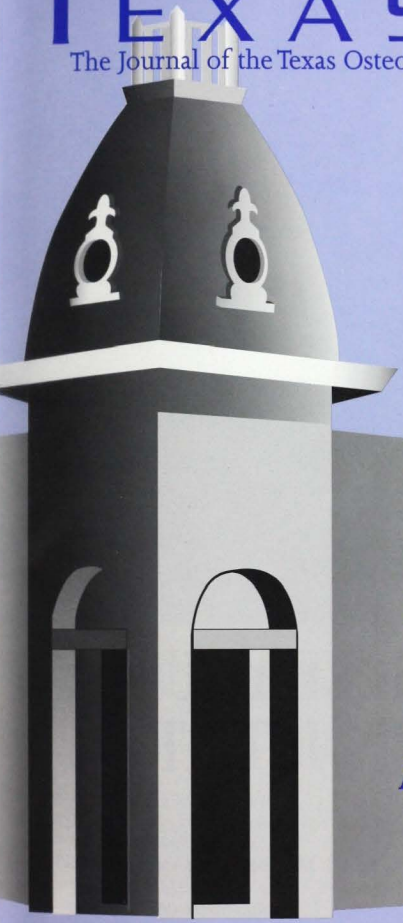
TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association



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for the

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"Building for the Next Millennium"

June 18 - 21, 1998

Turn to page 22 to see the line up of topics!

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

MARCH 1998

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Articles in the ***Texas D.O.*** that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising", according to Texas 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.

Calendar of Events

APRIL

17-18
12th Annual Spring Update for the Family Practitioner
Sponsored by the University of North Texas Health Science Center at Fort Worth

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

22-26
1998 Palmetto Coast Regional Osteopathic Scientific Conference
Sponsored by the South Carolina Osteopathic Medical Association

Location: Kiawah Island Golf and Tennis Resort Kiawah Island, SC
Contact: Dawn K. Mirran 800-499-5751 FAX 704-554-9851

23-26
98th Annual Convention: "OOA Derby Days"
Sponsored by the Oklahoma Osteopathic Association

Location: Shangri-La Resort, Afton, OK
CME: 26 CME hours
Contact: 800-522-8379 or 405-528-4848

APRIL 29 - MAY 2
90th Annual Clinical Assembly
Sponsored by the Pennsylvania Osteopathic Medical Association

Location: Adam's Mark Hotel Philadelphia, PA
CME: Over 40 AOA CME credits anticipated
Contact: 817-939-9318 or 800-544-POMA

APRIL 30-MAY 3
101st Annual Convention
Sponsored by the Indiana Association of Osteopathic Physicians and Surgeons

Location: Radisson Hotel, Evansville, IN
CME: 30 hours anticipated
Contact: IAOPS, 800-942-0501 or 317-926-3009

JUNE

4-7
1998 Chesapeake Regional Osteopathic Scientific Conference
Sponsored by the Maryland Association of Osteopathic Physicians

Location: Princess Bayside Resort Ocean City, MD
Contact: Dawn K. Mirran 800-499-5751 FAX 704-554-9851

18-21
TOMA's 99th Annual Convention & Scientific Seminar
Sponsored by the Texas Osteopathic Medical Association

Location: Austin Renaissance Hotel Austin, TX
CME: 26 AOA credits
Contact: TOMA, 800-444-8662 or 512-708-8662

24-28
18th Annual Primary Care Update
Sponsored by the University of North Texas Health Science Center at Fort Worth

Location: South Padre Island, TX
CME: 24 hours
Contact: Office of Continuing Medical Education 817-735-2539 or 800-987-2CME

25-28
96th Annual CME Convention and Scientific Exhibition
Sponsored by the Georgia Osteopathic Medical Association

Location: Opryland Hotel Convention Center Nashville, TN
CME: 25 category 1-A
Contact: GOMA, 2160 Idlewood Road Tucker, GA 30084 770-493-9278

16-19
Update on Office Procedures for the Primary Care Physician
Sponsored by the University of North Texas Health Science Center at Fort Worth

Location: Antlers Doubletree Hotel Colorado Springs, CO
CME: 24 hours
Contact: Office of Continuing Medical Education 817-735-2539

Due to the number of calendar events, **FOR YOUR INFORMATION** is located on page 34 of this issue.

MidWinter Memories

The 42nd MidWinter Conference and Legislative Symposium was well attended last month in Dallas. The Fairmont Hotel in the Arts District served as the background for this meeting. Program Chairman, Ray L. Morrison, D.O. complied an interesting and diverse group of lectures that were well received by all of the attendees. The Texas Osteopathic Medical Association would like to thank Dr. Morrison as well as all of the speakers, exhibitors and participants who helped make this program a success!

SGA President Roberta Abbott helps out at the TxACOFP booth

Robert Peters, D.O., Ruby Peters (C) and Gene Zachary, D.O. take a break in the Exhibit Hall between CME sessions.

TOMA President, R. Greg Maul, D.O. (R) presents an appreciation gift to Ray L. Morrison, D.O., MidWinter's Program Chair.

The AOA delegation members discussed many issues at their MidWinter meeting.

Country Dean (L) and Joseph Montgomery-Davis, D.O. visit in the Exhibit Hall.

Student Doctors, Niki Coverdale and Denise Casper, discuss the benefit of ACOFP membership with Delbert McCaig, D.O.

TOMA Executive Director, Terry Boucher, and Hector Lopez, D.O. share a fun moment at the MidWinter.

Texas ACOFP News

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

Apparently there is a new trend developing on the part of the legal profession in Texas. The task of opening one's mail is made harder when spotting a letter from a law firm. I usually put these types of letters to the side until the end of my day, as I don't want to spoil any day so early in the morning.

The vast majority of the "fat" letters from attorneys are requests for medical records pertaining to the reference cause to which is attached a subpoena duces tecum. A written question deposition is usually attached which must be completed and returned, whether or not you have any records in your possession. When completed, you have to sign the deposition before a Notary Public and send the records and completed deposition to the law firm by a specific date.

Apparently, this legal proceeding has undergone some changes which are detrimental to physicians; more oral depositions are being required.

Now physicians are being served with a subpoena duces tecum under Rule 178 T.R.C.P., along with a ten dollar check, to appear in person before a Certified Court Reporter to testify for evidence in a suit which is pending and to continue their attendance from day to day until discharged by the attorney taking said deposition.

These are not suits against physicians. They are suits involving physicians' patients where the physician is being called by the plaintiff or the defendant to give an oral deposition, based on the medical records at a time and place specified by the subpoena.

The physician can be called to be a witness against his or her patient. It is a "catch-22" situation! The physician has to retain a lawyer to advise and represent him or her at the oral deposition hearing. This is not handled by the physician's medical liability insurance company.

If called to testify against a patient, a physician must get a release from the patient which allows testimony without any legal liability for the good faith disclosure of records and information. Without such a release, the physician must invoke the doctor/patient privileges rather than breach patient confidentiality.

The expense of retaining a lawyer, traveling to and from the deposition site, coupled with your absence from your office for an entire morning or a whole day, is not compensated by a ten dollar check.

The subpoena duces tecum does not have to be signed by a judge and is usually signed by a Certified Court Reporter in and for the state of Texas.

Another Texas osteopathic physician in El Paso received a 10 dollar subpoena to give an oral deposition in a site located in San Antonio in a very short time period. After much discussion, the physician was excused. It can happen to you!

The subpoena duces tecum process in Texas is seriously flawed. TOMA will have to go to the Texas Legislature to attempt to change the current process. At a minimum, a judge's signature should be required on a subpoena duces tecum that requests an oral deposition from a physician called to give testimony regarding his or her patient. Most Texas judges are elected officials; Certified Court Reporters are not Texas elected officials and cannot be removed by the ballot process.

I will now switch to Workers' Compensation. The Texas Workers' Compensation Commission (TWCC) guideline for the upper extremity still has manipulation and acupuncture in its treatment tables.

At the last Medical Advisory Committee meeting of the TWCC on January 16, it was revealed that the 5 percent threshold requirement applied to manipulation and acupuncture was not applied to the other treatment modalities listed in the Lower Extremity Treatment Guideline (LETG). The TWCC selectively applied a standard to two modalities in a treatment guidelines without applying it to all the modalities listed. This is blatantly discriminatory!

At this time, the TWCC's LETG is being distributed with manipulation and acupuncture deleted from many treatment tables. It is anticipated that legal actions will be taken against the TWCC for manipulation and acupuncture, which do not meet their 5 percent threshold requirements, are not restored to the LETG treatment tables.

It was a very interesting discussion on January 16 as to who recommended removal of manipulation and acupuncture from the various treatment tables listed in the LETG. The adverse comments allegedly came from members of the TWCC focus groups looking at the LETG. However, the vocation of the focus group members looking at the LETG is not known. This strikes me as being strange because the TWCC focus group I attended in McAllen on January 21 had TWCC employees from Austin taking notes and the members all wore name tags.

Harold Lewis, D.O., the TOMA alternate to the TWCC MAC, Terry Boucher, TOMA Executive Director, and myself are working hard to get manipulation and acupuncture back in the appropriate treatment tables in the LETG. We are also working hard to keep manipulation and acupuncture in the appropriate tables in the UETG. The five percent threshold rule of the TWCC must go or be applied equally to all treatment modalities listed. It is not medical, it is political!

Your personal Texas State Senator and Representative should be made aware of this discriminatory treatment of osteopathic physicians and the patients they treat under the current TWCC LETG.

This is yet another example of why Texas osteopathic physicians need to contribute to TOMA-PAC. The TMA is neutral on osteopathic special issues such as OMT. The squeaky wheel gets the grease - no squeak, no grease in Austin.

