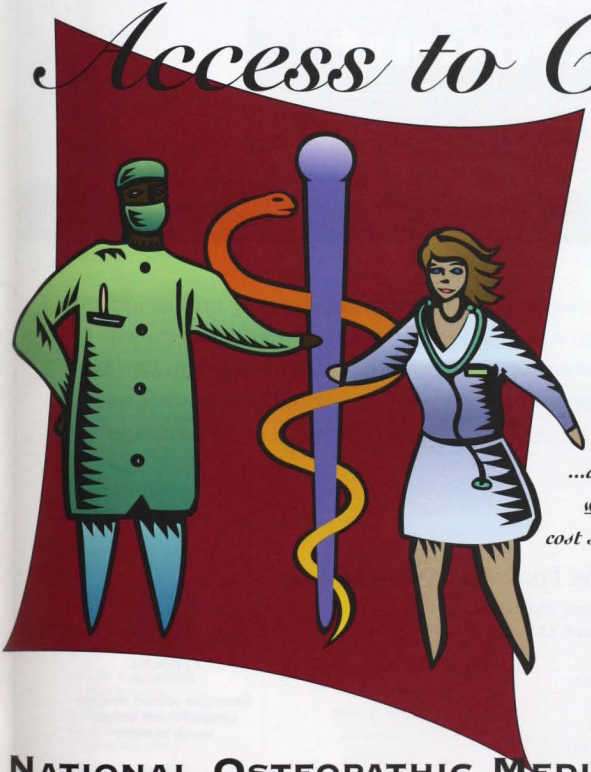
TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

Volume LIX, No. 9

October 2002

Access to Care



In 2001, more than 41 million Americans – one in seven – had difficulty accessing quality health care ...and 52 percent of people with insurance said that cost still remained a barrier to getting medical care.

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NATIONAL OSTEOPATHIC MEDICINE WEEK

OCTOBER 6 - 12, 2002

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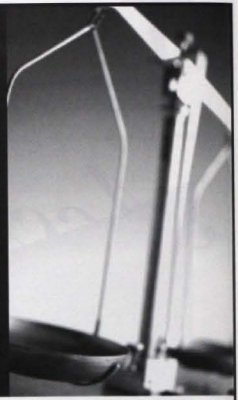

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TEXAS D.O.
The Journal of the Texas Osteopathic Medical Association

OCTOBER 2002

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

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

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

Published by the Texas Osteopathic Medical Association, Volume LIX, No. 9, October, ISSN 0275-1453.

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

INSIDE THIS ISSUE

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

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CALENDAR OF EVENTS

OCTOBER 6*

"Osteopathic Mangement of Patients with ENT/Respiratory Problems"

Sponsored by the American Academy of Osteopathy

Location: Las Vegas Convention Center, Las Vegas, NV
Contact: AAO, 317-879-1881
www.charlan@academyofosteopathy.org

* This one-day workshop is being held the day prior to the opening of the AOA's Annual Convention

OCTOBER 7 – 11

"AOA 107th Annual Convention and Scientific Seminar"

Sponsored by the American Osteopathic Association

Location: Las Vegas Convention Center, Las Vegas, NV
Contact: Ann Wittner, AOA
800-621-1773, ext. 8256 or 312-202-8014

DECEMBER 6 – 8

"21st Annual Winter Update"

Sponsored by the Indiana Osteopathic Association

Location: Sheraton Hotel & Suites, Indianapolis, IN
CME: 20 hours category 1-A credits anticipated
Contact: IOA, 800-942-0501 or 317-926-3009

FEBRUARY 26 – March 2, 2003

"Midwinter Basic Course"

Sponsored by The Cranial Academy

Location: AZCOM, Phoenix, AZ
CME: 40 hours anticipated
Contact: The Cranial Academy
8202 Clearvista Pkwy, #9-D
Indianapolis, IN 46256
317-594-0411; FAX 317-594-9299

CME CORRESPONDENCE COURSE

"Medical Ethics: Applying Theories and Principles to the Patient Encounter"

Sponsored by the University of Pennsylvania School of Medicine, the University of Pennsylvania Center for Bioethics and Clinical Consultation Services

CME: 60 hours Category 2-B
Course Tuition: $1,200
Contact: 800-480-5542

TOMA Congratulates George N. Smith, D.O.

Named Citizen of the Year in West, Texas

One of TOMA's most active members, Dr. George Smith, was recently named Citizen of the Year by the West Chamber of Commerce in West, Texas. The chamber's spokesperson said Dr. Smith was chosen for many reasons. "He gives hundreds of volunteer hours as the team doctor for all of the local high school's sporting events, serves as medical and safety director for the Labor Day Weekend Westfest and is the medical director for the West Volunteer Ambulance Service. In addition to his full-time practice in family medicine, he is also the medical director for the West Rest Haven Nursing Home and serves on the Board of Directors of West Comunity Hospital."

During the chamber's annual banquet, held in August, Dr. Smith was cited as being a devoted healthcare provider whose concern, compassion and dedication to the people of West are well known throughout this close-knit community near Waco.

Dr. Smith and his wife, Jeanie have lived in West for 27 years. They have four children; Michelle, Heather, Brian and Kevin.

TOMA's 2003 CME Conference Schedule
Mark Your Calendar Today!

47th MidWinter Conference & Legislative Symposium

February 7 – 9

"Caring for Your Practice"

John L. Wright, Jr., D.O., Program Chair

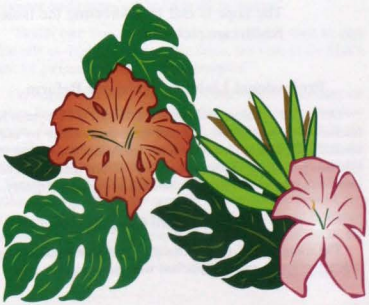
Omni Mandalay Hotel at Las Colinas
Irving, Texas

Patterned after the exotic charm of a Burmese city, the Omni Mandalay Hotel at Las Colinas invites you to experience the elegance of a luxurious hotel with an Asian touch of distinction. Located in the prestigious Las Colinas Urban Center on the Mandalay Canal, this AAA Four-Diamond hotel looks and feels like a resort, yet provides all the contemporary amenities for TOMA's MidWinter Conference activities.

104th Annual Convention & Scientific Seminar

June 18 – 22

Moody Gardens Resort
Galveston, Texas



National Osteopathic Medicine Week
October 6-12, 2002

A Focus on

"Access to Care"

In this past year, the problems Americans have faced regarding access to medical care continued to escalate. Issues of concern from Medicare to the uninsured to the status of minority health are broad and far-reaching. Physicians and health care entities are paying increasingly more for professional liability insurance, with some finding it no longer available to them. Increased premiums are resulting in closed practices, decreased services, and often a tendency to practice defensive medicine due to liability concerns. In turn, patients are faced with high insurance premiums, lack of physicians in many areas, limited medical services, and higher out-of-pocket expenses.

In 2001, more than 41 million Americans – one in seven – had difficulty accessing quality health care, according to the Center for Studying Health System Change. While the uninsured are three times as likely to go without care, access issues are not limited to those lacking health insurance. Almost 16 million insured Americans had unmet medical needs last year, and 52 percent of people with insurance said that cost remains a barrier to care.

Other issues, such as language barriers and rural and urban underserved areas, continue to impact access to medical care. To add to the crisis, shortages of physicians, nurse and other health care personnel continue to burden an already overwhelmed system. There are more than 168,000 unfilled positions in hospitals across the nation, while six out of 10 hospitals are filled to capacity. Many health care providers can no longer afford to practice in certain states; hospitals are closing trauma centers and limiting patient services; nursing homes are closing; and many safety-net programs relying on physician volunteers are no longer operating.

Because these issues have a large impact on patients, health care professionals, and the country, the American Osteopathic Association has dedicated this year's National Osteopathic Medicine (NOM) Week, October 6-12, 2002, to topics related to "Access to Care." The hope is that by addressing the issues, we will come a step closer to resolving these health care problems.

Professional Liability Insurance Reform

Our nation's professional liability insurance (PLI) system has reached crisis proportions. Affected most dramatically by astronomical increases in medical practice premiums, the current PLI system is profoundly impacting access to care and health care costs, jeopardizing patient safety, and ultimately compromises quality.

