients they had come to know as friends. Most of them spoke of a lack of emotional support from the community and, unfortunately, a lack of overt support from colleagues when they were dealing with a poor patient outcome, a malpractice suit, or personal problems.

Key Rewards

I'd like to believe that physicians in primary care medicine have some personal values that enable us to reach out to patients and that these very connections, in turn, reward us. There is an important difference between being a doctor and being a *personal* doctor, one who is willing to make a commitment of *person* to the patients he or she serves. This commitment is what allows us to turn a *case* into a *patient* and a *number* into a *name* - of a real person in a real family in a real community. It gives our medical encounters depth, but it also puts us at some emotional risk.

The relationships we develop with patients are the key rewards in our practice. They are what keeps us coming back for more. Often we have the privilege of caring for a patient through many years or even through the patient's life span. The flip side, though, is the emotional burden of foreseeing the medical problems that lie ahead for a patient. The joys of the doctor-patient relationship are tempered when a patient is dying or when we feel we or the medical community could have done something better.

Punishing Ourselves

When a patient's outcome is poor, we punish ourselves by second-guessing our decisions. But when a result is less than optimum, perhaps no one is to blame. As Rabbi H. Kushner says in his well-known book, bad things do happen to good people. We may be at the wrong place at the wrong time. Despite our competence and conscientious surveillance, some patients may experience side effects of medications or procedures. As financial considerations become more important in medical care, managed care guidelines or policies may distort our particular style of medical practice. We may pay too much attention to cost containment, thus increasing the potential for a poor outcome.

Instead of personalizing poor results and internalizing the discomfort, we need to remind ourselves that the situation may have been beyond our control. One long-time physician in my discussion group shared the pain of not diagnosing a carcinoma until it became metastatic in a patient who had just recently come in for an annual exam. The physician felt personally responsible for that patient's cancer and had grieved silently for years. Unfortunately, his family, his friends, and even his other patients also suffered because of his unresolved grief, damaged self-esteem, and mild depression.

Such self-doubts can get way out of hand: According to the National Institute for Occupational Safety and Health, physicians are No. 3 out of 230 occupations analyzed for risk of suicide with an odds ratio of 2.88 compared with the general public. Only psychologists and pharmacists rank higher, and lawyers hold the fifth spot.

A poor outcome is not necessarily the same as a mistake. As Mark Twain is quoted as saying, "Good judgment comes from experience, and experience comes from poor judgment." Reviewing events retrospectively, with all the advantages of hindsight, can be healthy. But it is easy to focus on a particular outcome and to forget about the confusion and complexities that surrounded the case in context. We are accountable for what we try to do, but not for everything that happens.

Sharing Our Feelings

We also need to remember that we cannot protect ourselves or others from the personal pain of living. Sometimes all we can do is try to ease someone's pain. But because we feel we need to be strong, we tend not to show our feelings. And when bad things happen, we blame ourselves too easily. We might feel such guilt that we dread seeing a patient or won't even call the patient's family. The point is, it's okay to say "I'm sorry." It's not an admission of guilt. And by sharing your feelings with your patients and their families, you become a *personal* doctor.

Like everyone else, physicians have to deal with personal problems - family illnesses and deaths, financial concerns, chemical dependency, divorce, disabilities, and the whole range of human frailty. Physicians who are struggling with such problems need tremendous support. The stress of silence can be almost unbearable, and not talking about our feelings contributes to a sense of isolation and hopelessness. Doctors are usually better at analyzing and evaluating facts, function, and form than at dealing with their own frustrations and feelings and their need to forgive and to be forgiven.

A Listening Ear

The physicians at the reunion shared their difficulty in coping with their personal pain within their practice setting. In one case, the least likely colleague initiated a healing discussion, while a best-friend physician would not or could not discuss the topic with the distressed physician. It's almost as if some physicians cannot talk about painful issues. Perhaps they think that the emotional feelings surrounding poor outcomes, malpractice cases, and personal pain are contagious. But, at least in the case of problems related to practice, support from colleagues who not only can understand the confidential nature of a poor outcome or the legal implications of a

malpractice threat, but also can identify with our vulnerability, is invaluable. We need our colleagues, with common experience, to become trusted listeners.

Support can also come from other sources. One doctor in the discussion group said that a unique, long-time patient-friend turned out to be his greatest source of support time and again. The important thing is to find a nonjudgmental listener who, by hearing and reflecting on our story, can help us understand our experience better. Sometimes all a patient needs is for us to listen. At times, a good listener may be all that we need too.

Reaching Out for Help

So who heals the healer? How do we talk, and how do we find trusted listeners? How do we deal with our burdens?

Look to your colleagues and friends. And perhaps consider a group, but don't call it a support group. Instead, call it a professional development group, or a case study seminar, or a journal club, and devote the last part of the discussion time to patient and personal issues. What often happens in such discussions is that the "doctor" in the doctor-patient relationship emerges as you talk about a patient's problems, and soon you are talking about your own place in the relationship and your own needs as a doctor.

If discussion groups aren't your cup of tea or if you are in an isolated rural solo practice, consider e-mail with other physicians. You might find that the distance adds a measure of safety and comfort when sharing personal issues. But be careful of confidentiality issues when discussing cases on e-mail. The point is, reach out for help. If you don't know where to turn, call a trusted faculty member at your local residency program or contact a medical school or your state or district society. If you are in severe distress, consider professional therapy.

Finally, don't forget to celebrate the everyday joys and successes of practicing medicine. We have all helped patients through difficult times. Let's start reminding each other of the successes we have had. And let's be a constructive force in helping colleagues to cope during difficult times. The need for help is not a sign of weakness. Don't let the burdens of caring hide the rewards of practicing medicine. ■

CDC Says SIDS Verdict Requires Autopsy

The cause of infant deaths should not be labeled as sudden infant death syndrome without an investigation and an autopsy to prove it, according to the Centers for Disease Control and Prevention.

SIDS is defined by the CDC as the sudden death of an infant that remains unexplained after a review of the baby's health history, an autopsy and a look at where the baby died.

"If there is no autopsy, a death should not be labeled SIDS. If the death is caused by criminal activity or child abuse, that needs to be investigated," noted Juliet Van Eenwyk, a Washington state epidemiologist who found that investigations into infant deaths varied widely in her state.