There is another issue that has the potential to impact in a negative way on Medicare patients who need and seek OMT. The government is working to implement resource-based Medicare practice expense values next year, and HCFA has suggested an across-the-board 50 percent cut in practice expense values for non-surgical office procedures that are provided in conjunction with a physician visit. It is crucial for the osteopathic profession that OMT be exempted from this policy.

In closing, I want to wish everyone a happy St. Patrick's Day on behalf of the Texas ACOFP Board of Governors.

TOMA Urges Support for ERISA Exemption Bills

Managed care organizations and other insurance companies have long taken advantage of a legal loophole to avoid accountability when their negligent decisions harm patients. Physicians can take action now to support a federal bill that would remove that loophole.

The federal Employee Retirement Income Security Act (ERISA) was designed to protect self-funded employee retirement plans, but for many years it has been applied in countless courtrooms across the country in ways counter to the law's intent. For instance, if the decision of a managed care organization resulted in a patient's harm, the organization could avoid legal accountability by claiming that as a federal law, ERISA preempts any state legal action against the organization. This strategy has been effective in protecting insurers and health maintenance organizations, leaving physicians, hospitals and other health care providers as the only defendants in such lawsuits.

Now, Senator Richard Durbin (D-IL) is sponsoring SB 1136, which says ERISA does not preempt a state's ability to hold managed care organizations liable when they deny necessary medical care.

TOMA asks its members to call or write Senator Phil Gramm (R-TX) and Senator Kay Bailey Hutchison (R-TX) and urge them to support and cosponsor SB 1136. Also, ask your congressional representatives to support and cosponsor Rep. Charles Norwood's HR 2960, which also says ERISA cannot preempt states' rights.

Senators Gramm and Hutchison can be contacted at the following addresses and telephone numbers;

The Honorable Phil Gramm
The United States Senate
Washington, D.C. 20510
202-224-2934
FAX 202-228-2856

The Honorable Kay Bailey Hutchison
The United States Senate
Washington, DC 20510
202-224-5922
FAX 202-224-0776

TRICARE News

Non-Participating Providers No Longer Required to File Claims for TRICARE Standard Patients

Authorized providers of care who see TRICARE Standard-eligible patients, but who don't "participate" in TRICARE Standard, are no longer required to file claims on behalf of their TRICARE Standard patients.

The requirement was eliminated effective November 18, 1997, with the signing into law of the Department of Defense Authorization Act of 1998 (Public Law 105-85). It returns the claim-filing process to the status that existed before October 1, 1996, when the requirement to file claims was imposed on non-participating providers by a previous federal law.

The change means that patients who receive care from a non-participating provider may file the claims themselves, without requesting a waiver, if the non-participating provider declines to file the claim.

Patients may also file claims for any care received before the November 18 effective date of the change, as long as the deadline for filing claims for the care hasn't come and gone. The claim filing deadline for outpatient care is one year from the date the service was received. For inpatient care, it's one year from the date of discharge from the inpatient facility where the care was received.

Participating TRICARE and network providers of care must accept the TRICARE allowable charge as the full fee for the care patients receive. They are also required to file the claims with the regional TRICARE contractor.

Questions & Answers

on Medicare Private Contracts

Q1. What is a "private contract" and what does it mean to a Medicare beneficiary who signs it?

A As provided in section 4507 of the Balanced Budget Act of 1997, a "private contract" is a contract between a Medicare beneficiary and a physician or other practitioner who has "opted out" of Medicare for two years for all covered items and services he or she furnishes to Medicare beneficiaries. In a private contract, the Medicare beneficiary agrees to give up Medicare payment for services furnished by the physician or practitioner and to pay the physician or practitioner without regard to any limits that would otherwise apply to what the physician or practitioner could charge.

Q2. What has to be in a private contract and when must it be signed?

A The private contract must be signed by both parties before services can be furnished under its terms and must state plainly and unambiguously that by signing the private contract, the beneficiary or the beneficiary's legal representative:

- Gives up all Medicare coverage of, and payment for, services furnished by the "opt out" physician or practitioner;

- Agrees not to bill Medicare or ask the physician or practitioner to bill Medicare;

- Is liable for all charges of the physician or practitioner, without any limits that would otherwise be imposed by Medicare;

- Acknowledges that Medigap will not pay towards the services and that other supplemental insurers may not pay either; and

- Acknowledges that he or she has the right to receive services from other physicians and practitioners for whom Medicare coverage and payment would be available.

The contract must also indicate whether the physician or practitioner has been excluded from Medicare. Also, a contract is not valid if it is entered into by a beneficiary or by the beneficiary's legal representative when the Medicare beneficiary is facing an emergency or urgent health situation.

Q3. Who can "opt out" of Medicare under this provision?

A Physicians and practitioners can "opt out" of Medicare. For purposes of this provision, physicians include doctors of medicine and osteopathic medicine. Practitioners include physician assistants, nurse practitioners, clinical nurse specialists, certified registered nurse anesthetists, certified nurse midwives, clinical social workers, and clinical psychologists.

The law does not define physician, for purposes of this provision, to include optometrists, chiropractors, podiatrists, dentists, and doctors of oral surgery; therefore, they may not opt out of Medicare and provide services under private contract. Also, physical therapists in independent practice and occupational therapists in independent practice cannot opt out because they are not within the law's definition of either a "physician" or "practitioner".

Q4. Can physicians or practitioners who are suppliers of durable medical equipment (DME), independent diagnostic testing facilities, clinical laboratories etc., opt out of Medicare for only these services?

A No. If a physician or practitioner chooses to opt out of Medicare, it means that he or she opts out for all covered items and services he or she furnishes, even if those items or services are covered under a different benefit. Physicians and practitioners cannot have private contracts that apply to some covered services they furnish but not to others. For example, if a physician or practitioner provides laboratory tests or durable medical equipment and chooses to opt out of Medicare, then he or she has opted out of Medicare for payment of lab services and DME as well as for professional services. If a physician who has opted out refers a beneficiary for medically necessary services, such as laboratory, DME or inpatient hospitalization, those services would be covered. (See #18.)

Q5. How can participating physicians and practitioners opt out of Medicare?

A To opt out of Medicare, a participating physician must first terminate his or her Medicare Part B participation agreement. Practitioners do not have participation agreements since the statute requires that assignment be accepted for all items and services they furnish.

At this point, the Part B participation agreement may be terminated only effective with the beginning of the year. Hence, a physician who participates in Part B of Medicare in 1997 would need to terminate the agreement during the Part B participation enrollment period for 1998 to be able to opt out of Medicare at any point in 1998. However, HCFA is exploring whether it would be administratively possible to permit physicians to terminate their participation agreement at times other than the annual enrollment period.

Q6. What happens if a physician who is a member of a up practice opts out?

A member of a group practice may enter into a private ıtract under section 4507 and opt out of Medicare, without ecting the ability of the other members of the group practice to vide and bill for services they furnish to Medicare beneficiaries. Medicare payment may be made to the group directly or ıugh an organization paid on a capitated basis for services ıished by the physician or practitioner who has opted out.

Q7. Can organizations that furnish physician or practitioner vices opt out?

No. Corporations, partnerships, or other organizations bill and are paid by Medicare for the services of physicians practitioners who are employees, partners or have other ıngements that meet the Medicare reassignment-of-benefits s cannot opt out since they are neither physicians nor ctitioners.

Physicians and practitioners who reassign benefits to anizations that participate in Medicare may not opt out ause they are bound by the participation agreement signed by organization that bills and is paid for their services. If a sician or practitioner has reassigned benefits to an anization that participates in Medicare and wants to opt out, ıer the organization should terminate its participation eement or the physician or practitioner should terminate the ssignment of Medicare benefits to the organization.

Q8. Can a physician or practitioner have "private contracts" h some beneficiaries but not others?

No. The physician or practitioner who chooses to opt of Medicare may provide covered care to Medicare ıeficiaries only through private agreements, regardless of who s and is paid for the services.

To have a "private contract" with a beneficiary, the physician ractitioner has to opt out of Medicare and file an affidavit with Medicare carriers to which he or she would submit claims, ising that he or she has opted out of Medicare. The affidavit st be filed within 10 days of entering into the first "private ıtract" with a Medicare beneficiary. Once the physician or ctitioner has opted out, such physician or practitioner must er into a private contract with each Medicare beneficiary to om he or she furnishes covered services (even where Medicare ment would be on a capitated basis or where Medicare would an organization for the physician's or practitioner's services to Medicare beneficiary), with the exception of a Medicare ıeficiary needing emergency or urgent care.

Physicians who provide services to Medicare beneficiaries olled in the new Medical Savings Account (MSA) nonstration created by the BBA of 1997 are not required to er into a private contract with those beneficiaries and opt out Medicare for two years under section 4507.

Q9. What has to be in the "opt out" affidavit?

A To be valid, the affidavit must:

- Provide that the physician or practitioner will not submit any claims to Medicare for any item or service provided to any Medicare beneficiary during the 2 year period beginning on the date the affidavit is signed;

-Provide that the physician or practitioner will not receive any Medicare payment for any items or services provided to Medicare beneficiaries;

- Identify the physician or practitioner sufficiently that the carrier can ensure that no payment is made to the physician or practitioner during the opt out period. If the physician has already enrolled in Medicare, this would include the physician's or practitioner's Medicare uniform provider identification number (UPIN), if one has been assigned. If the physician has not enrolled in Medicare, this must include the information necessary to be assigned a UPIN;

- Be filed with all carriers who have jurisdiction over claims the physician or practitioner would otherwise file with Medicare and must be filed no later than 10 days after the first private contract, to which the affidavit applies, is entered into; and

- Be in writing and be signed by the physician or practitioner.

Q10. Where and when should the "opt out" affidavit be filed?