Access to Care Limited

The rising cost of medical liability insurance rates is having a direct effect on many physicians who can no longer afford to maintain their practices. According to the Medical Liability Monitor, insurance rate increases – some as great as 70 to 300 percent a year – have caused physicians, regardless of specialty, to move their practices to states with lower rates. Some physicians are opting to close their practices all together.

Increasing numbers of physicians have been forced to stop conducting "high-risk" procedures, including prenatal care and deliveries. Now considered a "high-risk" specialty by many insurers, OB/GYN premiums have nearly quadrupled, and in some areas of the country, no coverage is available. This translates to a burden for physicians as wellas their female patients.

Volunteer care provided by physicians is also being hit by the cost of malpractice insurance. Free clinics and other volunteer organizations are having to spend their limited resources to obtain coverage, resulting in less money available for medical care for those who need it. According to the U. S. Department of Health and Human Services (HHS), the proportion of physicians providing charity care decreased from 76% to 72% between 1997 and 1999 alone.

Increasing Costs Reach Patients

Although there are several theories about the rising costs associated with liability insurance, it is widely believed that growing numbers of malpractice suits and high settlements have played a key role in driving premiums to alarming levels. In 1999, for example, the average cost to a physician to defend against a claim that was eventually dropped, withdrawn, or dismissed was $13,251, according to the Physician Insurer's Association of America. In 2002, experts estimate that amount to be as high as $20,000 per claim.

Medical liability and the litigation system impose direct and indirect costs on the health care system. Insurance companies are no longer providing medical malpractice insurance coverage to many physicians, and limiting the scope of coverage and benefits they provide to patients. As a result, much of the cost burden is passed on to health care consumers in the form of out-of-pocket medical expenditures. Increased costs that must be borne by the patient represent one of the most powerful barriers to care.

In addition, liability concerns force many physicians to practice defensive medicine. A July 24th, 2002 report by the Department of Health and Human Services (HHS) notes that the costs of defensive medicine add many billions of dollars more to American health expenditures. The report cites a survey of physicians that found 74% of survey respondents referred patients to specialists more often than they believed was medically necessary, due to litigation fears; and 51% recommended invasive procedures for diagnosis confirmation more often than they believed was medically necessary, also due to fear of litigation. Altogether, notes the report, medical liability adds $60 to $110 billion to the costs of health care each year.

Focus on Professional Liability Insurance Reform – The Texas Perspective –

The Facts

- ☆ A survey of doctors in the Rio Grande Valley by Texas Medical Association found that 71 percent said they were afraid to respond to emergency room calls because of lawsuits and 55 percent said they were inclined to leave the area if the lawsuit crisis does not improve. (*Texans Against Lawsuit Abuse*)
- ☆ Statewide, studies show that 85 percent of malpractice suits are settled with no payment going to the patient. These non-meritorious cases are expensive and add significantly to administrative costs in the health care system. (*Texas Alliance for Patient Access*)
- ☆ Each claim cost an average of $68,681 to litigate in 2000, compared with $46,079 in 1995. However, these figures do not include the amount of settlement or award. (*Texans Against Lawsuit Abuse*)

"...medical liability adds $60 to $110 billion to the costs of health care each year."

- ☆ Even physicians who have never been sued are finding their malpractice premiums skyrocketing. In addition, 10 percent of physicians in Texas in the past year and a half have lost coverage or been forced to look for a new carrier. (*Texans Against Lawsuit Abuse*)
- ☆ Medical malpractice insurance in Texas is the least profitable for insurance companies, compared with the other top 15 states, based on the 2000 NAIC Report on Profitability By Line By State (NAIC report does not include TMLT). For all measures of profitability, including Underwriting Profit and Return on Net Worth, Texas ranks last over the ten year period of 1991 through 2000. Under these market conditions, it will be very difficult for Texas to retain or attract medical malpractice insurers. (Presentation of *Texas Department of Insurance Commissioner Jose Montemayor to Senate Prompt Payment Committee*)

The Issue

On July 25, 2002, Bill Summers, who founded the country's first Citizens Against Lawsuit Abuse movement (CALA) in Texas' Rio Grande Valley and serves as its president, issued the following statement in response to President Bush's liability reform proposals:

"Skyrocketing number of questionable health care lawsuits are putting proper health care out of reach of many in our state. Instead of treating patients, many doctors are closing their doors because of junk lawsuits and skyrocketing malpractice premiums. Without additional civil justice reforms and greater awareness of the problem, our entire health care system is threatened. More doctors' offices will shut down. More specialty health care services will disappear from the Valley and other parts of Texas. And more important medications will be taken off the market.

"Health care lawsuits are making us sick. It's time to cure what ails us. It's time to stop this abuse. It's time to do what's right for patients and health care consumers."

On August 15th, 2002, the Texas Senate Special Committee on Prompt Payment of Healthcare Providers, chaired by Senator Jane Nelson, held a public hearing in San Antonio. Although the committee is determining ways to ensure that medical claims are paid by HMOs in a prompt manner, the committee is also interested in Texas' medical liability crisis. The hearing focused on Texas' patient access crisis and the need for both immediate prompt pay reform and medical liability reform. Texas Department of Insurance Commissioner Jose Montemayor presented information to the committee on the medical malpractice situation in Texas.

continued on next page

Texas Medical Malpractice Filed Rates for Selected Specialties

Mature claims made with $1,000,000/$3,000,000 Limits of Liability
Sorted from Highest Premium City to Lowest Premium City

City	County	Family Physician No Surgery	OB/GYN Surgery	Anesthesiology
McAllen	Hidalgo	$21,430-$28,250	$92,326-$131,601	$32,915-$46,730
Brownsville	Cameron	$21,430-$28,250	$92,326-$131,601	$32,915-$46,730
El Paso	El Paso	$16,469-$27,477	$73,118-$131,601	$23,029-$46,730
Houston	Harris	$16,469-$34,346	$62,318-$131,601	$23,029-$58,112
Beaumont	Jefferson	$16,469-$27,477	$62,318-$131,601	$23,029-$46,730
Corpus Christi	Nueces	$14,638-$27,477	$64,988-$93,457	$20,469-$46,730
Dallas	Dallas	$15,124-$27,477	$59,221-$93,457	$21,755-$46,730
Austin	Travis	$14,638-$27,477	$64,164-$93,457	$20,469-$46,730
San Antonio	Bexar	$16,638-$27,477	$64,164-$93,457	$20,469-$46,730
Lubbock	Lubbock	$12,680-$27,477	$42,710-$93,457	$18,708-$46,730

(Excerpted from Table 2, "Texas Medical Malpractice Filed Rates for Selected Specialties," Senate Prompt Payment Committee presentation, August 15, 2002.)

Texas Governor Calls for Reforms

Texas Governor Rick Perry has publicly addressed the issue of medical liability insurance by proposing the following:

- ☆ Pass meaningful tort reform for the health care profession that caps non-economic losses to plaintiffs at $250,000 and limits plaintiffs' attorney fees to a prescribed schedule based on the size of the award. More than 20 other states have capped non-economic damages, resulting in significantly lower liability insurance rates. California, for example, limits non-economic damages to $250,000 and has the 47th lowest medical liability rates in the nation.
- ☆ Create special courts or designate special judges to hear medical malpractice claims. These judges would have expertise in malpractice issues and would be better able to toss out frivolous lawsuits. Encourage the special courts to sanction lawyers and award litigation costs in frivolous cases.
- ☆ Improve the Board of Medical Examiners' ability to police the medical profession and safeguard patient care through enforcement of licensing laws and consistent disciplinary enforcement actions.
- ☆ In concert with doctors and hospitals around the state, develop clear procedures for reducing medical errors, and for clear and swift disciplinary actions against the relatively few bad doctors.
- ☆ Extend tort immunity to health care providers who treat low-income patients under contract with the state.
- ☆ Provide a form of temporary, emergency malpractice insurance coverage for doctors who have been denied coverage solely for economic reasons.
- ☆ Expand the Texas Department of Insurance's ability to review insurance companies' rates and ensure that malpractice premiums are commensurate with losses.