TRICARE/CHAMPUS News

All Providers Must File Claims on Behalf of TRICARE Standard (CHAMPUS) Patients

Effective October 1, 1996, all institutional or individual professional providers of care in the U.S. and Puerto Rico are required by federal law to file claims on behalf of TRICARE/CHAMPUS patients — whether or not the providers decide to participate in the TRICARE/CHAMPUS program.

Only pharmacies will be exempt from the claim filing requirement. TRICARE/CHAMPUS-eligible persons may still submit pharmacy claims to regional TRICARE contractors.

Patients will not be permitted to file other claims themselves, unless they request and receive a waiver from their regional TRICARE/CHAMPUS contractor. This waiver must be sent in with each claim submission. Contractors will only grant waivers to the legal requirement for providers to file all claims if they decide that, by not seeking care from the provider who refuses to file claims, the patient would have reduced access to needed medical care.

If a patient does submit a claim, this will alert the contractor that a potential problem may exist, since the provider did not file the claim. Unless a waiver is granted, the provider who has not filed the claim is risking his or her status as a TRICARE/CHAMPUS-authorized provider.

Providers of care who live outside the U.S. and Puerto Rico are not required to file claims for their patients.

The legal requirement is contained in the National Defense Authorization Act for Fiscal Year 1992. It applies to services or supplies provided on or after October 1, 1996. For service or supplies provided before October 1, 1996, TRICARE/CHAMPUS-eligible patients and families may still file claims as they have in the past.

Persons who have other health insurance that provides primary coverage (in other words, insurance that pays before TRICARE/CHAMPUS) for the services received may file the TRICARE/CHAMPUS claims themselves, and won't need a waiver.

Providers who refuse to file the claims for their TRICARE/CHAMPUS patients (or who charge an administrative fee for filing the claims) will have the allowable charges for the services provided reduced by 10 percent. Patients may not be billed for this 10 percent reduction. The 10 percent reduction will not go into effect until six months after the effective date of October 1, 1996.

Repeated failures or refusals by providers to comply with the claims submission requirement will also be considered abuse of the program, and will be grounds for termination of the provider's authorization to provide care to TRICARE/CHAMPUS patients, and be paid by the government.

Patients who have to file claims because their providers decline to do so must use the DD Form 2642 ("CHAMPUS Claim: Patient's Request for Medical Payment"). Individual professional providers who file claims will use the HCFA 1500 form. Institutional providers will use the UB-92 form for institutional charges; for professional charges, they'll use the HCFA 1500 or, they can still use the UB-92 if adequate CPT coding information is submitted.

In areas of the country where TRICARE is in operation, regional contractors can help families locate providers who participate in TRICARE, and who will handle the paperwork for their patients. Where TRICARE hasn't yet arrived, providers who participate in standard CHAMPUS are accustomed to filing claims for their CHAMPUS patients. ■

AOA Contracts with Academy

The American Osteopathic Association provided a grant to the American Academy of Osteopathy to address inconsistent physician payment policy on the part of insurance companies in regards to osteopathic manipulative treatment. The AAO represented the profession in the execution of this contract and will report to the AOA Board of Trustees on completion of the charge outlined in the agreement.

Under the direction of Osteopathic Medical Economics Committee Chairperson Dr. Judith Lewis, AAO leadership began last spring to develop a document which identified problems in physician reimbursement and outlined courses of corrective action. AAO leaders Boyd Buser, D.O., and Judith O'Connell, D.O., met with AOA's RUC representative Ray Stowers, D.O., in July to develop a proposal calling for the AOA to fund the development of a comprehensive statement of the problem of physician payment policy in regards to E&M and OMT.

The AOA accepted the Academy's proposal and responded with a formal "Memorandum of Understanding" which charged the Academy with the following:

A. Research into the history of OMT and the -25 modifier reimbursement code, including an assessment of current reimbursement policy among various third party payors and, a comparison of chiropractic and other forms of physical medicine with OMT;

B. Preparation of a position paper and statement of the issues;

C. Preparation of an impact statement on changing the -25 modifier and different options for such change;

D. Preparation and coordination of appropriate meeting(s) and coordination of any and all necessary pre-meeting reviews and strategy sessions;

E. Coordination and completion of all necessary post-meeting work, including any necessary work on publication of statements of clarification; and

F. Preparation of a formal report to the AOA on the project.

Following the AOA's approval of the Academy's proposal, the AAO hired Consultant Nancy Edwards to research the issues and facilitate the development of a final document which could be presented to key officials at the Health Care Financing Administration. Ms. Edwards also arranged for and facilitated a September 9 meeting with top level HCFA officials in Baltimore.

Dr. Stowers and the AOA delegation were encouraged by the response from HCFA officials at the meeting and expected prompt attention to the various alternative strategies discussed at the meeting. ■

Reminder: AOA CME Cycle is at Half-Way Point

Physicians should take note of the fact that the 1995-97 AOA CME cycle has reached the half-way point. The three-year cycle runs from January 1, 1995, to December 31, 1997. By the end of the third year, all D.O.s must have a minimum of 150 hours of CME, 60 of which must be AOA Category 1-A or 1-B.

☆ District Stars ☆

News from TOMA/ATOMA District VI

By Mrs. Jerry W. Smith (Joy)

Members of TOMA and ATOMA District VI met at the Sierra Grill on September 17, 1996. Attending as special guests were four student doctors from the University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery in Des Moines, Iowa, who are doing externships in Houston.

Dr. Carl Mitten, TOMA District VI President, conducted the business meeting and introduced the guest speaker, John Loome, M.D., Professor of Medicine at the Baylor College of Medicine. Dr. Loome presented a slide lecture entitled, "Psychiatric Disorders in the Elderly."

The program and dinner were sponsored by Pratt Pharmaceuticals. The host was Doug Frainor.

Joy Smith, ATOMA District VI President, reported on activities planned for National Osteopathic Medicine Week, scheduled for November 3-9. Plans are underway for local doctors to attend the local high schools on Career Day. Dr. and Mrs. Deweese Campbell volunteered to visit Pasadena; Dr. and Mrs. Robert Prangle will visit Clear Creek; and Dr. and Mrs. Jerry Smith will visit the Klein school. Volunteers are needed for other districts. Beth Boudreaux, ATOMA Public Health and Education Chairperson, will purchase NOM Week materials.

It was reported that Mrs. William H. (Marguerite) Badger has donated a microscope and other medical supplies for Dr. Larry Pepper, medical missionary in Uganda. We appreciate her support.