A The "opt out" affidavit must be filed with each carrier that has jurisdiction over the claims that the physician or practitioner would otherwise file with Medicare and must be filed within 10 days after the first private contract to which the affidavit applies is entered into.

Q11. How often can a physician or practitioner "opt out" or return to Medicare?

A Pursuant to the statute, once a physician or practitioner files an affidavit notifying the Medicare carrier that he or she has opted out of Medicare, he or she is out of Medicare for two (2) years from the date the affidavit is signed. After those two years are over, a physician or practitioner could elect to return to Medicare or to "opt out" again.

Q12. Can a physician or practitioner "opt out" for some carrier jurisdictions but not others?

A No. The "opt out" applies to all items or services the physician or practitioner furnishes to Medicare beneficiaries, regardless of the location where such item or service is furnished.

Q13. What is the effective date of the "opt out" provision?

A A physician or practitioner may enter into a private contract with a beneficiary for services furnished no earlier than January 1, 1998. The physician or practitioner must submit the affidavit to all pertinent Medicare carriers within 10 days of the date the first private contract is signed by a Medicare beneficiary.

Q14. Does the statute preclude physicians from treating Medicare beneficiaries if they treat private pay patients?

A No. Medicare does not preclude physicians from treating Medicare beneficiaries if they treat private pay patients, whether they are persons under age 65 or seniors who choose not to enroll in Part B.

Q15. Do Medicare rules apply for services not covered by Medicare?

A If Medicare does not cover a service, Medicare rules, including opt-out rules, do not apply to the furnishing of the noncovered service. For example, Medicare does not cover hearing aids; therefore, there are no limits on charges for hearing aids and beneficiaries pay completely out of their own pocket if they want hearing aids.

Q16. Is a private contract needed for services not covered by Medicare?

A No. Since Medicare rules do not apply for services not covered by Medicare, a private contract is not needed. A private contact is needed only for services that are covered by Medicare and where Medicare may make payment if a claim was submitted.

A physician or practitioner may furnish a service that Medicare covers under some circumstances but which the physician anticipates would not be deemed "reasonable and necessary" by Medicare in that particular case (e.g., multiple nursing home visits, some concurrent care services, two mammograms within a twelve month period, etc.). If the beneficiary receives an "Advance Beneficiary Notice" that the service may not be covered by Medicare and that the beneficiary will have to pay for the service if it is denied by Medicare, a private contract is not necessary to bill the beneficiary if the claim is denied.

Q17. What rules apply to urgent or emergency treatment?

A The law precludes a physician or practitioner from having a beneficiary sign a private contract when the beneficiary is facing an urgent or emergency health care situation.

When a physician or a practitioner, who has opted out of Medicare, treats a beneficiary with whom he does not have a private contract in an emergency or urgent situation, the physician or practitioner may not charge the beneficiary more than the Medicare limiting charge for the service and must submit the claim to Medicare for the emergency or urgent care. Medicare payment may be made to the beneficiary for the Medicare covered services furnished to the beneficiary.

Q18. Will Medicare make payment for services that are ordered by a physician or practitioner who has opted out of Medicare?

A Yes, provided the "opt out" physician or practitioner ordering the service has acquired a uniform provider identification number (UPIN).

Q19. Clinical psychologists and clinical social workers are currently not recognized by and enrolled by Medicare unless they meet certain criteria specified by HCFA, some of which are voluntary. Are the requirements for opting out of Medicare different for these practitioners?

A No. A clinical psychologist or clinical social worker must meet the affidavit and private contracting rules to opt out of Medicare.

Q20. What is the relationship between an Advance Beneficiary Notice and a private contract?

A A physician or practitioner may furnish a service that Medicare covers under some circumstances but which the physician anticipates would not be deemed "reasonable and necessary" under Medicare program standards in that particular case (such cases are also referred to as "medical necessity" denials). If the beneficiary receives an "Advance Beneficiary Notice" that the service may not be covered by Medicare and that the beneficiary will have to pay for the service if it is denied by Medicare, a private contract is not necessary to bill the beneficiary if the claim is denied.

Q21. Are there any situations where a physician or practitioner who has not opted out of Medicare does not have to submit a claim for a covered service provided to a Medicare beneficiary?

A Yes. A physician who has not opted out of Medicare must submit a claim to Medicare for services that may be covered by Medicare unless the beneficiary, for reasons of his or her own, declines to authorize the physician or practitioner to submit a claim or to furnish confidential medical information to Medicare that is needed to execute a proper claim. Examples would be where the beneficiary does not want information about mental illness or HIV/AIDS to be disclosed to anyone. The balance billing limits applicable to the physician or practitioner would still apply. Moreover, if the beneficiary or their legal representative later decides to authorize the submission of a claim for the service and asks the physician or practitioner to submit the claim, the physician or practitioner must do so.

Q22. How do the private contracting rules work when Medicare is the secondary payer?

A When Medicare is the secondary payer, and the physician has opted out of Medicare, the physician has agreed to treat Medicare beneficiaries only through private contract. The physician or practitioner must therefore have a private contract with the Medicare beneficiary, notwithstanding that Medicare is the secondary payer. Under this circumstance, no Medicare secondary payments will be made for items and services furnished by the physician or practitioner under the private contract.

AFFIDAVIT REGARDING SERVICES PROVIDED TO MEDICARE PATIENTS

I, _____, D.O., agree not to submit any claims for any items or services provided to any Medicare beneficiaries, and will not receive any reimbursement or amount for any such item or services from Medicare during the two year period beginning on _____/_____/_____ and ending _____/_____/_____. If this provision in the Balanced Budget Act of 1997 should be changed through legislation and a two-year waiting period is no longer required, this affidavit becomes null and void.

Name: (print) _____, D.O.

Signature: _____

Date: _____ UPIN#: _____

State of Texas

County of _____

Date of Acknowledgment:

Acknowledgment of:

This instrument was acknowledged before me this date by the person above subscribed, and if subscribed in a representative capacity, then for the principal named and in the capacity indicated.

_____

Notary Public

My commission expires: _____/_____/_____

PATIENT/PHYSICIAN/MEDICARE FINANCIAL AGREEMENT

I, _____ agree to be personally, financially liable for all charges, without any limits that otherwise would be imposed, for all Medicare covered services provided by _____, D.O. from the date of this contract to _____/_____/_____ (a minimum of 2 years is required by statute).

I agree not to bill or ask my physician to bill Medicare, Medigap or other supplemental insurer for these services. I understand that I retain the right to receive services from other physicians and practitioners for whom Medicare coverage and payment would be available.

Furthermore, I am currently not facing an emergency or urgent health situation.

Signed: _____
(Medicare Beneficiary)

Name: (print)_____

Date: _____

I, _____, D.O. acknowledge this contract and further state that I have not been excluded from Medicare.

Signed: _____
(Physician)

Date: _____ UPIN#:_____

***NOTE: Additional provisions could be added to this agreement relating to when payment for services are expected, e.g. payments for services are due at time services are performed, etc.*

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Federal Government Steps Into Retirement Planning Now - So It Can Step Out Later

The federal government has finally made a New Year's Resolution it has chance of keeping: putting the onus on Americans to provide their own retirement.

Individuals who take Uncle Sam up on his more than generous offer stand to reap significant benefits, while the government will be positioned to achieve a more important goal - permanently extricating itself from the retirement business.

The newly implemented Taxpayer Relief Act is some of the most important legislation to come out of Washington in recent years, not only for what it provides Americans saving for retirement, but also how it views its role in the lives of retired Americans.

Quite simply, that view is evolving (many would say reverting) from benevolent entitlement provider to reluctant safety net provider. Don't believe it? Consider data from the Social Security Administration, which points out that on average, 38 percent of retirement income for persons over 65 is derived from Social Security payments.

To more fully articulate this point, we should review again some other facts about Social Security:

- The Social Security Act was passed in 1935 as a means of providing a nationwide safety net for needy Americans aged 65 and over.

- Then as now, benefits to recipients were provided by the revenues collected from working Americans. By 1960, the ratio had fallen to 15 workers for every retiree. Today, it's about three-and-a-half to one. And in 2029, when the last of this nation's 76 million baby boomers turn 65, the ratio will be about two-and-a-half to one.*

- From 1937 to 1995, the Social Security tax rate has increased from 1 percent to 7.65 percent and the wage base on which the tax is levied has been increased from $3,000 to $61,200. That means the maximum annual contribution has risen from $30 a year to $4,682 a year.*

- Finally, in 2029, providing expected benefits for all retired American's at today's eligibility levels will require a 20 percent tax on every worker's entire income.*

Dr. Robert Goodman, senior economic advisor for Putnam Investments, has written a book that deals at length with the coming Social Security implosion. A relevant excerpt reads, "The question to be put to the millions of Americans now working is this: 'Would you like to take the chance that you will get Social Security and Medicare benefits at levels equivalent to today's when you retire in 30 or 3 years, when that working populati would have to vote to tax themsel up to 20 percent of their income t give it to you? Or would you rath have the ability now to utilize an expanded and enhanced individual retirement account or some other tax-favored means to build a supplemental pool of capital upon which to earn income when you retire or to leave with your heirs?"

Hello Senator William Roth. Chairman of the Senate's finance committee, it is his name on the "expanded and enhanced individua retirement account" Dr. Goodman accurately described - well before was signed into law.

What's more, riding in lockstep wi the new Roth IRA are enhanced benefits for traditional IRAs and a new Education IRA, to help parents and grandparents better prepare for the sometimes staggering cost of an advanced degree.

These IRAs contain many important benefits (along with a few restrictions) that we are happy to discuss at length; perhaps most important among them however is providing an extremely viable option for individuals to take responsibility for their own long-term investment goals. This, by definition, means th government's role will be dramatically reduced. And, by our definition, this is good for everyone

Our assessment of the federal government's inability to continue providing retirement and health care benefits to Americans in the future may seem overly pessimistic, but not when compared against the cold, hard facts surrounding Social Security. And also not when compared against our experiences when seeking government help with anything.