What is TOMA Doing?

James Froelich, III, D.O., President of the Texas Osteopathic Medical Association, has challenged every TOMA and ATOMA member to promote and increase our legislative agenda in keeping with his call for this year's annual theme: "Increasing Our Legislative Effectiveness."

Dr. Froelich has proposed a five-point plan: 1) organize grassroots personal involvement of TOMA and ATOMA members in meeting and interacting with their legislators, supporting their legislators and networking within the osteopathic family concerning legislative matters; 2) Educate TOMA and ATOMA members and leaders about ongoing legislation and the legislative process in Texas, TOMA and the AOA; 3) Support TOMA-PAC in an effort to triple PAC contributions and educate membership as to the value of PAC activities; 4) Create a highly efficient and usable system by which pertinent legislative and politically relevant information can be gathered, processed and disseminated to TOMA and ATOMA members and our supporters; and 5) Emphasize leadership development which will help identify, recruit, cultivate, inform and educate, motivate, utilize, retain and properly recognize our Texas osteopathic leaders from graduation to grave.

In keeping with the five-point plan, three ad hoc committees will work towards helping TOMA with its legislative agenda: Triple TOMA-PAC (3-PAC), chaired by Jim Czewski, D.O., has pledged to triple TOMA-PAC contributions this year; the D.O.s working for Medical Excellence (D.O.M.E.) Day, chaired by Kenneth Bayles, D.O., is busy working on establishing an opportunity for TOMA and ATOMA members to meet with legislators in Austin this coming January 29th; 2003, and the Information Dissemination Committee, chaired by Daniel Saylak, D.O., is creating a means of quicker information dissemination.

TOMA Joins with TAPA

TOMA has joined forces with the Texas Alliance for Patient Access (TAPA), a broad-based coalition of health care providers,

consumer groups, individual physicians and insurance carriers. The purpose of TAPA is to address Texans' ability to access quality health care and to develop legislative solutions to bring before the Texas Legislature.

"If Texas wants a fair and cost-effective professional liability system, something has to be done and it has to be done now," said Howard R. Marcus, M. D., board chair for TAPA. "Many South Texas counties have no doctor or obstetric provider, and many rural Texas family physicians have stopped delivering babies altogether. In urban areas, such as Austin, the People's Community Clinic helps over 3,000 patients a month; however, they turn away over 2,000 patients each month. Many active and retired physicians would eagerly volunteer their time and expertise; however, the fear of a medical malpractice lawsuit has a chilling effect.

"No one is suggesting that truly injured patients should not be indemnified. We believe Texas' current medical professional liability system needs substantial reform because it is inefficient, unpredictable, costly, slow, and unfair to patients and providers alike. TAPA will provide new creative thinking about how best to remedy this deteriorating situation."

TOMA Working Closely with TAPA and Legislative Activities

The following is a listing of legislative proposals developed by TAPA's legislative committee, as outlined in TAPA's July 15, 2002 newsletter. It was recommended that TAPA's advocacy efforts be focused on health care liability reforms, and that TAPA coordinate with other groups on broader tort reform issues.

Health Care Liability Priorities

1. Limitation on Non-Economic Damages
2. Limitation on Economic Damages
3. Collateral Source Rule
4. Periodic Payments on Future Damages
5. Limitations on Attorney Contingency Fees
6. Procedural issues that address frequency of claims, costs of litigation
7. Pre-judgment Interest
8. Charitable Immunity
9. Limitation on Liability for Prescribing of Drug or Device
10. Managed Care Liability

Other Liability Reforms

1. Allocation of Settlement Credits
2. Disqualification of juror during voir dire
3. Limitation on Punitive Damages Awards

(Citizens Against Lawsuit Abuse Statements Regarding President's Medical Liability Reform Proposals," news release, July 25, 2002, Texans Against Lawsuit Abuse at <www.tala.com>; Senate Special Committee on Prompt Payment of Health Care Providers Regarding Medical Malpractice Insurance," presentation of TDI Commissioner Jose Montemayor, August 15, 2002; Texas Alliance for Patient Access at <www.tapa.info>; "Ensuring Texans Have Access to Quality, Affordable Health Care," press release, April 5, 2002, at <www.governor.state.tx.us>.)

National Reform

The HHS report notes that liability reforms, including reasonable limits on non-economic damages ($250,000-$350,000), are working in many states to reduce costs and improve health care access. Liability premium increases last year averaged 12% in states with caps, and 44% in states without. Further, the report notes that if reasonable caps on non-economic damages were applied nationally, studies based on the experience of states with such reasonable caps indicate that: over $60 billion per year in health care costs could be redirected from lawsuits and unnecessary care toward paying for drugs and other treatments; over $30 billion in federal payments could be redirected toward improving Medicare, Medicaid and other federal programs; and over 2 million more Americans would be able to afford health insurance. In addition, these caps improve quality of care because of greater access to physicians.

President Bush supports federal reforms in medical liability law. Among the reforms:

- ☆ Improve the ability of all patients who are injured by negligence to get quicker, unlimited compensation for their economic losses, including the loss of ability to provide unpaid services like care for children or parents.
- ☆ Ensure that recoveries for non-economic damages do not exceed a reasonable amount ($250,000).
- ☆ Reserve punitive damages for cases where they are justified, such as when there is clear and convincing proof that the defendant acted with malicious intent or deliberately failed to avoid unnecessary injury to the patient and limit punitive damages to reasonable amounts (i.e., up to the greater of two times economic or $250,000)
- ☆ Provide for payments of judgments over time rather than in a single lump-sum, to ensure that appropriate payments are there when patients need them.
- ☆ Ensure that old cases cannot be brought up years after an event when medical standards may have changed, by providing that a case may not be brought more than three years following the date of injury or one year after the claimant discovers, or with reasonable diligence should have discovered, the injury.
- ☆ Ensure that juries are informed if a plaintiff has other sources of reimbursement for an injury.
- ☆ Provide that defendants pay judgments in proportion to their fault, not on the basis of how deep their pockets are.

Professional Liability Insurance Reform – AOA Position –

Tort reform is largely considered to be among the most progressive solutions to address the increase in professional liability insurance costs. The AOA supports six general principles (mirrored in California's 1975 "Medical Injury Compensation Reform Act") that, when utilized as a group, have

demonstrated the ability to address the current problems facing our health care system:

1. **Periodic Repayment of Future Expenses or Losses** - The AOA supports provisions that, in medical malpractice suits, would allow a plaintiff's future expenses or losses to be paid periodically over time, while past and current expenses are paid in full lump-sum.
2. **Limitations on Non-economic Damages** - The AOA supports a cap on non-economic damages awarded in medical malpractice cases. This type of cap does not prevent plaintiffs from collecting any amount necessary to pay for medical expenses, lost wages, rehabilitation costs or any other economic loss suffered as the result of a health care injury. It only limits those damages awarded for pain and suffering, mental anguish and loss of enjoyment.
3. **Joint and Several Liability Reform** - The doctrine of joint and several liability allows an injured plaintiff to recover all damages from any one or combination of defendants. AOA supports provisions that would hold defendants accountable for the amount of damages directly attributed to them. Under the current system, a defendant responsible for as little as one percent of the total fault may be required to pay the entire award.
4. **Limits on Attorney Contingency Fees** - AOA supports setting limits for attorney contingency fees utilizing provisions that discourage "big-ticket" cases that bog down the court system and prevent other cases from being heard.
5. **Establish Uniform Statutes of Limitations** - The AOA supports enactment of uniform statutes of limitations; provisions that require claims to be filed within one year from the date of discovery and within three years of the date the injury occurred. Exceptions should be made for children and for claims where a foreign body is left in a claimant's body and not discovered for many years.
6. **Eliminate the Collateral Source Rule** - If a plaintiff includes medical expenses in a lawsuit, defendants should be allowed to introduce to a jury evidence of any reimbursements to the claimant by health or disability insurers or other source for losses resulting from an injury. This provision prevents a plaintiff from recovering identical expenses from multiple parties.

The AOA continues to pursue the approval of comprehensive medical liability legislation that will increase the availability of coverage and stabilize premiums. The AOA has made PLI reform one of its top legislative priorities for the 107th Congress.