Lois Campbell is busy planning the Christmas and Hanukkah party. Mark your calendar for Sunday, December 8, from 2-5 p.m., at Brady's Landing for a holiday lunch, music and good time. Santa always comes and brings surprises for our children and grandchildren.

Our next meeting, scheduled for November 12, will honor TOMA President Dr. Arthur J. Speece, III, of Burleson, and ATOMA President Shirley L. Bayles of Dallas. See you then!

TOMA District VI Officers

President - Carl Mitten, D.O.

Vice President - Sharron O'Day, D.O.

Recording Secretary - Jerry Wasserstein, D.O.

Treasurer - Sharron O'Day, D.O.

ATOMA District VI Officers

President - Joy Smith

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ATOMA News

By Lewis H. Isenberg
ATOMA Political Advisor

Any casual observer can see that this year's presidential election has brought with it plenty of political action and a wealth of legislative morsels to feed on. From legislation introduced by our president wishing reelection, to votes pressed and passed in Congress to give the impression that the political process is still alive, the many decisions made on health care and other issues in the near future will have lasting effects on the health of our country. The current year has had the standard lurches and starts of an election year, and the dormant issues that have surfaced will demand even more thoughtful and comprehensive action after the current binge has ended.

On the national scene, two new laws recently signed by the president will soon impact the business world. The bill to raise the minimum wage and provide offsetting tax relief to the businesses that will provide that wage increase will have a wide range of effects, depending on whose prognosis comes true. For the self-employed, this bill will increase the amount of deduction for insurance expenses to 80 percent by the year 2006 and it will create the availability of a new retirement fund with higher contribution limits and streamlined administration.

The second piece of legislation seems much more important to our organization. It centers around provisions for incremental health insurance reform. These easily digestible items include a medical expense deduction for long-term expenses and certain long-term care insurance premiums, a prohibition for a new employer's health coverage from excluding coverage for pre-existing conditions for any employee who was covered under another plan, and a five year pilot program to test tax-advantaged medical savings accounts. Even these small steps to add to the many market-driven changes in the medical profession seemed like huge leaps to a legislative body attempting to keep every player in this industry satisfied.

Closer to home, the Texas Legislature expects the number one issue facing them in 1997 to be healthcare. The regulation of HMOs and doctors has become the responsibility of state legislators, and they have a personal and professional interest in who decides what treatment a patient in an HMO should receive. "If and when the federal government passes new laws regulating health care, Texas may need to conform to these regulations, depending on how they are written. However, Texas cannot afford to wait on Washington to protect Texas residents," says Texas State Senator Chris Harris. "Because so many of us now have our coverage through HMO agreements, it is important to ensure that medical care decisions are made by the doctors."

These statements reflect a straightforward approach to the challenges facing Texas and other states, and we can hope that most legislators in our current legislative environment have the interests of all at heart. Certainly special interests will make their push, but those who make their decisions early and stand by those decisions will receive the most support from their constituents. It is imperative that we each determine where our elected officials stand now, before we go into the voting booth to determine who will make those decisions in the future. ■

ATOMA Sponsors Tour for Magnet Students

On September 30, an informational session and tour of the University of North Texas Health Science Center/TCOM was conducted for seniors attending the School of Health Professions at Townview Magnet Center, Dallas Independent School District. The tour was organized by ATOMA President Shirley L. Bayles, who notes that the students not only had the opportunity to tour the OMT lab, hyperbaric chamber, DNA lab and the computer lab, but were able to interact with faculty members and medical students as well.

Left to right: Mr. Lewis Seales, Multicultural Department Director, UNT/TCOM; Peggy Jones, Townview High School Coordinator; and ATOMA President Shirley Bayles.

Left to right: Mr. Seales, Ms. Jones, medical student; Mrs. Bayles; and Peggy Rodgers, ATOMA District V President.

Seniors with DNA Lab Director.

What's Happening In Washington, D.C.

• ***Tax Reform Delayed.*** On September 17, House Ways and Means Committee Chairman Bill Archer confirmed that his comprehensive legislative proposal for reforming the tax code would not be offered for several more months. Archer said that he wants more time to get grass roots support for the kind of radical tax structuring he envisions, and to assess the outcome of the November Presidential election. Archer has repeatedly stated that he wants to get the IRS out of the lives of taxpayers and to completely abolish the income tax.

• ***Big IRS Number.*** A recent report of the General Accounting Office confirms that the IRS presently has approximately 100,000 employees, who last year processed more than 200 million tax returns involving approximately 86 million refunds, 39 million calls for tax help, 1.4 million audits, and issuance of approximately 19 million collection notices for delinquent taxes.

• ***One Trillion Dollar Tax Break.*** The Joint Committee on Taxation recently confirmed that the tax cut proposed by Presidential nominee Bob Dole would total approximately $1.1 trillion over a ten year period. In contrast, the Joint Committee on Taxation confirmed that President Clinton's tax proposal would raise net revenues by approximately $63.9 billion over the ten year time frame.

• ***Weak Controls in IRS.*** The recently enacted Taxpayer Bill of Rights 2 requires that the IRS report to Congress every year on employee misconduct and taxpayer complaints. However, a recent report of the General Accounting Office confirms that the IRS does not have the right tools or controls in place to spot abuse when it occurs. The IRS has once again pledged to better track what it refers to as "taxpayer complaints" to meet the mandate under the new law.

• ***ADSAs Could Get Expensive.*** The proposed American Dream Savings Account (ADSA) would replace the nondeductible individual retirement account, would permit nondeductible contributions and would allow individuals to withdraw amounts on a tax free bases for specific purposes. In essence, it would be a tax free savings account for specific purposes According to a recent report of the Joint Committee on Taxation, the cost of this American Dream Savings Account would be only $2.8 billion over the next six years, but the cost would escalate to $18.5 billion from years seven to ten.

Watch Out for Those Employees

Nearly every private business owner is dependent upon human resources, imperfect, fallible human resources. In order to carry out the business objectives and advance the profit making plan, the business owner is required to hire employees and unleash them on the rest of the world.

The law extracts a price for this privilege. In general, the business owner is responsible and liable for those acts of his or her employees which are carried our within the scope of their employment. This is a true vicarious liability. It is one of the broadest forms of vicarious, third party liability in the law.