Consider our encounters in trying to obtain information for this column: A call to Senator Roth's office was referred to the Senate Finance Committee's office. That call was referred to the Senate public affairs office, which was then referred back to Senator Roth's office. When a request was made to have the information sent by fax instead of mail, it was met with a curt "no." When that staffer was reminded who was paying her salary, the no turned reluctantly to, "I guess we can."

The fax, of course, never came.

Thank you for the new and expanded IRAs Uncle Sam. We'll gladly take responsibility for our own long-term investment goals by using them, rather than relying on you.

**Independently Wealthy: How to build financial security in the new economic era; Robert Goodman, Ph.D.*

A. G. Opinion on HMO Complaints Causes Uproar

A Texas attorney general opinion that says complaint details about HMOs should not be made public has consumer advocates up in arms. In the opinion, which was issued in the fall, Assistant Attorney General Vickie Prehoditch wrote that the Texas Department of Insurance can't grant the public access to most documents detailing grievances against HMOs, which includes HMOs' responses to specific accusations and the Insurance Department's findings as to whether a complaint was justified.

The attorney general's office used a broad interpretation of a confidentiality clause in the Health Maintenance Organization Act, passed last year by the Texas Legislature.

Under the provision, complaints against HMOs remain public, but patients' identities are to be blacked out. The law also shields all records submitted to the Insurance Department in connection with an examination of an HMO, to protect any proprietary information. However, the law did not spell out the exact definition of an examination.

Karina Kasari, Director of the Senate Economic Development Committee and aide to its chairman, Rep. David Sibley (R-Waco), who was lead sponsor of the HMO legislation, said that the attorney general's opinion is contrary to the intent of the new laws.

"It's in the public interest for the state to know and the public to know how an HMO handles medical decisions," said Kasari.

Consumer advocates say the opinion denies access to the very type of records that led the campaign for managed care changes.

"We just had no idea this provision in the law would be interpreted this broadly by the attorney general's office." said Kathy Mitchell, an attorney for Consumers Union. "It's remarkable to me that the HMOs don't want to release information they give to the Insurance Department in their own defense."

In a recent letter to Attorney General Dan Morales, the Insurance Department asked him to reconsider the opinion, saying that open-record exceptions should apply only in cases where the Insurance Department has conducted a full examination of a company's operations, such as the kind required for an HMO to obtain or renew a license. The letter also stated that complaints from individuals should not fall under the act's confidentiality provision.

Ron Dusek, spokesman for Morales, said, "Our interpretation is based on the way the law is written and any legislative intent that can be deciphered. If certain legislators don't like the way they wrote their law, they can rewrite their law."

News

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

TCOM and U.T. Dallas Agree on Seven-Year Medical Education Program

Earning a degree in medicine usually means four years of college and four years of osteopathic medical school. For those dedicated to becoming physicians or surgeons, a program to decrease the time in school while still receiving a medical education is now available.

Education forces in Fort Worth and Dallas are now offering a seven-year degree program. Developed by the University of North Texas Health Science Center's Texas College of Osteopathic Medicine (TCOM) and The University of Texas at Dallas (U.T. Dallas), the institutions will make it possible to earn a bachelor's degree after three years at U.T. Dallas plus one year of medical school at TCOM. Then, the osteopathic degree is awarded after three additional years at TCOM.

To allow students to transition into the medical school environment while still fulfilling their undergraduate education, the fourth and final year of undergraduate studies will be combined with the first year of osteopathic medical school.

According to Dr. Ronald Yasbin, head of the Department of Molecular and Cell Biology at U.T. Dallas, most college seniors take elective courses during the last two semesters, so the first year of the medical school's curriculum fits into their schedules without taking away important college course requirements.

"Using the collaborative approach developed by TCOM and U.T. Dallas, students will be able to receive their bachelor's degrees from U.T. Dallas after finishing their first year of medical school," said Dr. Yasbin. "An early focus on their medical education at TCOM will greatly benefit the many pre-med students at U.T. Dallas, especially those with an interest in becoming primary care physicians."

The summer prior to students' junior years, they would take the Medical College Admissions Testing (MCAT) exam and complete a preliminary application to be considered for TCOM admission. During their junior years at U.T. Dallas, they would be notified of their acceptance to TCOM.

By the end of their junior years, the U.T. Dallas undergraduate students would have completed their required core courses and TCOM admission requirements. Prerequisite courses at U.T. Dallas that are accepted by TCOM include biology, chemistry, calculus, and physics.

"During their three years of undergraduate work at U.T. Dallas, students are encouraged to interact at the health science center and learn more about TCOM in clinical settings, research labs, and internships," said David Richards, D.O., president of the UNT Health Science Center. "Allowing U.T. Dallas students to expand their education and receive medical training at TCOM gives the students a real career advantage and it gives the institutions a real recruiting advantage."

The program is expected to begin this year. Both U.T. Dallas and the UNT Health Science Center are committed to promoting the program starting with the present recruitment season. In addition, faculty from U.T. Dallas are including the fundamentals of osteopathic medicine and the research interests of the health science center in their discussions with students at U.T. Dallas.

For more information on the seven-year degree program, contact TCOM's Admissions department at 817-735-2204 or U.T. Dallas' Admissions department at 972-883-2342. The University of Texas at Dallas website also includes information at www.utdallas.edu/dept/biology.

U.T. Dallas provides outstanding education and research programs from the freshman through Ph.D. levels and ranks among the top Texas public institutions in terms of student achievement and faculty research. The U.T. Dallas freshman class regularly ranks first or second in average SAT scores among Texas public universities. Additionally, U.T. Dallas students often are most successful in achieving entrance to professional schools. Specifically, last year, 72 percent of the students from U.T. Dallas who applied to medical, osteopathic or dental schools were admitted.

The Texas College of Osteopathic Medicine produces the highest percentages of primary care physicians among all eight Texas medical schools. In 1997, over 70 percent of the graduating class chose primary care residencies in general internal medicine, pediatrics, obstetrics/gynecology and family medicine. TCOM is the state's only osteopathic medical school and one of 19 osteopathic medical schools in the nation.

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Expanded Medicare Benefits

Last year's budget agreement gave rise to a larger package of preventive Medicare services, designed to give more attention to wellness care.

Services now available include:

✦ Annual mammograms for women over age 40. The enrollee pays the usual 20 percent copayment and Medicare pays the remaining 80 percent.

✦ Pap smears and pelvic exams every third year for women at average risk for vaginal and cervical cancer, and once a year for women at high risk. Medicare pays 100 percent of Pap lab tests and 80 percent of the other services. The deductible is waived.

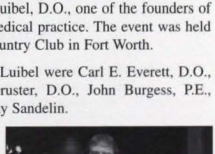
✦ Fecal-occult blood tests, flexible sigmoidoscopies, colonoscopies (for those at high risk) and, in certain cases, barium enemas. Each test for colorectal cancer is covered under different circumstances, so consult your Medicare manual.

Beginning July 1, Medicare will cover glucose monitoring and self-management training for diabetes patients and bone-density measurement for those at risk for bone abnormalities. Screening for prostate cancer is due to begin January 1, 2000.

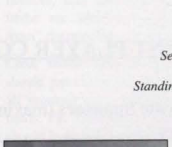
Toast and Roast Honors Retirement of TCOM Founder George Luibel, D.O.

The University of North Texas Health Science Center/Texas College of Osteopathic Medicine Foundation hosted a Toast and Roast Dinner to honor George Luibel, D.O., one of the founders of TCOM, who has retired from medical practice. The event was held January 31 at the River Crest Country Club in Fort Worth.

Among those "roasting" Dr. Luibel were Carl E. Everett, D.O., Irene Herring, David R. Armbruster, D.O., John Burgess, P.E., William R. Jenkins, D.O., and Jay Sandelin.



Seated: George Luibel, D.O., and his wife, Mary. Standing: Irene Herring, assistant to Dr. Luibel for 44 years.



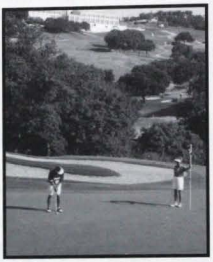
Gib Lewis, former Speaker of the House for the state of Texas, with Dr. Luibel.

Since Scotland's King James IV first addressed a ball, golf has been one of life's great traditions. The annual TOMA Golf Tournament has also become a great tradition and this year's event promises to be the best ever!

This year's tournament starts another new tradition as well. Proceeds received from the TOMA Golf Tournament will be used to support the Auxiliary of TOMA. This provides a great opportunity and means for you to offer your support to ATOMA.

The 1998 TOMA Annual Golf Tournament will be held at the beautiful River Place Golf Course, designed by PGA legend Tom Kite, and threaded through spectacular Texas hill country scenery.

After golf, you'll enjoy some great food and fun in the spectacular clubhouse where you can enjoy the breathtaking views that surround you.



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Corporate Sponsorships (Silver)	**$250**
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Sponsors will receive special recognition via signage placed on tee boxes and around greens. Also, sponsors will be listed on a board at the clubhouse and at all of the tables during dinner. Gold Corporate sponsors will receive special recognition during the award presentations. All sponsorships are 100% tax deductible.

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Physicians and Guests	**$75**
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Non-Sponsoring Exhibitors	**$125**

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Make checks payable to ATOMA. Mail to TOMA @ 1415 Lavaca St., Austin, TX 78701

Fiscal Responsibility

Everyone's Job

By Lewis Isenberg, ATOMA Vice President

"CHAPTER TREASURER" - not a very exciting sounding title, huh? Not nearly as exciting as the name President or Chairman, oops, Chairperson congers up in our mind's eye. Let's take a closer look at what's involved with this less than exciting title.