(Texas Alliance for Patient Access, <www.tapa.info>; "Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing our Medical Liability System," July 24, 2002, U.S. Department of Health and Human Services at <http://aspe.hhs.gov/daltcp/reports/litrefm.pdf>.; Fact Sheet – President proposes Minimum Standards for Medical Liability System at <www.whitehouse.gov/news/release/2002/07/20020724-11.html>.)

Patients Want System Reform

☆ Four out of five Americans (78 percent) express concern that skyrocketing medical liability costs could limit their access to care, as doctors in many parts of the country scale back services or abandon their practices.

☆ Seven out of ten (71 percent) agree that medical liability litigation is one of the primary forces driving up health care costs.

☆ Nearly half (48 percent) believe the number of malpractice suits against health care providers is "higher than justified" compared to 17 percent, who said the number of claims is "lower than justified."

☆ By a wide margin (73 percent to 26 percent), Americans support reasonable limits on awards for "pain and suffering" in medical liability cases.

☆ More than 76 percent favor a law limiting the percentage a trial lawyer can collect in a settlement or award from a medical liability case.

(Wirthlin Worldwide Survey conducted for the Health Care Liability Alliance)

Focus on the Uninsured

In 2001, an estimated two million Americans lost their health insurance, the largest one-year increase in the number of uninsured in nearly a decade, according to new data released February 12, 2002, by *Covering the Uninsured*. Covering the Uninsured is comprised of 12 national organizations representing diverse points of view that have come together, along with The Robert Wood Johnson Foundation (RWJF), to sponsor a variety of educational activities and including national advertising, to publicize the extent of the problem of the uninsured and find solutions. In releasing the new data, Covering the Uninsured announced a new, $10 million advertising campaign and launched a new Web site.

"This is the most dramatic one-year increase in the number of uninsured Americans in nearly a decade," said Dr. Steven A. Schroeder, President and CEO of The Robert Wood Johnson Foundation, a co-sponsor of the effort. "While we were celebrating the Dow reaching record highs in the 1990s, tens of millions of Americans, the majority of whom were working full time, did not have health insurance. Now that the economy has slowed, millions more Americans are losing their health coverage. This is simply unacceptable for a nation as great as ours."

According to the most recent information from the Census Bureau, nearly 39 million Americans did not have health care coverage in 2000. Since that time, a slow economy, higher unemployment and rising health care costs likely mean that more Americans became uninsured. The new data show that of the estimated two million job losses with resulting loss of insurance, more than a quarter of the increase occurred during the month of October.

A separate national survey conducted for the campaign found that even those who currently have private health insurance are worried about losing it. Of those surveyed, 43 percent said they believed their employer or their spouse's employer might cut back or eliminate certain health care benefits and coverage options sometime over the next year.

According to the Center for Studying Health System Change, health care spending rose 7.2 percent in 2000, the largest jump in

a decade. The Center found that during the same year, premiums for employer-sponsored coverage increased 8.3 percent followed by an 11 percent increase in 2001.

(Excerpts from "Two Million Americans Lost Their Health Insurance in 2001; Largest One-Year Increase In Nearly a Decade." News release. 2-12-02. <www.coveringtheuninsured.org>.)

The Uninsured Face Premature Deaths

Americans without health insurance are more likely to have poorer health and die prematurely than those with insurance, according to a report from the National Academys' Institute of Medicine. Uninsured patients with colon or breast cancer face up to a 50 percent greater chance of dying than patients with private coverage. Uninsured victims of trauma also are more likely to die from their injuries. Being uninsured for even a year appears to diminish a person's general health.

The committee that wrote the report examined the consequences of being uninsured for people suffering from cancer, diabetes, HIV infection and AIDS, heart and kidney disease, mental illness, traumatic injuries, and heart attacks. It focused on the roughly 30 million – one in seven – working-age Americans without health insurance. This group does not include the population over 65 that is covered by Medicare or the nearly 10 million children who are uninsured in this country.

According to the report:

* **Cancer** - Uninsured cancer patients die sooner than people with insurance, largely because of delayed diagnosis. Likewise, uninsured patients tend to reach severe renal failure before they begin kidney dialysis.

* **Diabetes** - The longer diabetics go without health insurance, the grater the chance they will experience uncontrolled blood-sugar levels. Studies show that 25 percent of adult diabetics who were uninsured for a year or more went without a checkup for two years, compared to 5 percent of diabetics with insurance.

* **Hypertension or High Cholesterol** - Uninsured adults with hypertension or high cholesterol are less likely to monitor their blood pressure or stay on drug therapy – if they are fortunate enough to be screened at all. Patients admitted to emergency rooms with severe uncontrolled hypertension are more likely to be uninsured.

* **HIV or AIDS** – Uninsured adults are less likely to receive the highly effective "drug cocktails" that have become the standard treatment in the past five years. And when they do get the newer drug therapies, their wait to receive treatment has been an average of four months longer than that of patients with private insurance.

* **Mental Illness** - Mentally ill patients with insurance that covers their treatment are more likely to receive appropriate care than those with no insurance. Even when health insurance does not specifically cover mental-health expenses, just having it increases the likelihood that someone with depression or anxiety will receive some care.

* **Traumatic Injuries and Heart Attacks in the Hospital Setting** - To see how uninsured patients fare in a hospital setting, the committee focused on two conditions for which most people are treated regardless of whether they are insured: traumatic injuries and heart attacks. It found that uninsured persons with traumatic injuries are less likely to be admitted to the hospital, receive fewer services if they are, and are more likely to die than insured victims. One statewide study of car crash victims discovered that uninsured victims had a 37 percent higher mortality rate. Another statewide study found that although uninsured trauma patients were just as likely to be placed in intensive care, they were less likely to be operated on or to receive physical therapy.

Research also shows that uninsured patients hospitalized for a heart attack have a greater risk of dying during their hospital stay or shortly thereafter than patients with private insurance. They also are less likely to go to a hospital that performs angiography or other catheterization techniques, and even if they do, they are less likely to receive such sophisticated procedures.

Studies that have monitored the health of people who had no insurance or temporarily lost it for a period of one to four years show that a person's overall well-being suffers during the time they lack coverage. The decline in health caused by a lack or loss of coverage is most profound for adults between 55 and 65 years old. Symptoms of worsening health might include high blood pressure, greater difficulty climbing stairs or walking, or a decline in general self-perceived wellness.

Being uninsured magnifies the health risks for chronically sick and mentally ill patients, as well as for groups that are already at greater risk of poor health, such as racial and ethnic minorities and adults with low incomes. Increasing health insurance coverage would reduce some, but not all, of the disparities in health care experienced by racial and ethnic minorities.

(Excerpts from "Uninsured Adults Are More Likely To Die Prematurely." News release. May 21, 2002. <www.nationalacademies.org>.)

Current Health Care Coverage Survey

Sharply rising health care costs and the downturn in the economy have resulted in higher premium contributions and cost-sharing requirements for workers, and cutbacks in the scope of health benefits offered by firms, according to a new survey. The annual survey of employer health benefit plans was released September 5, 2002, by the Kaiser Family Foundation and the Health Research and Educational Trust.

Survey findings illustrate that workers are paying more while benefits erode:

* Premiums increased 12.7%, the highest increase since 1990. Single premiums are now, on average, $3,060 for single coverage, and $7,954 for family coverage.

* The amount employees pay for coverage has risen substantially. For single coverage, employees now pay an average of $454 per year – a 27%, or $95 increase from last year. The employee share of premiums for family coverage averaged $2,084 per year – a 16%, or $283 increase from last year.

* Deductibles for PPO in-network providers rose 37% to $276 in 2002, up from $201 in 2001.

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"Each year new studies report rampant disparities in health care for certain populations, particularly for African Americans, Hispanics and Native Americans."

* The use of three-tiered cost sharing has nearly doubled since 2000, from 29% to 57% tin 2002. The cost of drugs within these tiers is also higher – brand name drugs with generic substitutes now cost $26 per prescription, up from $20 per prescription in 2001.