The scope of this vicarious liability should be a concern to every private business owner. Too often, the temptation is to toss up one's hands and conclude that since the responsibility exists, there is nothing that can be done about it. The truth is that steps can be taken to mitigate the exposure for the private business owner. It requires some planning and attention to detail, but this effort may pay off big. ■

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

Ten Years Ago in the "Texas D.O."

• Opening ceremonies for a hyperbaric oxygen treatment facility took place on November 11, 1986, at Texas College of Osteopathic Medicine. An anonymous donor supplied the funds to TCOM to purchase the equipment.

• President Reagan signed the Sixth Omnibus Budget Reconciliation Act, enacting deficit reductions and other changes approved by the 99th Congress. Under this Act, all physicians were to receive an increase in prevailing charges January 1, 1987, based on the percentage increase in the Medicare Economic Index.

• The Texas State Board of Medical Examiners, in their official count reflecting statistics for July 1 of each year, revealed that the number of licensed physicians in Texas had increased three percent since 1985, for a total of 27,846. The total represented 1,398 D.O.s and 26,448 M.D.s, a four percent growth for D.O.s during the year and a three percent growth for M.D.s. ■

Membership *On-The-Move*

We have "Knock out the FLU, Get Your Flu Shot!" postcards available for physicians. To receive a complimentary set, call Stephanie at 800-444-TOMA. We'll get them in the mail to you just in time for you to mail them to your patients before flu season begins.

HEALTH INSURANCE PORTABILITY and ACCOUNTABILITY ACT

(H.R. 3103 - Kassebaum/Kennedy)

Change for the Better?

The final conference agreement states that the purpose of this legislation is "to improve portability and continuity of health insurance coverage in the group and individual markets, to combat waste, fraud, and abuse in health insurance and health care delivery, to promote the use of medical savings accounts, to improve access to long-term care services and coverage, to simplify the administration of health insurance." The conference agreement was passed by the House on August 1, 1996, and the Senate on August 2, 1996. It was signed into law by the President on August 21.

Health insurance for physicians has long been like sleeping on a "bed of nails." However, recent state legislation, along with the above federal legislation, has opened up numerous new options and alternatives for physicians in the area of Health Insurance.

- **GUARANTEED ISSUE**
- **PORTABILITY OF COVERAGE**
- **GUARANTEED ACCESS AND RENEWABILITY**
- **MEDICAL SAVINGS ACCOUNTS**
- **DEDUCTIBILITY FOR THE SELF-EMPLOYED**
- **LONG-TERM CARE INSURANCE**

If you haven't reviewed your health insurance lately, now is the perfect time to do so. **TOMA** endorses **DEAN, JACOBSON FINANCIAL SERVICES, LLC** to handle the complexities and uncertainties of the health insurance environment for you.

DEAN, JACOBSON FINANCIAL SERVICES, LLC is recognized statewide for their expertise in insurance and related areas. So, regardless of your current situations with health coverage either individually or group, call **DEAN, JACOBSON FINANCIAL SERVICES, LLC** today to find out how these law changes may affect you.

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News From Osteopathic Health System of Texas

Wandering Monitors

OMCT's Geriatric Center of Excellence is making hospital stays easier and safer than ever for geriatric patients.

"We're trying to reduce the use of restraints and also prevent patients from falling - both in the hospital and at home," said geriatric clinical nurse specialist Katy Scherger, M.S.N., R.N.

In addition to raising awareness with prevention training and pamphlets on how to prevent falls, four areas of the hospital are now equipped with "wandering monitoring systems."

Patients with cognitive impairments who could normally wander out of the hospital unless restrained now have the freedom to roam their entire unit, thanks to a simple ankle bracelet. The bracelet holds a small cube in place around the ankle. Patients are free to travel throughout their entire unit, but if they come too close to outside doors or elevators, the anklet triggers a warning system.

"Only mobile patients who have a cognitive impairment wear the ankle bracelet," said Katy. "It gives them the most freedom while preventing injury."

Nurses are also using floor beds that sit only inches off the ground along with bed and chair alarms to encourage safe activity.

Floor beds give more freedom to patients who could fall out of a normal bed unless restrained. Patients who roll out of floor beds are at less risk for injury because the bed sits so low to the ground. Bed and chair alarms warn nursing staff and immobilized patients against trying to get up without assistance.

"People forget they may have had a leg amputated, and they try to walk," Katy said. "The bed and chair alarms automatically notify the nurse's station."

"Not everybody needs these measures," Katy said. "But we're trying to give people the most freedom we can while making sure they're safe. We're trying to fit the needs of the population."

Stephen Elected to AOHA Board of Trustees

Ron Stephen, Executive Vice President and Administrator of Osteopathic Medical Center of Texas, has been elected to serve on the American Osteopathic Healthcare Association (AOHA) Board of Trustees.

Founded in 1934, the AOHA is the only national association dedicated to the interests of osteopathic hospitals and health care systems. The Association's mission is to serve its members by promoting the health and welfare of the American public through effective leaderships; serving as the unified voice in areas of common interest for the advancement of osteopathic health care; and providing advocacy and education to ensure members' success.

The Association currently represents 100 osteopathic hospitals nationwide, more than 70 percent of which are teaching institutions.

Mr. Stephen's term will end at the close of the 1998 annual meeting. ■

Recent FDA Actions

• ***Elmiron***, approved by the FDA on October 1, is the first oral medication in the country for interstitial cystitis. The drug, when taken three times a day, helps restore the bladder lining, thought to be damaged in people with the condition. Interstitial cystitis affects an estimated 500,000 Americans, mostly women.

• ***Nasalcrom*** nasal spray, used for allergy relief and currently dispensed by prescription only, will soon be available over-the-counter. Scientific advisors to the FDA voted unanimously to allow such a move.

• ***TUNA*** (transurethral needle ablation), a procedure developed by Vidamed that uses radio waves instead of microwave therapy to treat enlarged prostates, was approved by the FDA on October 8. During the TUNA procedure, physicians thread needles into the prostate and use radio waves to heat them and kill the tissue. A study found that although patients' symptoms improved equally after standard surgery or TUNA, 13 percent of standard surgery patients suffered impotence and 4.3 percent became incontinent. None of the TUNA patients had such complications.

• ***Copolymer 1,*** a drug that allows multiple sclerosis patients to have fewer and milder attacks, is likely to win FDA approval, according to an FDA advisory panel. If approved, the drug, which was developed in Israel, would become the second type of drug available to treat people with mild to moderate forms of multiple sclerosis.