Duties and Responsibilities

Generally published by-laws clearly state that control of Chapter funds rests with the Chapter Board of Directors and Officers. Just how this is accomplished is not always so clearly stated. Let's take a look at some of the mechanics involved in the "how."

The Chapter Treasurer, as custodian of Chapter funds, is responsible for the financial records, reports and all monies handled by the Chapter. The Treasurer:

- Prepares the Chapter's annual financial budget and presents it to the board.
- Deposits and withdraws Chapter funds.
- Presents all bills for approval by the Board of Directors/Officers.
- Pays approved bills by check.
- Presents a financial report to the Board for inclusion with the minutes.
- Prepares an annual report of receipts and disbursements.
- Collects meal charges and other charges at all Chapter activities and pays any expenses for the same. These collections and payments must be included in reports of the Chapter receipts and disbursements.

Depository and Authorized Signatures: The Board of Directors determines the bank at which the Chapter will establish its checking account. Recommendation: That all checks contain two (2) signatures for validity, usually but not restricted to, the Treasurer and the President.

Review Committee: The Chapter should have a Financial Review Committee of at least three Directors appointed by the President and excluding the President and the Treasurer. The Chapter past presidents and other Chapter members usually serve as members of this committee. The Committee's responsibility is to verify that proper procedures are followed for the issuance of checks and receipts of money.

Cash Receipts: Income should be recorded and identified as received. With checks, note the payer's name, check number, and date of the check. Cash items are identified with a "received from" description.

Cash Disbursements: Board members should present in writing to the Treasurer all requests for expenditure of Chapter funds. The Treasurer's report to the Board should include these requests for approval. The individual vouchers, once approved, are recorded in the minutes and presented to the President, who then returns them to the Treasurer for payments. All payments should be made by check.

Financial Reports: At least annually the Treasurer should present a report to the Chapter Board of Directors reflecting the current cash position and composition of Chapter funds. To be complete, the report should be accompanied by the report from the Financial Review Committee. Note: If the Chapter is required to file Form 990 with the Internal Revenue Service, the Treasurer has the responsibility, along with the President, to assure this is accomplished. A "copy" of the filed Form 990 should also be included in this report.

Record Retention: The Treasurer should confer with the Secretary and the Board each year, making sure that certain items are preserved in the Chapter's permanent record file. Among the items should be:

- The tax-exempt letter and status
- The Chapter's Tax Number
- Copies of any and all tax returns
- Annual financial report

Items outlined here are not all inclusive but what is considered a "bare minimum " for the orderly operation of any "not-for-profit" organization. As indicated, these responsibilities are not solely that of the Treasurer. All Directors/Officers, both past and president, as well as all Chapter Members share in this responsibility. The current President must be especially prudent to assure that sound fiscal practices are followed on "their watch."

Two very important factors are involved here:

- Finding the right person(s) for the job. (These responsibilities can be shared by co-treasurers or any combination of directors/officers.)
- Communications. The Treasurer must talk with the President and other Board members/Officers and vice versa. Communication is the primary prerequisite for leadership.

When a good fiscal management policy is defined and followed by all Officers/Directors and Members, the results are measured not only in dollars and cents, but in a much more fulfilling way: peace and harmony among the entire membership.

Self's Tips & Tidings

By Don Self

What is Non-participating with Medicare?

Since the passage of laws that infringe upon the physician/patient relationship, and the promise of additional restrictions using the 1998 documentation guidelines that will go into effect July 1, 1998 (see Texas D.O. - February edition), many physicians are divorcing themselves from Medicare. We've received several faxes and notes from D.O.s in Texas who have sent letters to their Medicare patients either asking them to find another physician or telling their patients they no longer participate with Medicare. Most of them have also been misinformed about how they will be required to treat Medicare patients in the future. Just because you elect to "withdraw" from the Medicare program (and I don't blame you one bit), that does not mean that you can treat a patient with private insurance as primary and then not file their Medicare secondary claim if the patient requests it. If the patient has Medicare as primary or secondary, you still have to abide by the Medicare rules regarding filing of the claim, signing of waivers, contracts, etc. Also, there is a law that states that you cannot charge a patient more than the Medicare Limiting Charge, even if the patient does not have Medicare, but if the patient qualifies for Medicare (age 65 or over). So, if you wish to never file Medicare claims or abide by any of Medicare's regulations, you had better not even see any patients who are 65 or over.

Put a Target on your Smock

Some interesting numbers were released by Health & Human Services, which should be a warning that you are a target by those entrusted to safeguard the nation's finances. It doesn't really matter if you've committed fraud purposely or made innocent mistakes or even if you've never made an error in your billing. You're still a target! In FY 1997, HHS identified $1.2 billion for collection in total fines, restitutions, settlements, and recoveries — the most ever identified in one year. The FY 1997 total was six times higher than recoveries for FY 1996, and over three times higher than the previous best year for recoveries. In addition, criminal and civil prosecutions totaled 1,340 cases in FY 1997 — double the number for FY 1996, and more than five times the total number in FY 1995. Over 2,700 health care providers and entities were excluded from doing business with Medicare, Medicaid, and other federal and state health care programs for engaging in fraud or abuse of the programs — an 86 percent increase from the 1,400 exclusions in FY 1996. Since 1993, actions affecting HHS programs alone have saved taxpayers more than $20 billion and increased health care fraud convictions by 240 percent.

How to Handle Refunds

When you realize that an account has been overpaid, how do you handle it? Some offices send a refund to the carrier, if insurance is involved, and then six months or a year later, the carrier sends a request to the physician asking for a refund. They have no idea what happened to the check you sent six months ago and they want their refund now or they'll withhold future payments. So, sending an unrequested refund isn't the answer. Here are a few suggestions from some consultants around the country:

1. Never, never, never send an unsolicited refund. If you send a check to the Blues, for example, what will they do with it? Since we do not know, how can we expect them to? I have found that calling the carrier and explaining that we need a letter requesting the refund (even a FAX) will get the money back ASAP. Besides, your accountant will go nuts with unsubstantiated refunds. (I like this approach.)

2. We don't send refunds to insurance carriers. Since the patient is our client, we send them the refund if one is due and let the carrier get the money back from them. (I don't like this approach - this will cause problems with future payments.)

3. Many times our patients overpay, in that case, I send them back their original check asking for the proper amount. They usually call and ask for clarification, but it does promote goodwill. If the check has cleared and we got another payment, then I try to get a refund out to them within a few weeks. Most of the time the patient has no idea what it is and, again, we get another phone call. (I don't like this approach. Why mess with phone calls? My advice is to send a preprinted letter explaining that an overpayment was made on their account. Avoid phone time when possible.)

4. If it's Medicare, we contact Medicare via phone or fax and tell them we need a written request from them for a refund. They always send us one and we return the refund with the request - it always smoothes things out. (I like this one.)

Modifier 57

Although the AMA now says you can use modifier 57 for the evaluation and management code on the same day as you provide a minor procedure or surgery, keep in mind that the AMA does not set HCFA's or Medicare's rules. Medicare still says you should only use a modifier 57 (Decision for Surgery) for the E&M when a major procedure (90 day global fee period) was done. Our advice is to continue using modifier 25 to be paid for the separately identifiable E&M service on the same day as a minor procedure and not modifier 57.

Don Self & Associates
P.O. Box 1510, Whitehouse, TX 75791-1510
(903) 839-7045; Toll Free (888) Don-Self
fax: 903 839-7069; email: donself@gower.net
http://www.gower.net/donself/ds&a.html

Trigger Point & Joint Injections

At a seminar I taught in Fort Worth, I had a doctor hand me 15 Medicare EOBs and ask me why Medicare would not pay for more than 1 trigger point during an encounter. His EOB indicated only one was filed, so I had him fax me a few copies of the claims. The reason he was only being paid for one trigger point was because his staff was trying to bill multiple units on one line of the HCFA 1500 form. If you want to be paid for multiple trigger points, you must list each one individually on the HCFA 1500 claim form and we recommend you put the 59 modifier next to each one. Keep in mind that you'll only be paid for up to 5 in one day and the multiple procedure reductions (approved amount reduced by 50%) does apply. For private carriers, we recommend you file the exact same way. Doctor, if you poke the patient 3 times with the needle, charge for 3 trigger points, plus the injectable drug. I would apply the exact same thing as above for arthrocentesis with one modification - I recommend using the LT and RT modifier for all carriers with joint injections.

You're About to be Ripped Off Again

Doctor, hopefully you know by now that Medicare does not always pay you as much as your expense is for injectable drugs. That's about to get worse, unless you take an active role and do something. If you sit back and do nothing, then don't be surprised if Medicare further reduces the amount they pay for injections. Clinton has already stated he will try to reduce the amount Medicare pays this year (1998), so we recommend you have someone on your staff take the time to gather together what you are spending for injectable drugs and compare that to what you are getting paid by Medicare for the same dosage. Then, put together a letter and send it to the following:

Senator Kay Bailey Hutchison
Senator Phil Gramm
Your local U.S. Congressman

We are doing this for our retainer clients and plan to meet with these same elected officials again, but that's not enough. It's your money and you're the one losing money - it's up to you to act today.

Beware of the Services You Bill

Recent instances where physicians made the job of the OIG or FBI agents easy:

1. A psychiatrist now on a long, federally funded vacation who billed for more hours of individual psychotherapy than there are hours in a day.

2. A critical care physician who billed more hours of critical care in one day than there are hours in a day. He also is wearing the attire of a federal prison.

3. A general surgeon who billed for the assistant surgery services of her Certified Surgical Assistant with the -AS modifier. The -AS modifier should be used for services of the Physician Assistant only. This doctor did not have a PA in her practice or on her payroll. She had substantive recoupment and fines levied against her.