* While Congress continues to struggle over how to structure a prescription drug benefit under Medicare, retiree benefits remain the main source of drug coverage for many seniors. Meanwhile these benefits continue to erode. Overall, 34% of large companies offer retiree benefits, compared to 66% in 1988, but about the same as 2001. The 2002survey found that 9% of large firms (200 or more workers) eliminated retiree benefits for new hires or existing employees in the last two years. Forty percent of large firms increased retiree share of the premiums, 30% introduced three-tired cost-sharing for drugs, and 26% increased the amount retirees pay for prescription drugs.

* The days of using health benefits to attract and keep workers appear to be over for now. Sixty-two percent of all firms offer health benefits. While virtually all large firms (200 workers or more) offer health benefits (99% in 2002), firms with fewer than 200 workers (small firms) continue to struggle with increasing health care costs. Only 61% of small firms (3-199 workers) offered health benefits in 2002, compared to 67% in 2000, an early indicator of possible erosion in the number of small firms offering coverage.

(Excerpts from "New Survey Shows Workers Are paying More and Getting Less For Their Health Coverage." News release. September 5, 2002. The Kaiser Family Foundation at <www.kff.org>.)

Focus on Minority Health Care and Access – Background –

The 2000 Census revealed as many as 63 different racial and ethnic groups in the United States. A recent study conducted by The Commonwealth Fund revealed that minority Americans do not fare as well as Caucasians on a wide range of measures, including effective patient-physician communication, overcoming cultural and linguistic challenges, and access to health care and insurance coverage. As a result, many minority groups are more likely to suffer health problems than Caucasians, yet less likely to seek or receive preventive care.

Rampant Disparities in Minority Health

Each year new studies report rampant disparities in health care for certain populations, particularly for African Americans, Hispanics and Native Americans. These groups repeatedly show deficiencies with regard to infant mortality, immunizations, HIV infection, cardiovascular disease, cancer, and diabetes. According to the U.S. Public Health Service, African American infants, for example, are two-and-one-half times more likely to die in their first year than Caucasian infants. Native Americans are three-to-five times more likely to develop diabetes than Caucasians.

A congressionally mandated report, entitled "Unequal Treatment: Confronting Racial and Ethnic Disparities In Health Care," from the National Academys' Institute of Medicine notes that racial and ethnic minorities tend to receive lower quality health care than whites, even when insurance status, income, age, and severity of conditions are comparable. The committee that authored the report emphasized that differences in treating heart disease, cancer and HIV infection partly contribute to higher death rates for minorities. Minorities are less likely to be given appropriate cardiac medications, undergo bypass surgery, receive kidney dialysis or transplants; and more likely to receive certain less desirable procedures, such as lower limb amputations for diabetes and other conditions.

Patient-Physician Communication Difficulties and Language Barriers

A Commonwealth Fund 2001 Health Care Quality Survey revealed the following:

* Minority Americans were more likely than Caucasians to experience difficulty communicating with their physicians. Hispanics were more than twice as likely as Caucasians (33% vs. 16%) to cite one or more communication problems such as not understanding the doctor, not feeling the doctor listened to them, or that they had questions for the doctor but did not ask. One fourth of Asian Americans (27%) and African Americans (23%) experience similar communication difficulties.

* Fewer than half of Hispanics (45%) report it is very easy to understand information from the doctor's office, compared with three of five Caucasians. (59%).

* Nearly one of four adults who had visited a doctor in the last two years said there was a time when they did not follow their doctor's advice; the reasons most often given for not following the advice are disagreement with the advice (39%) and that it cost too much (27%). Among those who did not follow a doctor's advice, two of five (41%) Hispanics and nearly one of three African Americans (30%) noted that high cost was the reason for noncompliance, compared with about one of four Caucasians (24%) and Asian Americans (27%).

Not surprisingly, language barriers result in communication complications for many ethnic groups, including the inability to adequately describe symptoms to health care providers, discuss treatment options and understand treatment directions. While speaking a language other than English as a primary language nearly doubles the risk of having a communication breakdown with health care providers, English-speaking segments of various

minority groups also report significantly higher rates of problems communicating with their health care provider than Caucasians.

In addition, the survey found that minority Americans are more likely than Caucasians to have negative experiences in the health care system. Nearly one of six African Americans (15%), one of seven Hispanics (13%) and one of ten Asian Americans (11%) feel they would receive better health care if they were of a different race or ethnicity, compared with 1% of Caucasians.

Lower Rates of Insurance, Access

Hispanics and African Americans are most at risk of being uninsured. According to The Commonwealth Fund survey in 2001, nearly one-half of working-age Hispanics, or 46 %, lacked health insurance, as did one-third of African Americans. As a result, uninsured minorities are even more likely than uninsured Caucasians to experience problems obtaining access to health care. Uninsured minorities are more likely than uninsured Caucasians to report little or no choice in their source of health care. Of those uninsured at any point during the survey, two of five Hispanics (39 %) and African Americans (38 %) and one-third of Asian Americans (32 %) said they had very little or no choice in their source of health care.

Minority Health – The AOA Position –

The AOA recently established the Minority Health Initiative aimed at protecting the health care rights of minority patients, while at the same time, bringing more diversity to the osteopathic profession. Directed by the AOA Minority Health Advisory Committee, this new initiative was designed to attract under-represented minorities to osteopathic medical colleges, promote cultural competence among all osteopathic physicians (D.O.s) and medical students and alleviate minority-related disparities in health care. The AOA Minority Health Initiative seeks to incorporate the following principles into the osteopathic profession:

Zero-Tolerance Policy. Combating the astounding racial and cultural disparities in health care begins by enforcing a zero-tolerance policy for patient discrimination on all levels – cultural, religious, gender, age, and socio-economic.

Promoting Diversity Within the Profession. Increasing the number of minorities in the osteopathic medical profession means greater numbers of D.O.s who are better able to meet the medical needs of minority populations. This begins with targeting recruitment efforts toward minority populations, and expanding scholarship monies for minority applicants to osteopathic medical schools.

Cultural Competence. Promoting cultural competence among all D.O.s and medical students will engender broader understanding of the special needs of multicultural populations. Many of the colleges of osteopathic medicine are incorporating thorough cultural competency training in medical school curricula. Michigan State University College of Osteopathic Medicine, for example, is just one of 20 of the nation's osteopathic medical colleges to integrate comprehensive multicultural training and awareness into its curriculum. Beginning in pre-med undergraduate school and continuing through residency, students are offered a range of courses devoted to diversity training. In their third year, Michigan's osteopathic medical students are assigned to a practicing D.O., and serve a clinical experience in communities with high percentages of minority, underserved, and disadvantaged populations.

("Minority Americans Lag Behind Whites On Nearly Every Measure of Health Care Quality, March 6, 2002, news release, Commonwealth Fund at <www.cmwf.org>; "Minorities More Likely to Receive Lower-Quality Health Care, Regardless of Income and Insurance Coverage," news release, March 20, 2002, National Academies of Science at <www.national-academies.org>.)

The Facts

According to a 2000 report of the U.S. Census Bureau, Hispanics (67%) were less likely than white non-Hispanics (89%) to be covered by health insurance. American Indians and Alaska Natives were less likely to have health insurance than other racial groups, with the exception of Hispanics.

* Just over half of all Hispanics (57%) said they have a regular doctor, as did 68 percent of Asian Americans and 70 % of African Americans. In contrast, four-fifths of Caucasians (80%) reported having a regular doctor. African American (13%) and Hispanic adults (14%) were more than twice as likely as Caucasian adults (6%) to report no regular source of care, or that the emergency room is their usual source of care. *(The Commonwealth Fund)*
* Almost half (45 percent) of Hispanic adults, two of five (41%) Asian American adults, and more than one of three (35 %) African American adults report difficulty paying for medical care, compared with one of four (26%) Caucasian adults. *(The Commonwealth Fund)*
* While about two-thirds (65%) of Caucasian Medicare beneficiaries were vaccinated against the flu in the past year, about four of 10 (43%) African Americans received a flu shot in the past 12 months. Half (49%) of Hispanics had a flu shot in that time. *(The Commonwealth Fund)*
* Among part-time workers, 64% of Caucasians have employer-based insurance, compared with 45% of African Americans and 40 percent of Hispanics. *(The Commonwealth Fund)*
* Among workers earning more than $15 per hour, 79% of Caucasians have employer-based insurance, compared with 67% of African Americans and 54% of Hispanics (*The Commonwealth Fund)*

Focus on Physician Shortages/Access to Care – Background –

According to the National Health Services Corps, approximately 53 million people reside in areas without access to primary health care. Many communities throughout the country have been federally designated as Medically Underserved Areas (MUAs) and Health Professional Shortage Areas (HPSAs), determined by inadequate provider-to-population ratios, high rates of poverty, uninsured families, percentage of elderly residents and distances to health care resources.