• ***Adrenal cortex extract,*** distributed by Phyne Pharmaceuticals of Scottsdale, Arizona, and labeled as a product of Hallmark Labs, Inc., is a subject of a nationwide alert by the FDA. Although promoted as a drug for weight loss, burn treatment and for lessening substance abuse addictions, an FDA spokesman said the preparation is not approved for any use and has not been shown to be effective for treatment of any medical condition. At least 54 people have contracted serious bacterial infections after receiving injections of adrenal cortex extract and 17 patients have had to undergo surgical incisions to drain abscesses.

"Physicians or consumers who have adrenal cortex extract products bearing 'Hallmark Labs' on the label should immediately stop using the product," according to the FDA announcement. Patients who have experienced swelling at the injection site, along with other signs of infection, should seek medical treatment immediately. The warning also advised persons who have the injectable product to call the FDA at 714-667-7416. ■

Blood Bank Briefs for Physicians

"Prevention of Transfusion-Associated Cytomegalovirus Infection Guidelines"

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

Forty percent to 80 percent of the adult population are infected with the Cytomegalovirus (CMV) at some point in their lives. Transmission may occur by oral secretions, genital secretions, breast milk, transplacentally during active infection and transfusion of cellular blood components. In the immunocompetent host, CMV most frequently causes pharyngitis. Occasionally, it presents a clinical picture indistinguishable from infectious mononucleosis. Once infection occurs, the CMV remains latent in circulating mononuclear cells, the cells of the respiratory tract, and in other tissues. Recurrence of the active infection results from reactivation of latent virus in CMV-seropositive individuals and may cause CMV disease more frequently than primary infection. However, certain individuals who are CMV-seronegative are at risk for transfusion-associated primary CMV infections and are most likely to benefit from preventive strategies.

These guidelines are primarily an educational resource for physicians and do not necessarily assure a successful medical treatment or result. CMV prevention strategies are currently indicated for:

a) CMV-seronegative allogeneic marrow or organ transplant recipient with a seronegative donor;

b) CMV-seronegative patients with hematologic malignancies or marrow failure states who are likely candidates for allogeneic marrow transplantation;

c) CMV-seronegative patients with organ failure who are likely candidates for organ transplantation;

d) Low weight (<1,200g) neonates born to CMV-seronegative mothers;

e) CMV-seronegative pregnant women;

f) Intrauterine transfusions;

g) CMV-seronegative HIV-infected patients;

h) Patients whose CMV serology is unknown but who otherwise fulfill the above criteria.

CMV prevention strategies may be considered for:

a) CMV-seronegative patients with Hodgkin's Disease or non-Hodgkin's lymphoma;

b) CMV-seronegative individuals getting immunosuppressive therapy, especially when shown to be susceptible to opportunistic infections;

c) CMV-seronegative candidates for autologous marrow transplantation;

d) CMV-seronegative individuals with hereditary or acquired cellular immunodeficiencies.

Blood Component Alternatives Available are:

a) Blood components from CMV-seronegative donors are preferred. Carter Blood Center performs on donor blood screening for CMV, IgM and IgA antibodies using FDA approved assays.

b) Filtered cellular blood components are now an acceptable alternative. These components can be used in emergencies that do not allow time for screening, transplant patients receiving large numbers of components and when no seronegative components are available. If filtered leukocyte-reduced components are used, there must be an ongoing quality assurance process to guarantee the effectiveness of the leukocyte depletion procedure for each component to achieve 1x10 6 leucocytes/unit or less. Quality assurance procedures must include prefiltration leucocyte load determinations to detect units with high numbers of "passenger" eucocytes that may require double filtrations and chamber counts post filtration.

c) Deglycerolized red blood cells may be considered as an alternative in emergencies when CMV-seronegative or filtered red blood cells are not available.

d) Only cellular blood components (Red Blood Cells and platelets) need be considered.

The numbers of patients with temporary or permanent states of immunodeficiency who require CMV-negative blood components are increasing. This had led to shortages in supply. CMV-seronegative blood donors are a minority in the donor population which compounds the problem. These guidelines are provided to assist in CMV prevention strategies and methods to prevent transmission associated CMV infections. ■

References:

Bowden RA, Sluchter SJ, Sayers M. et al. A comparison of filtered leucocyte-reduced and cytomegalovirus (CMV) seronegative red blood cells for prevention of primary cytomegalovirus infections after marrow transplant. Blood 1995;86;3598-3603.

Przepioka D, LePave G, Werch J, Liehtiger B. Prevention of Transfusion-Association Cytomegalovirus Infection Practice Parameter. AJCP 1996;106:163-169.

Medical Board Homepage Now On-Line

The Texas State Board of Medical Examiners ventured onto the World Wide Web in April. The Board's homepage contains articles, statistics, directories and other information useful to you.

The homepage provides information on: physician demographics in Texas; functions of the Board; the complaint process; history of the Board; making a complaint; continuing medical education; Board member biographies; obtaining a physician license; using on-line verification; rural health initiatives; mission statement; new rules; calendar of events; latest press release; policy statements; phone and fax directory; non-disciplinary rehabilitation order; directions to the Hobby building; and physician disciplinary statistics.

Coming soon to the homepage will be information on P.A.s and acupuncturists; the Medical Practice Act; Board rules; and the newsletter.

With any Web software package and an internet connection, you can access the homepage at:

http://www.tsbme.state.tx.us ■

Texas Osteopathic Medical Association

Political Action Committee

Established to protect and promote the interests of osteopathic medicine in Texas.

During the 74th Legislative Session, TOMA had many successes . . .

FACT: S.B. 965 was signed by Governor Bush on May 11, 1995. This law prevents Texas hospitals from discriminating against osteopathic physicians, who have osteopathic board-certification or residency training, when applying for staff privileges.

FACT: TOMA worked with the Texas Osteopathic Hospital Society to secure passage of H.B. 1965. This law allows the Insurance Commissioner to investigate and discipline managed care organizations that discriminate against osteopathic hospitals.

FACT: TOMA was a member of the Texas Med-Malpractice Coalition that was successful in securing passage of H.B. 971, a package of Medical Liability Reforms which should significantly reduce the number of non-meritorious lawsuits, tighten the standards for expert witnesses and eliminate pre-judgement interest on future damages.

The above is proof positive of the power of **your** Association! As you can see, TOMA has many friends in the Texas Legislature. Campaign season is upon us again and we need your help in replenishing our political war chest.