4. An internist who ordered a chest x-ray and EKG on every new patient encounter. This was determined to be screening in 62% of the cases reviewed. He had to repay Medicare more than $130,000.00.

Questions You've Asked

We get, on average, two questions per day e-mailed, faxed or mailed to us from readers of the *Texas D.O.*, our website, *Geriatrics* magazine or our monthly newsletter subscribers. Here are a few that you've submitted this month:

1. How many times can a provider use a consult code for the same patient with the same problem?

A physician can only use the initial consult code (99241-99255) once on a patient for the same problem. After the first one, the doctor either has to use the follow-up consult codes (99261-99263) or appropriate E&M service (office visit, hospital visit, nursing home visit, etc).

2. Can a physician charge for a hospital discharge and a skilled nursing facility admit on the same patient, on the same day if the two facilities have different facility/provider numbers?

Yes, you can and should charge for both the discharge and the admit if your documentation meets the requirements. We also recommend you file them on different claims since both places of service have to be shown on the claims.

3. Can a PA bill Medicare for a consult?

Unfortunately, no, not at this time. Once Medicare determines how they will assign new provider numbers to PA's, that may change, but right now - PA's can only bill per "incident-to" services, which prohibit billing consult charges.

4. Can we bill the inconvenience charge for after hours (99050) to the patient?

If the patient is Medicare, the answer is no. If the patient is not Medicare, why not?

Note
You can email Don at: donself@gower.net, fax him at (903) 839-7069, call him at (888)-DONSELF, or visit his website at: www.gower.net/donself and get free information on codes, claims, charges or Medicare approved amounts.

Thanks To You

Texas Medical Foundation wishes to thank the physicians' groups and health-care providers that participate in quality improvement projects and community-based projects.

Your diligence and enthusiasm have brought success to our collaboration.

Physician and provider involvement has been and will continue to be the driving force behind health-care quality improvement in Texas.

Texas Medical Foundation

AOA Washington Update

Action Item: Maintain Physician Supervision of Nurse Anesthetists

HCFA may soon allow nurse anesthetists to treat Medicare patients without the supervision of physicians. HCFA is proposing to eliminate a Medicare requirement that all nurse anesthetists be supervised by physicians (D.O.s or M.D.s). While state licensing boards could still limit the scope of practice for these nurses, you probably don't want to be fighting this battle in your state.

To protect your patients from medical care provided by non-physicians, voice your objections to HCFA now! Please send your thoughts to HCFA (in quadruplicate) at: HCFA, Attn: HCFA-3745-P, P.O. Box 7517, Baltimore, MD 21227-0517. Please tell HCFA how this change could affect the quality of care delivered to your patients. The AOA will be registering objections and we would appreciate a (single) copy of your comments. Please fax us a copy at 202-544-3525.

Billing for E&M Services Along with OMT

Data we recently received from HCFA shows that most Medicare payment denials for evaluation and management (E&M) services on the same day as OMT are usually due to the omission of modifier -25 on the claim. About 20 percent of these E&M claims do not include the proper modifier in 1996 and most of these claims were rejected. Only four percent of the claims with a modifier -25 were denied. We are analyzing this data further and will have more to report at a later date.

Private Contracting

House Democrats are fighting attempts to liberalize Medicare's private contracting rules. Three key congressmen have introduced legislation to completely ban private contracts for all Medicare covered services. The new HCFA Administrator has stated that Medicare beneficiaries can pay for services that are not covered by Medicare without entering a private contract.

Patient Bill of Rights

The AOA stands by President Clinton's position that patients should have the right to choose the doctor they want for the care they need. The AOA first put forth a Patient Bill of Rights in 1981 and the current version of the AOA's Bill of Rights is very similar to the President's. We will work hard to enact these rights before the next election.

Senator John Breaux Chosen to Chair National Bipartisan Commission on the Future of Medicare

Senator John Breaux (D-LA) has been appointed chair of the National Bipartisan Commission on the Future of Medicare, whose charge is to issue a report and recommendations on preserving Medicare's long-term solvency to President Clinton and Congress by March, 1999. The commission was established by the Balanced Budget Act of 1997.

The 17-member commission includes lawmakers, health experts, insurance industry leaders and a Medicare beneficiary who works for Senate Majority Leader Trent Lott (R-MS). Agreement by at least 11 of the commission members will be required for recommendations to be in the final report.

The commission will be examining the recommendation of raising the Medicare eligibility age to 67, and the feasibility of permitting people age 62 and older to buy into Medicare.

Don't Be Fooled

On September 1, 1997, a new Texas law pertaining to the release of medical records went into effect, and some records retrieval companies have been trying to use the new law to trick physicians into improperly releasing medical records. It has been reported that some such companies have been telling physicians that the new law allows them to obtain patients' records without the patients' consent, or without a court order or subpoena.

Senate Bill 975 did make new exceptions for releasing hospital medical records without a patient's approval in order to comply with court orders, and in cases where the patient is a party to a suit and a subpoena is issued under the Texas Rules of Civil Procedure. Although there may be limited situations where the law applies to physicians, such as when a medical clinic is owned or controlled by a hospital, the new law generally applies to hospitals, not physicians.

Physicians who do not routinely receive requests to release medical records often do not know when they are allowed to do so, much less what the proper legal documents look like that charge them to release records. Physicians who do not completely understand when and how to release records should always call their own attorneys.

"Building for the Next Millennium"

Texas Osteopathic Medical Association
99th Annual Convention & Scientific Seminar
June 18-21, 1998
Renaissance Hotel
Austin, Texas

Donna Hand, D.O. - Program Chair ✻ ***26 AOACatagory 1-A Hours Available***

Thursday - June 18th

7:00	Opening Breakfast - Arythmias
8:15	Arthritis
9:00	Psoriasis
10:00	Exhibit Hall Break
10:30	Smoking Cessation
11:00	Lymphoma
11:30	CHF Update
12:15	Keynote Luncheon
1:30	Update on Vaginitis
2:30	Exhibit Hall Break
3:00	Workshops
7:00	Sustainer's Party The Salt Lick Pavillion Driftwood, Texas

Friday - June 19th

7:30	Breakfast with Exhibitors
8:00	Geriatrics
8:45	Chronic Pain
9:30	Break with Exhibitors
10:00	Concurrent Workshops: Medicare Fraud Detection Treatment of Postmenopausal Osteoporosis Correct Code Initiative
12:00	Lunch with the Exhibitors
12:15	Golf Tournament Riverplace Golf Course
1:00	Family Day Schlitterbahn Waterpark

Saturday - June 20th

7:00	TxACOFP Breakfast
8:00	Fibromyalgin
8:45	Fibromyalgin-OMT
9:15	GERD
10:00	Exhibit Hall Break
10:30	Update on Seizure Disorders
11:00	CT Scan vs. MRI
11:30	Diagnosis and Treatment of Hernias
12:15	AOA Luncheon
1:30	Hormone Replacement
2:30	Concurrent Workshops: Stroke Prevention Pediatric OMT Preceptor and Rural Rotation Supervisor
6:30	President's Reception
7:00	President's Banquet

Sunday - June 21st

7:30	Breakfast
8:00	Risk Management Program
10:00	Break
10:15	Risk Management (Continued)

1998...1999...2000...

Watch your mail and next month's ***Texas D.O.*** for complete schedule and registration information!

TOMA President-elect Seeks Committee Appointees

Each year, the president-elect of the Texas Osteopathic Medical Association must name TOMA members to the Association's various committees when he or she assumes the office of president. Strong committees are an essential part of the Association's operations, and require dedicated and knowledgeable members.

Nelda Cunniff-Isenberg, D.O., who will succeed R. Greg Maul, D.O., as the Association's president during the 1998 Annual Convention in Austin, would like all TOMA members interested in serving on a committee to write her as soon as possible so she can begin to consider her appointments.

Simply note the TOMA committee or committees in which you are interested, enclose a brief CV detailing your training, practice and related experiences, and send your letter to Dr. Cunniff-Isenberg, c/o Terry Boucher, Executive Director, Texas Osteopathic Medical Association, 1415 Lavaca Street, Austin, TX 78701-1634.

Appointments will be made to the following committees: Archives; Awards and Scholarship; Constitution, Bylaws and Documents; Environmental Health & Preventive Medicine; Ethics; Governmental Relations; Membership, Services & Professional Development; Military Affairs; Osteopathic Principles and Practice; Physicians Assistance Program; Professional Liability Insurance; Public Information & Publications; Socioeconomics; Strategic Planning; Student/Postdoctoral Affairs; and other needed special committees.

If you are interested or know of someone who is, check the bylaws beginning on page 101 of the 1998 TOMA Membership Directory for more details and information on the various appointed positions available, or contact the TOMA State Office for specific committee charges.

TOMA members have an immense amount of talent. The Association's future depends on you and your willingness to become an active part of the organization. Dr. Cunniff-Isenberg looks forward to hearing from you by April 30.

REMINDER - "Grace Period" for New Documentation Guidelines

Physicians are reminded of HCFA's extension to its "grace period' before full implementation of the new documentation guidelines for evaluation and management services. The mandatory use of the new documentation guidelines is delayed until July 1, 1998.

District Stars
News from TOMA/ATOMA District VI

By Dr. and Mrs. Jerry W. Smith

The TOMA/ATOMA District VI Christmas Party was celebrated at the home of Dr. and Mrs. Ralph Love on December 14, 1997.

(L to R) Dr. and Mrs. Ralph Love, Dr. Wasserstein and Dr. Jerry Smith.

Members of TOMA/ATOMA District VI met at Brennans Restaurant on January 27, 1998.