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"Sadly, when managed care and other third-party payors reduce payments to providers, the cushion used to deliver care to the uninsured and underinsured disappears."

Factors Impacting Rural Access

Of the estimated 70 million rural Americans, more than 20 million have inadequate access to health care, according to the U.S. Department of Health and Human Services (HHS). Not only does a geographic maldistribution of health care providers in rural areas impact access, but statistics also reveal that lower education levels, unemployment, part-time and seasonal employment associated with smaller communities also contribute to increased numbers of uninsured as well as underinsured. At the same time, hospitals and other health care providers are vital to the rural economy, yet can be disproportionately burdened by fluctuations within these economies.

Health Status Disparities

According to the HHS' Agency for Healthcare Research and Quality, almost one in three adults living in rural America is in poor to fair health. Nearly half of all rural Americans suffer from at least one major illness, yet average fewer physician contacts per year than in urban communities. Limited access to health care providers also results in failure to seek needed treatment as well as preventive care. Furthermore, many rural Americans face increased health problems associated with poverty, including high rates of chronic disease and infant mortality, while rates of alcoholism and drug abuse parallel those in urban areas.

Care for the Rural Uninsured

Rural providers are able to serve the uninsured (often on a pro bono basis) to the extent that other revenues cover fixed costs and provide enough margin to absorb the extra expense. Sadly, when managed care and other third-party payors reduce payments to providers, the cushion used to deliver care to the uninsured and underinsured disappears. At the same time, increasing practice costs, such as professional liability insurance premiums, are forcing greater numbers of rural physicians to streamline their services, move to other states, retire early or close their practices, further limiting the availability of care in many areas of the country.

Initiatives to Help the Rural and Urban Underserved – The AOA Position –

Through policies that support D.O. - Run programs as well as association-wide efforts designed to improve health care in underserved areas, the American Osteopathic Association is dedicated to addressing the health and access disparities plaguing many parts of the country.

The following examples reflect the osteopathic profession's long-standing commitment to improving access to care in underserved areas:

The Tutwiler Clinic - Operated by Sister Anne Brooks, D.O., the Tutwiler Clinic in Tallahatchie County, Mississippi, has been dedicated to providing much-needed care to the medically underserved for more than two decades. In 2001, more than 80 percent of the clinic's patients had no health insurance, while 33 percent of the county's population is below poverty. With a population of roughly 15,000, the county is one of the poorest in the state, struggling with unemployment, limited resources and marginal economic viability. Still, the clinic is one of the largest employers in Tutwiler, and has served nearly 140,000 patients since 1983. The AOA has mobilized D.O.s across the country in support of the Tutwiler Clinic and other efforts of its kind with donations ranging from medication and medical supplies to clothing, household items and financial support.

Program for the Medically Underserved - More than 20 years ago, the Student Osteopathic Medical Association launched the Program for the Medically Underserved (PMU) in an effort to promote and improve the quality of primary health care in areas of greatest need, including rural and urban underserved areas, migrant health worker communities, federal prisons and Native American reservations. In addition to externship and postgraduate opportunities, the program encompasses educational seminars and workshops, national and local community service initiatives and distribution of an annual guidebook covering underserved sites, affiliated agencies and contacts. With support from the Merck & Co. Foundation, the Student Osteopathic Medical Association granted more than 20 scholarships in 2002 alone, placing osteopathic medical students in rotations serving federally designated underserved sites.

Rural Health in Texas Given a Helping Hand

With the passage of HB 7, the 77th Texas Legislature created the Office of Rural Community Affairs (ORCA), which was signed into law in June 2001. ORCA encompasses three program and service units, one being rural health. The Rural Health Unit was created in 1989 by the 71st Legislature as the Center for Rural Health Initiatives, which became ORCA's Rural Health Unit in January 2002. The charge of the Rural Health Unit is to ensure access to and quality of health care services in rural Texas by facilitating the growth of rural clinics, establishing emergency medical care networks, and encouraging health care professionals to practice in rural areas.

Texans in rural and/or underserved areas were also assisted by the passage of two bills by Senator Mike Moncrief. SB 788 allows telemedicine services to be reimbursed under Medicaid, and SB 65 allows the use of telepharmacy systems in Texas. Both took effect on September 1, 2001. According to Senator Moncrief, "We hear a lot about health care delivery in our state, but too often, it's the other way around – we literally have to deliver the patient to the healthcare services. That can be just as difficult for the patient who's too old to drive, or can't afford a car, as it is for the patient

who lives in far west Texas and has to make a 150 mile round trip to get to a hospital or a pharmacy. Telemedicine and telepharmacy are not panaceas, they are tools. They should complement, not replace, traditional hands-on, face-to-face consultations. Using the best technology available today, telemedicine can ensure that all Texans have access to a minimum level of services."

(Health Professions Resource Center of the Texas Department of Health at <www.tdh.state.tx.us/dpa>.; The Rural Texan, Summer 2002; "Telemedicine and Telepharmacy Bills Pass Into Law, news release, June 19, 2001 at <www.mike-moncrief.com>.)

The Facts

* D.O.s make up 18%of the total physician population practicing in towns of 10,000 people or less, and as many as 22% of all physicians practicing in communities of 2,500 persons or less. (American Osteopathic Association)
* Just over 30% of all rural counties have physician shortages as defined by the U.S. Division of Shortage Designation.
* While the overall number and percentage of Americans without health insurance continues to increase nationwide, those in rural and frontier areas have a 20% higher rate of being uninsured than their urban counterparts. *(National Rural Health Association)*
* About one in four Medicare beneficiaries lives in rural America. *(U.S. Department of Health and Human Services)*
* The growth of managed care in the 1990s, which some proponents hoped would create savings that would have allowed more coverage for the uninsured, has actually contributed to an increase in the number of uninsured. At the same time, the number of Americans who are underinsured has also increased dramatically. *(National Rural Health Association, "Access to Health Care for the Uninsured in Rural and Frontier America")*
* In its FY2003 budget, the Bush Administration proposed a 50% cut in funding for State Offices of Rural Health, but included increases for Community Health Centers and National Health Service Corps programs, which serve rural and urban underserved communities.

Focus on the Medicare Program – Background –

When the Centers for Medicare and Medicaid Services (CMS) announced in November of 2001 that Medicare payments to all physicians and other health care providers would fall by 5.4% (beginning in 2002), it further jeopardized quality patient care and access for the 85% of elderly and disabled Americans relying on fee-for-service Medicare.

Continuing Cuts Hinder Affordable Access

This action represents the most substantial payment cut since the Medicare fee schedule was developed, and the fourth significant reduction in reimbursements since 1992, bringing the average increase in Medicare fees for physicians between 1991 and 2002 to just 1.1% per year. In addition, since payors in the private market base their rates on the Medicare program, these reductions have a broad and far-reaching impact on access to quality care. Collectively, these steep cuts have the potential to force health care practitioners to reduce staff, no longer accept new Medicare patients, retire early and simply forgo participation in the Medicare program. Because Medicare beneficiaries in rural areas already face barriers to access, further cutbacks pose a serious threat to the availability and affordability of much-needed medical care for our nation's seniors.

The Future of Medicare

Not only does the current rule compromise access in the near term, but physicians also face a cumulative 17% cut in payments from 2002 to 2005, meaning that reimbursement levels in 2005 will be lower than those in 1993. At the same time, it is well known that as increasing numbers of Baby Boomers reach the age of Medicare eligibility, the Medicare program will undergo a challenge to solvency and survival. Congress has demonstrated its sensitivity to that coming test by establishing the Bipartisan Commission on the Future of Medicare, and the osteopathic medical profession pledges its support and cooperation to advancing the recommendations of the Commission.