Your financial support to TOMA-PAC will provide us with the opportunity to develop and continue ongoing relationships with the legislators as TOMA fights for issues relevant to the osteopathic profession.

PLEASE MAKE A COMMITMENT TO SUPPORT YOUR PROFESSION BY CONTRIBUTING NOW!

END CONTRIBUTIONS TO:

TOMA-PAC
1415 Lavaca Street
Austin, Texas 78701-1634

Terry R. Boucher, MPH, Treasurer

Be sure to include your name, mailing address, occupation and name of employer with your contribution.

Note: TOMA-PAC contributions are not tax-deductible as a business expense. Federal law requires political committees to report the name, mailing address, occupation and name of employer for each individual whose contributions aggregate in excess of $200 in a calendar year.

Self's Tips & Tidings

Don Self & Associates

Medicare Denying Claims Due to Your ICD9 Codes

We have received at least 50 copies of EOMBs asking us what code C016 is on the Medicare EOMB. In almost every instance, the line following C016 has remark code M76. Remark code M76 states, "Incomplete/Invalid patient's diagnosis(es) and condition(s)." This is Medicare's way of saying that you didn't code your ICD9 code to the appropriate specificity. Effective July 1, Medicare began denying claims that were not coded to the appropriate 4th or 5th digit or codes that have the description: Unspecified, Not Otherwise Specified or Nonspecific Code. For instance, code 466.0 (Bronchitis Acute) is also used for Bronchitis Acute Catarrhal, Croupus, Mucopurulent, Pneumococcal, Simple, Subacute, with Brochospasm, and with Tracheitis. The problem is that you can't use this code and expect the claim to be paid because it is also the same exact code listed for NOS (Not otherwise specified). Consequently, you have to code the claim to a further degree, such as 491-21 (with COPD or Emphysema). I have had doctors ask me if they are supposed to lie to Medicare in order to be paid on the claim, and I have told them that I cannot say. It looks as though if a patient comes in with Simple Bronchitis Acute, Medicare will not pay on the claim, so you have to find another ICD9 code other than 466.0.

If the ICD9 code ends in a number 9, then the chances are very good that it is a "Nonspecific Code" and will be automatically denied; however, the 9's are not the only ones to watch for. The Nonspecific Codes could be coded with anything, so we can't take anything for granted and expect to be paid. Therefore, we recommend you double check every ICD9 code you use. Some of those that are routinely being used and denied are:

414.0 (Coronary Atherosclerosis)	Needs 5th digit of either 0, 1, 2 or 3
535.5 (Gastritis)	Needs 5th digit of either 0 or 1
427.9 (Cardiac dysrhythmias)	Too Non Specific - NOS Arrhythmia
429.2 (ASCVD)	Unspecified Code
780.4 (Dizziness)	Not otherwise Specified
599.0 (Urinary Tract Infection)	Unspecified Code
436 (CVA)	Unspecified Code
487.1 (Influenza)	Not Otherwise Specified
787.91 (Diarrhea)	Not Otherwise Specified

CLIA for Physician Labs May Go Away

There is a move by the Practicing Physician's Advisory Council (PPAC) to eliminate CLIA rules for private practitioner's labs. This move may be successful, as the PPAC has the ear of the Health Care Financing Administration.

Global Fee Periods - Can You Bill for E&M Code Also?

One question asked quite often is whether or not you can bill for an evaluation and management service on the same day as a minor procedure (a procedure having a one-day global fee period). The rule, according to HCFA and Medicare, is that you cannot, if it's related to the procedure. Of course, if the E&M service is for a different reason (such as diabetes management, hypertension follow-up, cholesterol management, etc.), and the procedure is not the primary reason for the visit, bill for the E&M also, making sure you use a different ICD9 code than the one you used for the procedure, and a 25 modifier on the E&M code. The following codes have NO global fee period and a modifier 25 is not necessary for the E&M service:

11300-11313	Shaving Lesions
11000	Surgical Cleansing
11001-11040	Additional Cleansing
11050-11052	Trim Lesions
19100	Breast Biopsy
19000	Drain Breast Lesion
46600	Diag. Anoscopy
45300-45309	Proctosigmoidoscopy
45330	Diag. Sigmoidoscopy
60001	Asp./Inj. Thyroid Cyst
88170	Fine Needle Aspiration

■

Billing for Flu Shots and E&M Services

Physicians should make sure they are billing correctly when filing claims for flu shots and E&M services.

G0008 is administration of the influenza vaccine and 90724 is the influenza immunization. The administration code G0008 should be used when a physician administers the vaccine to a patient. If the patient is seen by the physician for the sole purpose of receiving the vaccination, the physician cannot bill for an E&M service in addition to the influenza administration. A physician may only bill an E&M code in addition to G0008 and 90724 if the patient was seen for a separate condition or symptom. The following examples illustrate common situations involving influenza administration:

- A beneficiary makes an appointment with a physician to receive a flu shot. The physician can only bill for the influenza injection; he cannot bill Medicare or the patient for an office visit. The Medicare claim should only include G0008 and 90724.
- A beneficiary makes an appointment with a physician due to a rash on his leg. The physician treats the patient for the rash and also administers a flu shot during the same visit. In this case, the physician can bill Medicare for the appropriate E&M service (99202-99215) the administration code (G0008) and the vaccine code (90724).

Texas Society of the ACOFP Update

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

Most osteopathic physicians think that legislative oversight of Texas state health care agencies is a very important function. Equally important to the economic well-being of osteopathic physicians is physician oversight over their office billing procedures.

Some medical practices have higher turn-over rates for employees than others; however, quality assurance practices such as verification of charge profiles is needed in every medical office. This is especially true for osteopathic physicians who utilize and bill for osteopathic manipulative therapy (OMT).

When TOMA and the TxACOFP negotiate with third party payors for fair and equitable OMT rates, they are constantly reminded of data showing a substantial number of Texas D.O.s who submit claims for OMT with fees that are less than the approved rates paid by insurers.

One of the reasons for these lower OMT fees is the disparity between what Texas D.O.s charge for OMT (billed charges) and what they actually receive from third party payors (approved charges). Some office personnel are not always consistent in their billing practices since they know that the OMT approved charge is the maximum actual reimbursement they will receive from the third party payor. The end result is that over time, the billed charges for OMT tend to creep down to the approved charges of insurers. Unfortunately, in many cases, the physician profile for OMT also creeps lower as approved charges for OMT are billed, rather than the historical higher billing charges.