Dr. Jerry Wasserstein, TOMA District VI President, introduced ATOMA President Dodi Speece, TOMA President R. Greg Maul, D.O., and TOMA Executive Director Terry Boucher. All three speakers gave interesting updates concerning state business. Stephen A. Fletcher, D.O., presented a slide lecture entitled, "Current Trends in Neurosurgery for Family Practitioners."

The program and dinner were sponsored by Pfizer Pharmaceuticals. Greeting district members from Pfizer were Luci L. Nix, Amy C. Dobson and Keri Kimler. There was great attendance for this presidential visit, with about 70 members present.

TOMA District VI Officers

President - Jerry C. Wasserstein, D.O.
Past President - Carl Mitten, D.O.
Secretary - Jerry W. Smith, D.O.
Treasurer - Kathleen Bottroff, D.O.

ATOMA District VI Officers

President - Joanna Love
President-Elect - Tami Prangle
Secretary - Joy Smith
Treasurer - Lois Mitten

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

The Texas College of Osteopathic Medicine's three-story library was formally dedicated, after a construction period of over two years. Gibson D. Lewis, Speaker of the Texas House of Representatives, was the main speaker during the ceremonies.

Royce K. Keilers, D.O., was elected president-elect of the over 9,000-member American College of General Practitioners in Osteopathic Medicine and Surgery.

An American Bar Association poll noted that of more than 54,600 complaints lodged against attorneys in 1986, less than eight percent were found to have any merit.

Hailed as a major achievement, the Harvard relative value scale (RVS) study included distinctive osteopathic services.

POISON ALERT

For anyone who ingests a poisonous substance, help is a phone call away: 1-800-POISON-1 (764-7661).

The state's Poison Control Center Network has call centers in Amarillo, Dallas, El Paso, Galveston, San Antonio and Temple. Nurses and pharmacists on staff answer emergency calls year round, 24 hours a day.

Of the 363,000 calls handled in fiscal 1997, about half concerned children under six who had gotten into the home medicine cabinet or under the kitchen sink. Of the calls involving exposure to poison or venom, almost 20 percent required a trip to a physician or emergency room; the remainder were handled over the phone.

The network's fiscal 1997 operating budget of $5.7 million was funded chiefly by a 0.3 percent surcharge on intrastate long-distance phone calls. Besides providing phone banks, the centers regularly send representatives to schools and community groups to teach poison prevention.

Most Common Calls

Rank	Cause	Number of Calls
1	Aspirin, other analgesics	15,850
2	Cleaning substances	14,460
3	Shampoo, other personal care products	12,980
4	Cough and cold medicines	8,640
5	Bites, stings	8,410
6	Plants	6,920
7	Foreign objects	5,960
8	Skin cream, other topical medications	5,390
9	Insecticides, pesticides	5,170
10	Sedatives, anti-psychotic drugs	5,040

Poisoning Deaths in Texas Fiscal 1997

Accidental poisoning	493
Self-inflected solid or liquid	229
Self-inflicted gas	112
Assault	4
Other/unknown	77
Total 911	

Sources: John Sharp, Texas Comptroller of Public Accounts, and Texas Department of Health.

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For years, physicians were considered the preferred class of insureds among disability insurance companies. But not anymore! Instead, physicians are continually being offered lower benefits at higher prices.

If you'd like to go back to the "good old days" with discounted premiums, "own-occupation" definitions of total disability and lifetime benefits, then give us a call. As the only TOMA endorsed provider of disability insurance, you can be assured that the products we'll provide to you are second to none. That's right! Our plans are superior to group and association plans and even the majority of individual disability policies.

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News

from the Texas Workers' Compensation Commission

Revised Publications Price List Now Available

A revised Publications Price List is available on request from the Texas Workers' Compensation Commission's Publication Office. The revised price list includes the new Lower Extremity Treatment Guideline (Rule 134.1003), which was adopted by the TWCC in November. The guideline became effective on January 1, 1998.

The Lower Extremity Treatment guideline costs $8.40 if picked up at the TWCC Publications Office, and $10.10 if mailed.

To obtain a copy of the revised Publications Price List, please call 512-440-3618. A recorded telephone message provides the price of publications available for purchase, payment information and the address to which publication orders should be directed.

The TWCC Publications Office is located on the first floor of the Southfield Building in Austin, 4000 South IH-35. It is open Monday through Friday from 8 a.m. until 5 p.m.

The Publications Price List and other TWCC information are available through the TWCC's web site at www.twcc.state.tx.us.

Rules Supplements 97-02, 97-03 and 97-04

Rules Supplements 97-02, 97-03 and 97-04 are now available and include rules amended and new rules adopted by the TWCC from March, 1977 through December, 1997.

Supplement 97-02 contains:

Chapter 134 Guidelines for Medical Services, Charges and Payments

Supplement 97-03 contains:

Chapter 110 Required Notice of Coverage
Chapter 122 Claimants

Supplement 97-04 contains:

Chapter 102 Practice and Procedures - General Provisions
Chapter 108 Fees
Chapter 114 Self-Insurance
Chapter 125 Education and Training of Ombudsman
Chapter 126 General Provisions Applicable to all Benefits
Chapter 129 Income Benefits - Temporary Income Benefits
Chapter 133 General Medical Provisions
Chapter 134 Guidelines for Medical Services, Charges and Payments
Chapter 147 Dispute Resolution - Agreements, Settlements, Communications
Chapter 166 Accident Prevention Services

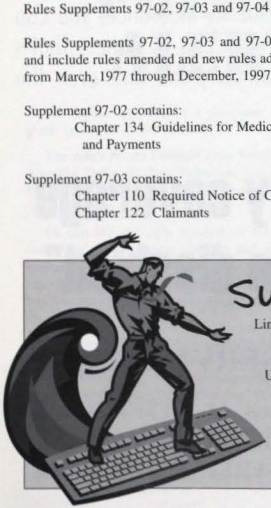
These supplements are available in 5 1/2 x 8 1/2-inch size and 8 1/2 x 11-inch size. Those who are interested in purchasing the individual rule supplement packets for 1997 are encouraged to do so as the individual rules supplement packets will be available only until March 31, 1998. All may be ordered from the TWCC Publications, MS-72, 4000 South IH-35, Austin, TX 78704.

The 8 1/2 x 11-inch Rules Supplement 97-02 costs $7.40 if picked up, and $9.10 if mailed. The 5 1/2 x 8 1/2-inch Rules Supplement 97-02 costs $5.60 if picked up, and $6.38 if mailed.

The 8 1/2 x 11-inch Rules Supplement 97-03 costs $2.00 if picked up, and $3.24 if mailed. The 5 1/2 x 8 1/2-inch Rules Supplement 97-03 costs $6.40 if picked up, and $7.18 if mailed.

The 8 1/2 x 11-inch Rules Supplement 97-04 costs $4.40 if picked up, and $6.10 if mailed. The 5 1/2 x 8 1/2-inch Rules Supplement 97-04 costs $6.60 if picked up, and $8.53 if mailed.

For more information, call the Publications Office at 512-440-3618. The automated telephone system will provide information for ordering forms. To speak to an individual in the Publications Office, call 512-440-3650.



Surfin' the Web

Links to Texas government sites, including legislative information: http://www.texas.gov

The definitive Texas legislative information site: http://www.capitol.state.tx.us

U.S. Government Printing Office - click on "GPO Access": http://www.access.gpo.gov

Library of Congress site that takes you to state, federal and international agency sites: http://www.loc.gov

IRS/tax information: http://www.irs.ustreas.gov

OSHA information: http://www.osha.gov

New Law Denies Some Medicare Patients Home Health Services

A new law, intended to cut costs and curb abuses in the home health industry, has resulted in thousands of Medicare patients losing home care services. Effective February 5th, home health care was ended for patients whose sole medical need is to have a visiting nurse draw their blood for lab tests. The law was part of the balanced budget bill passed by Congress last year.

Under previous rules, homebound patients who needed to have their blood tested also qualified for personal care services, such as health aides to assist in such services as bathing and dressing. These patients tend to be chronically ill, needing monitoring due to anti-stroke or diabetes medications.

Under the new law, many of these patients could lose Medicare coverage for the personal care they depend on to help keep them out of nursing homes. And, instead of having a visiting nurse check their blood, they will have to go to the doctor's office or find a lab that will send a technician to their homes.

"I don't want to see thousands of elderly patients disenfranchised and end up in hospitals and nursing homes if they can be maintained at home," said Dr. Don Williamson, director of the state health department in Alabama. He noted that a home health agency in his department is dropping about a quarter of its 8,400 Medicare patients as a result of the new rule.

"It troubles me that at a time when we're providing health insurance to uninsured children, old people are potentially losing a benefit they need," he said.

Similar complaints are being generated across the country, particularly in rural areas, prompting a letter of complaint to Medicare from five senators: John D. Rockefeller, IV (D-W.Va.); Charles Grassley (R-IA); Max Baucus (D-MT); Dale Bumpers (D-AR); and Richard Bryan (D-NV). "Some families will be forced to somehow transport very frail seniors once a month to have their blood drawn," the senators wrote in the letter.

Some lawmakers want the provision repealed or suspended. "Medicare didn't think through the potential impact," stated Rep. Robert Aderholt (R-AL). "It could start an elderly person downwards on the road to an early grave if something isn't done." He has introduced a bill that would delay the effective date of the law for 18 months to study how it would affect patients.

Meanwhile, Nancy-Ann Min DeParle, HCFA Administrator, has warned home health agencies that they could be dropped from the program for "misinforming beneficiaries" or canceling coverage inappropriately.

Medicare spokesman Chris Peacock stressed that patients affected by the new law can still receive personal care services if they have a medical need other than blood testing, or if a doctor orders it. "If it's medically necessary, Medicare can cover it," he said. He urged patients whose benefits are canceled to contact Medicare directly.