Support for Bipartisan Initiative

Language featured in the "Medicare Modernization and Prescription Drug Act of 2002" takes important steps toward ensuring Medicare beneficiaries have access to quality health care by reducing unreasonable and unfair financial burdens imposed on physicians and health care providers. The bill, approved by the House of Representatives in June 2002, would eliminate the projected cut in Medicare's 2003 physician payments.

Medicare – The AOA Position –

As the Medicare program ensures access to medical care for millions of senior citizens, the AOA supports the program and pledges its cooperation in ensuring the continued availability of quality medical care at reasonable cost. Recognizing that a legislative solution is necessary to correct the system and reverse the negative impact on access, the AOA recommends the following actions to decrease the projected cuts, which could be carried out by CMS without Congressional action:

* Use multi-factor productivity in the MEI instead of labor productivity only;
* Employ more realistic assumptions of utilization growth;
* Abandon its volume offset assumptions and recognize that Medicare payment cuts will reduce physician willingness to accept Medicare patients, thus leading to volume reductions, rather than increases;
* Use a consistent approach to correct previous errors in its estimates of actual spending and target spending;
* Remove Medicare covered outpatient drugs costs from the SRG;
* Make a one-time adjustment to the MEI to reflect for rapidly increasing professional liability insurance costs; and

* Increase target spending to allow for the effects of national coverage decisions issued by CMS.

(Address of Paul Rudolf, D.O., and Karen Nichols, D.O., AOA Board of Trustees, before the Practicing Physician's Advisory Council, March 2002)

The Facts

* On average, older Americans spend approximately $3,142 on health care, which equals 22% of their disposable income. In 1970, the typical adult spent 11% of his or her income on health care.
* The typical person with Medicare has an annual income of approximately $14,300. Forty-three percent of people eligible for Medicare because of a disability have incomes below $10,000.
* Thirty-one percent of people with Medicare currently live in counties with no Medicare managed care plans, up from 28% in 1998.
* In the past three years, approximately 1.7 million adults and people with disabilities were dropped by HMOs that did not renew their Medicare contracts. Of the 934,000 people dropped in 2000, close to 159,000 had no other Medicare HMO option available in their county.
* About one in three Americans with Medicare has no coverage for outpatient prescription drugs, and those with low incomes are less likely to have coverage than those with high incomes.
* Four and a half million people with Medicare pay more than $1,000 a year on prescription drugs. Of that number, 1.3 million of them pay more than $2,000; the price of 25 prescription drugs most commonly used by older Americans increased at two or more times the rate of inflation from 1999 to 2000.

(Medicare Rights Center)

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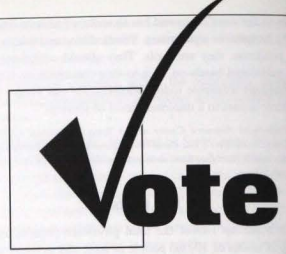


Wednesday, October 23, Designated as "TOMA Early Voting Day"

On Tuesday, November 5, Texans will go to the polls to elect officials who will ultimately play a key role in determining the outcomes of important issues affecting physicians and their patients. The 78th Texas Legislature convenes on January 14, 2003, at which time professional liability and lawsuit abuse reform will be one of the hot topics, along with workers' comp, managed care and prompt pay issues. Thus, this general election takes on a higher level of urgency, and even more so since the recent redistricting has caused turnover in Austin. An unfortunate side effect is that several friends of the osteopathic profession, such as Senators Mike Moncrief and Carlos Truan, will no longer be serving Texans. Physicians have the opportunity and obligation to cast their votes for public officials committed to restoring and preserving medicine as it should be practiced – for the benefit of patients.

TOMA has chosen Wednesday, October 23, as "TOMA Early Voting Day" and urges all osteopathic physicians, families and staffs to join us in our efforts to support this important concept. By allowing employees time off during working hours, there will be fewer excuses for not voting. If every osteopathic physician and health care facility in Texas would adopt this concept, our political clout would be staggering

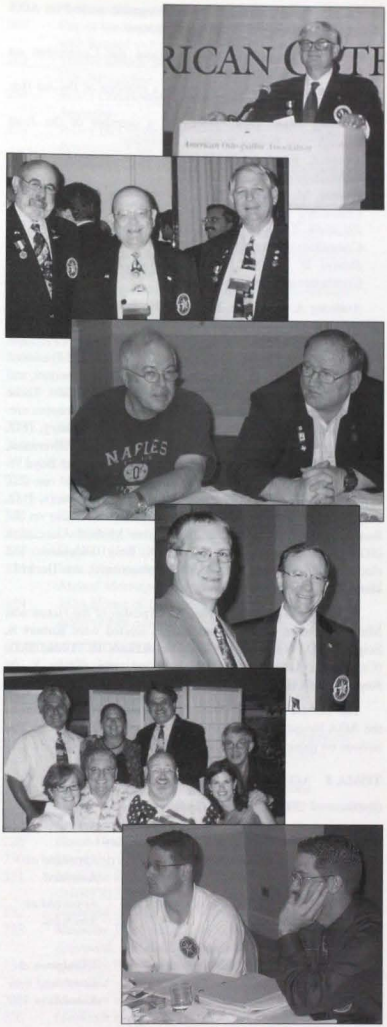
"TOMA Early Voting Day" concept was established by the 1994 TOMA House of Delegates by Resolution No. 94-03, with the intent to make this an annual event. The House noted that Texas D.O.s do not believe that a minority of the total electorate should be making government policies concerning such crucial issues as health care.

We encourage all Texas D.Os and facilities to join us in promoting October 23 as Early Voting Day. This simple yet effective policy has the potential to create an impact that can make a beneficial difference. The health care issues upcoming in the next legislative session are too important to be left to chance – every vote is vital.

News from the AOA

Dr. Zachary and Dr. Baker Re-elected at the AOA House of Delegates

by Terry R. Boucher, M.P.H.
TOMA Executive Director



Your colleagues who served at the American Osteopathic Association's House of Delegates contributed a lot to make the AOA House a valuable experience for Texas osteopathic physicians. Our delegation worked hard to build a level of trust and understanding among the other osteopathic organizations. Some of our delegation's efforts were realized when T. Eugene Zachary, D.O. was re-elected to a three-year term on the AOA Board of Trustees and Mark A. Baker, D.O. was re-elected to serve as Speaker of the House for the American Osteopathic Association. I would like to personally thank the Texas physicians, residents and students who attended the AOA House of Delegates. It was a sacrifice of time and finances, but it shows your dedication to TOMA and the osteopathic profession.

The Texas delegation to the American Osteopathic Association's House of Delegates, led by Chair *Rodney M. Wiseman, D.O.* and Vice Chair, *James W. Czewski, D.O.*, met in Chicago on July 18 through July 21, 2002 for the AOA Annual House of Delegates. Sixteen delegates, eight alternate delegates and two student delegates from the Texas College of Osteopathic Medicine traveled to the meeting. The Texas Delegation included: *Drs. Kenneth S. Bayles* of Dallas; *George M. Cole* of Amarillo; *James W. Czewski* of Fort Worth; *Robert C. DeLuca* of Eastland; *Al E. Faigin* of Fort Worth; *James E. Froelich, III* of Bonham; *Russell G. Gamber* of Fort Worth; *Patrick J. Hanford* of Lubbock; *Royce K. Keilers* of La Grange; *Hector Lopez* of El Paso; *James R. Marshall* of Abilene; *Robert G. Maul* of Lubbock; *R. Greg Maul* of Rowlett; *Jack McCarty* of Lubbock; *Ray L. Morrison* of Crockett; *Elizabeth A. Palmarozzi* of Fort Worth; *Robert L. Peters, Jr.* of Round Rock; *Daniel W. Saylak* of Bryan; *George N. Smith* of West; *Arthur J. Speece, III* of Burleson; *Monte E. Troutman* of Fort Worth; *Rodney M. Wiseman* of Whitehouse; *John L. Wright, Jr.* of McKinney; and *T. Eugene Zachary* of Colleyville. *David Braham,* MS III was the student doctor delegate and *Patrick Keehan,* MS II was the student doctor alternate.