Texas osteopathic physicians who utilize OMT should periodically review their OMT office billing procedures to make sure that their profile charge data for OMT is correct and accurate. In the era of managed care, physician profiles are like financial credit reports; you have to check their validity periodically!

As the states are assuming more and more responsibility from the federal government over health care programs, there is a disturbing trend in the drafting of rules. HCFA has always been a thorn in the side of physicians by drafting federal rules and regulations which often had no relationship to the enabling legislation.

One of the positive aspects of Texas control of health care programs was not having to deal with HCFA. However, now there is a disturbing trend in Austin, Texas. Some Texas health care agencies are currently drafting rules and regulations which have no relationship to enabling legislation.

We do not need Texas health care agencies getting into the legislation business; that is the function of the Texas Legislature. We don't need proxies for HCFA doing business from Austin. What we do need is Texas legislative oversight over Texas health care agencies! We need to get rid of non-elected Texas health care legislators who are using their position in state government to bring about health care changes not called for in the enabling legislation.

One recent development in California may prove to be applicable in Texas regarding HMOs. California state officials are asking a private-sector organization to evaluate the quality of its health plans - to check the licensed HMOs' compliance with state laws governing managed health care. Independent review of managed health care in Texas is needed. This review should never be performed by an organization that can benefit financially as a result of their review.

As 1996 moves rapidly to completion and the tax man cometh, don't forget that a donation to the TOMA Building Fund is tax-deductible. Also, if you have not yet contributed to TOMA-PAC, now is a good time to invest in your future as an osteopathic physician in Texas. Our friends in the Texas Legislature need our help. If their calls for financial assistance go unheard by osteopathic physicians, will they hear our calls for legislative assistance in the upcoming Legislative session?

A reminder to our members - we have a new toll-free number: 888-TxACOFP. Some of our members have experienced difficulty calling the new 888 number. They found that the difficulty was in their own office phone system and had to have their phone management company correct the problem.

For those members who want to become ACOFP Fellows, there is new informational material on file spelling out this procedure. Copies can be obtained by calling Janet Dunkle, TxACOFP Executive Director, at 888-TxACOFP.

The TxACOFP would like to thank the Lubbock Osteopathic Foundation for their grant to obtain new computer equipment at our home office in Austin.

There will be a meeting of delegates and alternatives from the TxACOFP to the Congress of Delegates of the National ACOFP at TOMA's MidWinter meeting on February 15, 1997, at the Fairmont Hotel in Dallas. Any questions regarding this meeting can be addressed to Janet Dunkle at the above mentioned number.

We have not forgotten the revised copy of TxACOFP Bylaws. It will be published, along with a directory of our membership, in the near future.

On behalf of the TxACOFP Board of Governors, I want to wish everyone a Happy Thanksgiving. Despite the adversities and hardships of life for many Americans, this is still the greatest country on the face of the earth. Very few citizens of this country would be willing to trade places with citizens of other countries. That is why the United States of America will always have an immigration, rather than a migration, problem. ■

TEXAS STARS

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

Rene Acuna, D.O.
Bruce Addison, D.O.
Ted C. Alexander, Jr., D.O.
Richard Anderson, D.O.
Sara Apsley-Ambriz, D.O.
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ATOMA District II
Aus-Tex Printing and Mailing
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Patrick Haskell, D.O.
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News from the University of North Texas Health Science Center at Fort Worth

TCOM Alumnus, Bank Executive Honored at Convocation

Bank executive Robert M. Lansford addresses standing-room-only crowd at UNT Health Science Center at Fort Worth after receiving the TCOM Founders' Medal.

An 1986 graduate of the Texas College of Osteopathic Medicine and a Fort Worth bank executive were presented with the two highest awards of the University of North Texas Health Science Center at Fort Worth during the annual convocation officially welcoming this year's entering classes of the medical school and graduate school.

Robert M. Lansford, Senior Vice President and Trust Chairman of Bank One, Texas, received the TCOM Founders' Medal. A. Ray Lewis, D.O., was presented with the Mary E. Luibel Distinguished Service Award.

Lansford, who is President of the TCOM Advisory Council and a member of the health science center/TCOM Foundation Board of Directors, was recognized for his longtime support of the center and the osteopathic medical profession. President David M. Richards, D.O., told the standing-room-only crowd that "the UNT Health Science Center and osteopathic medicine have no better friend than Bob Lansford." Chancellor Al Hurley, Ph.D., reading from the citation accompanying the Founders' Medal, described Lansford as a "true pillar of his community."

A. Ray Lewis, D.O., TCOM Class of 1986, receives the Mary E. Luibel Distinguished Service Award from UNT Health Science Center Chancellor Alfred Hurley, Ph.D. (left), and President David M. Richards, D.O., (right), during convocation.

Dr. Lewis, owner of the East Fort Worth Medical Center and the medical director or staff physician at seven Fort Worth nursing homes, "exemplifies the values of the Mary E. Luibel Distinguished Service Award," according to the citation given to the family physician. Dr. Richards encouraged the incoming medical and graduate school students to "emulate Dr. Lewis' value system. He does not forget where he came from; he does not forget those who helped him along the way; and he does not forget the real purpose of medicine, to help others." Dr. Lewis is the first graduate of TCOM to receive the Luibel award.

Dr. Lewis told the new students that, each day, they should examine their motivation for choosing a medical career. "Our motivations have gotten misplaced," he said. "It is hurtful to see people - your patients, your neighbors, your friends - have the opinion that the physician's motivation is social gain - to get rich," he said. He asked each student to reaffirm and refocus on "what our motivation is for being in medicine and let us find a way to serve with humility and love."

Lansford also encouraged the students to "give back to the community." He said he was fortunate to work for a company that encourages its employees to do so. Lansford said he was honored to represent the health science center in the community. "We are a valued asset to the city of Fort Worth and the state of Texas," he added.

Health Advisories for International Travelers Now on Internet

Thanks to the Internet, travelers to virtually any country on earth can now obtain current health warnings and advisories for their intended destinations.

The new Web site address: **http://www.hsc.unt.edu/clinics/itmc/travel.htm** was recently announced by John Licciardone, D.O., Medical Director of the International Travel Medicine Clinic at the University of North Texas Health Science Center at Fort Worth.