News

from Osteopathic Health System of Texas

Osteopathic Medical Center of Texas Employee First Technologist in Tarrant to Perform Vein-Closing Procedure

A cardiac catheterization technologist at Osteopathic Medical Center of Texas has become the first certified technologist in Tarrant County to perform Angio-Seal, an artery-closing procedure that helps speed recovery for patients undergoing angiograms and angioplasty.

Chris Lester, a five-year employee at OMCT, is one of only 10 allied health professionals in the country to become certified to perform the procedure. Lester participated in the same certification course that physicians undergo before certification.

Angio-Seal closes punctures in the wall of the femoral artery (in the groin) made during procedures to check for blocked arteries and repair blood vessel damage. After angioplasty or an angiogram, the femoral artery wall must be closed to stop bleeding. Angio-Seal can accomplish this in minutes.

"Chris' certification will allow us to perform more procedures for patients," said Lloyd Brooks, Jr., D.O., an interventional cardiologist and chief of medicine at OMCT. "I've been very pleased with the results of Angio-Seal. The procedures have gone very smoothly."

The 265-bed Osteopathic Medical Center of Texas (the largest osteopathic hospital in Texas) is the flagship of Osteopathic Health System of Texas, a complete provider of osteopathic health care, with more than 300 physicians and 13 family medicine clinics. In addition, OHST offers the APPLE Club (Adult Prevention Program for Life Enhancement) for people 50 and older; Carswell Osteopathic Medical Plan (COMP) for retired and active-duty military personnel in the area and a variety of allied health services, including One Day Surgery Center, The Health & Fitness Connection, Diagnostic Imaging Centre/Novus Breast Center, The Psych Center adult psychiatric services, Home Health Care/IV Infusion, CareLink Health Referral, Medical Center Pharmacy & Medical Supplies and Occupational Health Solutions. The hospital has been providing the best osteopathic medical care to the Tarrant County community for more than 50 years.

Membership on the Move

Your 1998 TOMA membership dues should have been paid by January 1st. If you have not sent in your check, please do so now. And while you are at it, contact a colleague who is not a member and invite him or her to attend a district meeting or a TOMA conference. Once folks realize how valuable membership in their professional association is, they will definitely want to become active members. And membership recruitment is everyone's job!

TOMA is now offering a new membership benefit. American Business Forms is a mail order purchasing program that supplies quality medical forms, a complete line of computer products and office supplies ranging from paper and filing systems to copiers and telephones. TOMA office staff have used ABF and been very pleased with the quality, convenience and speed of delivery. ABF will meet or beat any advertised price for any office product. And the best part – TOMA receives a royalty from every purchase made by a member. For more information, contact the TOMA office at 1-800-444-TOMA.

Public Health Notes

By Alecia Anne Hathaway, M.D., M.P.H., F.A.C.P.

A Child in a World with HIV

As we come closer to approaching the new millennium with the start of 1998, the newest citizens joining us in this world will be confronted with enormous challenges of all dimensions and magnitudes. The ever-looming threat of nuclear warfare, environmental pollution, poverty, hunger, violence, social-moral decay; new and re-emerging biological pathogens are among the long list.

Evidence supports HIV having been traced back in our country to the late 1960s. It did not become recognized as a syndrome (AIDS) until the early 1980s. The virus was identified later that decade and is now well established throughout the world's population. The impact of this pandemic on the societal and economic well-being is unprecedented. Following are excerpts, from the American Association for World Health's World of AIDS Day Newsletter, World AIDS Day 1997, Special Issue. I believe they highlight the gravity of the HIV/AIDS pandemic from the perspective of our children, our greatest and most threatened resource.

HIV/AIDS is a disease of the young. Last year, 400,000 children under the age of 15 years old became infected with HIV worldwide, bringing the total number of children living with the virus at the end of 1996 to 830,000. Hundreds of thousands of HIV-positive babies are born every year to HIV-positive mothers around the world.

UNAIDS, the Joint United Nations Programme on HIV/AIDS, has designated "Children Living in a World with AIDS" as the theme for World AIDS Day this year. To incorporate a message of hope, the American Association for World Health has adapted the UNAIDS theme to "Give Children Hope in a World with AIDS."

By the end of 1997, UNAIDS estimates that one million children worldwide will be living with HIV. In 1996 alone, of the 1.5 million people who died of AIDS, 350,000 were children younger than 15. Analyses indicate that by the year 2010, if the spread of HIV is not contained, AIDS may increase infant mortality by as much as 75 percent, and under-5 children mortality by more than 100 percent in regions most affected by the disease.

The UNAIDS mission for the 1997 World AIDS Campaign includes fewer children infected, fewer children affected, fewer children who are vulnerable to the impact of HIV/AIDS, and an increasing number of girls and boys who are protected in a world that upholds their rights.

Today's children are growing up in a world with AIDS. They are having to cope not only with issues and problems that have long existed and are now being revealed by the HIV/AIDS pandemic, but also with those that result directly from the epidemic and which, until recently, people had to face only as adults.

More children are contracting HIV than ever before, and there is no sign that the infection rate is slowing. Unfortunately, the magnitude of the global challenge remains to be documented with any precision.

Additionally, by the year 2000, the World Health Organization projects that 10 to 15 million children will be orphaned due to AIDS. Individual households struck by AIDS often suffer disproportionately from sigma, isolation and impoverishment, and the emotional toll on the children is heavier still.

In the final analysis, according to UNAIDS, "all children of the world henceforth face a lifetime of risk from HIV. They are exposed to the risk of HIV infection at different life stages as they grow into adulthood because of circumstances such as sexual exploitation and abuse or simply due to violation of their rights to information, to education and services."

"PEPline" - A 24-Hour Hotline for Health Workers Exposed to HIV

Health care workers who experience exposure to blood-borne diseases such as hepatitis and HIV can now call the new 24-hour National Clinician's Post Exposure Prophylaxis Hotline ("PEPline," 1-888-448-4911). Trained physicians staff the hotline to provide state-of-the-art knowledge for treatment recommendations and counseling for workers with needlestick injuries and other hazardous occupational exposures. The new national service is a joint project of the Health Resources and Services Administration and the Centers for Disease Control and Prevention, in collaboration with the San Francisco Department of Public Health and the University of California in San Francisco. The CDC estimates that at least 5,000 needlestick exposures to HIV occur every year in the United States.

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.
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Sara Apsley-Ambriz, D.O.
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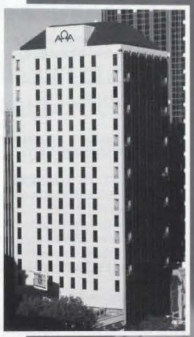
Hold the Phone!

AOA has new phone number

On Jan 1, the direct telephone number for the American Osteopathic Association's Chicago Office changed to:

(312) 202-8000



The toll-free number for the AOA Chicago Office remains **(800) 621-1773**, and the toll-free number for the AOA Washington Office remains **(800) 962-9008.**

When the AOA Chicago Office's direct number changed, the AOA's main fax number changed to **(312) 202-8200.** In addition, the extensions for individual AOA employees also changed. However, the following extensions remain the same:

Ext 1—membership questions and address changes

Ext 2—information on internships and residencies

Ext 3—public relations

Ext 4—information on earned continuing medical education credits

Ext 5—registration for the AOA convention

Ext 6—healthcare facilities accreditation

For Your Information

OSTEOPATHIC AGENCIES

American College of Osteopathic Family Physicians 800/323-0794
Texas Society of American College of Osteopathic Family Physicians 888-892-2637
. . . . . 512/708-9959
American Osteopathic Association 312/202-8000
. . . . . 800/621-1773
Washington Office 202/544-5060
. . . . . 800/962-9008
American Osteopathic Healthcare Association 301/968-AOHA (2642)
Physician's Choice Medical Malpractice 800/366-1432
Dean, Jacobson Financial Services
For Premium Rates, Enrollment & Information 800/321-0246
TOMA Major Medical Insurance 800/321-0246
TOMA Disability Insurance Program 800/321-0246
UNTHSC/Texas College of Osteopathic Medicine 817/735-2000
Dallas Metro 429-9120
Medicare Office
Part A Telephone Unit 800/813-8868
Part B Telephone Unit 903/463-4495
Profile Questions 214/766-7408
Provider Numbers
Established new physician (solo) 214/766-6162
Established new physician (group) 214/766-6163
All changes to existing provider number records 214/766-6158
Medicaid/NHIC 512/343-4984
CHAMPUS/General Inquiry 800/406-2833
Texas Medical Foundation 512/329-6610
Toll free 800/725-9216
Texas Osteopathic Medical Association 512/708-TOMA
in Texas 800/444-TOMA
FAX: 512/708-1415
E-Mail. . . . . toma@txosteo.org
TOMA Physicians Assistance program. 800/896-0680
TOMA Med-Search 800/444-TOMA

TEXAS STATE AGENCIES

Texas Health and Human Services Commission 512/416-0366
Department of Health 512/458-7111
Department of Public Safety:
Controlled Substance Division 512/424-2188
Triplicate Prescription Section 512/424-2189
Texas State Board of Medical Examiners 512/305-7010
FAX: 512/305-7006
Registration 512/305-7020
Formal Complaints 800/201-9353
Consumer Disciplinary Hotline 800/248-4062

Texas State Board of Pharmacy 512/305-8000
Texas Workers' Compensation Commission 512/448-7900
Medical Review Division 512/440-3515
Texas Hospital Association 800/252-9403
Texas Department of Insurance 512/463-6169
Texas Department of Protective and Regulatory Services 512/450-4800
Texas Poison Control Center Network 800/POISON-1
. . . . . 800/764-7661

FEDERAL AGENCIES

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

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

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