Dr. Licciardone monitors health information as it is reported by international health and government agencies, including the World Health Organization and the U.S. Centers for Disease Control. His Web page covers health conditions of 215 countries in 16 areas of the world, from Afghanistan to Zimbabwe.

"We stress pre-travel precaution as the most important preparation for safe and healthy international travel," Dr. Licciardone said.

The clinic's new Internet Web site discloses worldwide infectious disease information: food and beverage precautions; swimming advisories; environmental risks and measures for injury prevention. It also describes such realities as the "meningitis belt" of sub-Saharan Africa as well as threats of malaria in India and the incidence of various dysenteries in Asia.

"Our purpose is not to alarm, but to arm the prospective traveler with sound advice, any needed vaccinations and some real-world information about the real world," said Dr. Licciardone.

The UNT Health Science Center's International Travel Medicine Clinic opened in 1990. Its mission is to prepare its clients - including business travelers, vacationers, missionaries, educators, researchers, students and even gamblers - to avoid health hazards while overseas. The clinic advises travelers who visit the Fort Worth facility on what to include in personal medical travel kits.

Dr. Licciardone stated that appointments for executives and employees of the clinic's corporate clients are made on 24 hours notice.

The International Travel Medicine Clinic is located at the UNT Health Science Center at 3500 Camp Bowie Boulevard, Fort Worth, and can be reached for appointments or information at 817-735-2608. "The clinic's Web page will be updated monthly or sooner, if health conditions anywhere in the world call for it," said Dr. Licciardone.

Health Science Center Awarded Grant to Encourage Careers in Health Professions

U.S. Rep. Pete Geren (D-Fort Worth) has announced the award of a $591,340 grant to the UNT Health Science Center to implement a summer enrichment program that encourages economically and educationally disadvantaged undergraduate students to consider careers in the health professions. The Health Careers Opportunities Program also helps prepare the students to successfully compete in the qualifying examinations such as the Medical College Aptitude Test (MCAT). The three-year grant is from the Bureau of Health Professions.

The national HCOP program has proven successful in guiding many of the students into health careers including medicine, dentistry, nursing or other allied health professions. Officials of the health science center believe in the program so strongly that local funds were used to continue the local program one year when federal funding was not available

About 20 students from across Texas will be selected to participate in the HCOP project beginning in June, 1997. In addition, the grant includes funds for a prematriculation program for 10 students accepted for admission to TCOM but who may be educationally disadvantaged. They will be on campus eight weeks before the start of their medical school courses to learn study habits, note and test taking, and reading and comprehension abilities. "This program gives the students a jump start in building the skills necessary to successfully complete their medical education," said Adela Gonzalez, Associate Vice President for Multicultural Affairs.

Outstanding Teachers, Department Recognized at Faculty Meeting

Three faculty members and one department at the UNT Health Science Center were honored at the faculty meeting on September 20. The educational awards were presented by Executive Dean Benjamin Cohen, D.O., to: William McIntosh, D.O., associate professor, Department of Internal Medicine, the Clyde Gallehugh Award; Nizam Peerwani, M.D., associate professor, Department of Pathology, the Golden Apple Award for Outstanding Preclinical Teaching; Frederick Schaller, D.O., associate professor, Department of Internal Medicine, the Gold Apple Award for Outstanding Clinical Teaching; and the Department of Internal Medicine, the Department of the Year for Excellence in Education: 1995-96.

An additional award, Educator of the Year, is currently under development.

The preclinical and clinical teaching awards are a recognition and reaffirmation of the decision made by each graduating class and presented at the Senior Banquet.

Dr. Luibel Honored by AOA

George J. Luibel, D.O., Fort Worth physician and a founder of TCOM, was presented the highest award of the American Osteopathic Association at the AOA's 101st Annual Convention and Scientific Seminar in Las Vegas, Nevada.

Dr. Luibel received the AOA Distinguished Service Certificate which is granted "only to deserving members for outstanding accomplishments in scientific or professional affairs," according to the letter notifying Dr. Luibel of his selection. "Your award is made in recognition of your outstanding service in osteopathic education and organization," wrote AOA President John P. Sevastos, D.O.

MIT Researcher Honored by UNT Health Science Center

Vernon R. Young, Ph.D.

Vernon R. Young, Ph.D., D.Sc., whose research helped set minimum protein requirements on a global basis, was honored October 21 by the UNT Health Science Center.

Dr. Young, professor of nutritional biochemistry at the Massachusetts Institute of Technology, received the Roger J. Williams Award in Preventive Nutrition.

Dr. Young's early work involved determining total protein requirements by humans from infancy through advanced age. His later work with the World Health Organization and the Food and Agriculture Organization produced guidelines for protein and specific amino acids requirements which now are world standards. Due to the widespread incidence of malnutrition in developing countries, Dr. Young's findings are highly relevant to international nutritional and agricultural policies.

The Roger J. Williams Award, which includes a cash prize of $10,000, is made possible through an endowment from E. Bruce and Virginia Street of Graham, Texas. It is presented in recognition of outstanding contributions to the prevention of disease and promotion of health through nutrition. The award commemorates the pioneering nutritional research of Roger J. Williams, Ph.D., founding director of the Clayton Foundation Biochemical Institute of the University of Texas at Austin.

Dr. Young also is a biochemist in the Department of Surgery at Massachusetts General Hospital and Harvard Medical School, and is director of the Mass Spectrometry Facility at the Shriners Burns Institute in Boston. He was elected to the National Academy of Sciences in 1990 and was elected a member of the Institute of Medicine, National Academy of Science, in 1993.

Dr. Young previously served as director of the American Board of Nutrition and president of the American Institute of Nutrition.

Dr. Young's undergraduate and Doctor of Science degrees were received from the University of Reading in England; he earned his doctorate in nutrition from the University of California at Davis. He has been a member of the faculty at MIT since 1966.

Previous recipients of the Roger J. Williams Award in Preventive Nutrition were Scott M. Grundy, M.D., Ph.D., professor of medicine, University of Texas Southwestern Medical Center at Dallas; Bruce N. Ames, Ph.D., professor of biochemistry, University of California at Berkeley; Richard J. Wurtman, M.D., professor of neuroendocrine regulation, Massachusetts Institute of Technology; Robert L. Levy, M.D., professor of medicine, Columbia University; Hector F. DeLuca, Ph.D., professor of biochemistry, University of Wisconsin at Madison; and William Shive, Ph.D., professor of chemistry, University of Texas at Austin. ■

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