The TOMA delegation met for over three hours on Thursday evening to receive their assignments to reference committees and to review and discuss the resolutions that were available at that time. The delegation met again on Friday and Saturday mornings to discuss other resolutions and to report on the reference committee each delegate attended. The TOMA delegation is to be commended for their participation and input on the resolutions.

Members of the reference committee heard testimony and reviewed resolutions submitted by various committees, specialty colleges and state divisional societies. TOMA was well repre-

sented as several members of our delegation served on AOA Reference Committees in various capacities:

Monte E. Troutman, D.O., chaired the Committee on Constitution and Bylaws;
George M. Cole, D.O., served as a member of the Ad Hoc Committee;
R. Greg Maul, D.O., served as a member of the Joint Board/House Budget Review Committee;
James E. Froelich, III, D.O., served as a member of the Committee on Public Affairs;
Rodney M. Wiseman, D.O., served as a member of the Committee on Professional Affairs;
Elizabeth A. Palmarozzi, D.O., served as a member of the Committee on Resolutions;
Daniel W. Saylak, D.O., served as a member of the Committee on Rules and Order.

Anthony A. Minissale, D.O. of York, Pennsylvania, assumed the presidency of the American Osteopathic Association. Other officers elected were: **Darryl A. Beehler, D.O.** (Minnesota), President Elect; **Martin S. Levine, D.O.** (New Jersey), 1st Vice President; **John W. Becher, Jr., D.O.** (Pennsylvania), 2nd Vice President; and **Gerald E. Brenton, D.O.** (Michigan), 3rd Vice President. Those elected to serve 3-year terms on the AOA Board of Trustees are: **Amelia G. Tunanidas, D.O.** (Ohio); **T. Eugene Zachary, D.O.** (Texas) ; **George Thomas, D.O.** (Ohio); **William M. Silverman, D.O.** (Florida); **Max T. McKinney, D.O.** (Michigan); and, **Boyd W. Bowden, II, D.O.** (Ohio). Elected to serve an unexpired one-year term on the AOA Board of Trustees was **Ray E. Stowers, D.O.** (Oklahoma). Osteopathic student representative to serve on the Board, elected by the Student Osteopathic Medical Association (SOMA), is Student Doctor **Natasha N. Bray** (Oklahoma) and elected to serve as the Intern/Resident representative was **Darin L. Haug, D.O.** (Missouri).

Re-elected to his 3rd term as AOA Speaker of the House was **Mark A. Baker, D.O.** (Texas). Others elected were **Robert S. Seiple, D.O.** (Ohio), vice speaker; **Ethan R. Allen, D.O.** (California), Osteopathic Progress Fund; and, **Kevin V. de Regnier, D.O.** (Iowa) to a 3-year term on the Bureau of Insurance.

The TOMA House of Delegates referred eight resolutions to the AOA House of Delegates for consideration and action. The actions on those resolutions are as follows:

TOMA #	AOA #	TITLE	ACTION
02-01	293	Dietary Supplements	*Approved as Amended*
02-02	294	Rural & Urban Practices-Disparities Between	*Approved as Amended*
02-03	295	D.O. Day on the Hill	*Approved as Amended*
02-05	296	Professional Liability Insurance	*Withdrawn & Combined with Resolution 309*
02-07	297	Senior Prescription Drug Discounts	*Approved*
02-08	298	Take Back Laws	*Approved as Amended*
02-11	299	Conversion Factor for Medicare Fee Schedule	*Approved as Amended*
02-12	300	AOA Code of Ethics Revision	*Approved as Amended*

Joint Board/House Budget Review Committee

This committee met on July 19th to review the proposed budget for the American Osteopathic Association for fiscal year 2003. The committee reported that the AOA has exceeded its goal of having one year's operating funds in reserve. The basic figures listed below reflect the proposed budget for the fiscal year 2003.

Total Operating Revenues	$18,613,439
Total Operating Expenditures	$18,311,169
Excess of Operating Revenue over Expenses	$302,269
Non-operating Revenues (AOA Building and Investments)	$1,010,661
Increase AOA Net Assets in FY '02	$1,142,259
TOTAL ASSETS	$50,417,531
TOTAL LIABILITIES	$16,547,478
TOTAL NET ASSETS	$33,870,053

This budget was recommended to the house and was approved as of July 21, 2002. A copy of the complete AOA budget is on file in the TOMA office for examination by the membership.

Committee on Constitution and Bylaws

The following proposed amendments to the AOA Constitution and Bylaws were approved:

CODE OF ETHICS

Section 17 (New Language)

From Time To Time, Industry May Provide Some AOA Members With Gifts As An Inducement To Use Their Products Or Services. Members Who Use These Products And Services As A Result Of These Gifts, Rather Than Simply For The Betterment Of Their Patients And The Improvement Of The Care Rendered In Their Practices, Shall Be Considered To Have Acted In An Unethical Manner.

PROPOSED AMEMDMENTS TO THE BYLAWS

Article V, Section 12 – REPRESENTATION OF STUDENT OSTEOPATHIC MEDICAL ASSOCIATION

THE STUDENT OSTEOPATHIC MEDICAL ASSOCIATION (SOMA) MAY BE REPRESENTED IN THE HOUSE OF DELE-

GATES BY ONE MEMBER OF THE SOMA BOARD SELECTED BY VOTE OF THE SOMA BOARD (OR SUCH SOMA MEMBER'S ALTERNATE, WHO SHALL ALSO BE A MEMBER OF THE SOMA BOARD SELECTED BY THE SOMA BOARD). NO SOMA DELEGATE OR ALTERNATE SHALL ALSO BE A MEMBER OF A DIVISIONAL SOCIETY'S DELEGATION REPRESENTING THE STATE IN WHICH SUCH SOMA BOARD MEMBER'S OSTEOPATHIC COLLEGE IS LOCATED. THE SOMA DELEGATE SHALL BE ACCREDITED IN THE SAME MANNER AND HAVE THE SAME PRIVILEGES AS THE OTHER MEMBERS OF THE DIVISIONAL SOCIETY DELEGATION; HOWEVER, THE CHIEF ADMINISTRATIVE OFFICER OF SOMA SHALL CERTIFY THE SOMA DELEGATE AND ALTERNATE TO THE EXECUTIVE DIRECTOR OF THIS ASSOCIATION IN WRITING OR BY WIRE AT LEAST 30 DAYS PRIOR TO THE FIRST DAY OF THE ANNUAL MEETING OF THE HOUSE OF DELEGATES.

PROPOSED AMENDMENTS TO THE CONSTITUTION

Article VIII – Board of Trustees and Executive Committee
Section I – Board of Trustees

The Board of Trustees composition was changed to include an Intern/Resident member who will serve a one-year term of office, but may be re-elected to serve an additional one-year term.

COMMITTEE ON PROFESSIONAL AFFAIRS

201 Development of Bureau of Scientific Affairs – *Approved as Amended*
205 Healthcare Delivery Systems – *Approved*
206 Anti-Discrimination - *Approved as Amended*
207 Regulation of Healthcare – *Approved*
208 Counseling Female Patients on Reproductive Issues – *Approved*
214 Protocol & Guidelines for Emergency Medical Identification - *Approved as Amended*
217 Ethical and Sociological Considerations for Medical Care - *Approved*
218 Gender Discrimination – *Approved as Amended*
221 Graduate Osteopathic Medical Education Programs – *Approved*
222 Healthy Life Styles - *Approved*
227 Hospice Care Programs – *Approved as Amended*
239 Military Medical Readiness – *Approved*
241 Supervision for Osteopathic Manipulative Treatment – *Approved*
242 Occupational Safety & Health Administration (OSHA) Regulations – *Approved*
243 Osteopathic Licensing – *Approved as Amended*
244 Osteopathic Musculoskeletal Evaluation – *Approved as Amended*
245 Patient's Bill of Rights – *Approved*
249 Preservation of Post-Doctoral Training in Hospitals – *Approved*
252 Primary Care Physicians – Training Reaffirmation – *Approved as Amended*
253 Public Health Service – AOA Support - *Approved*
254 Promotion of School Based Health Education – *Approved as Amended*
256 Sexual Harassment – *Approved as Amended*
259 Violence in the Media – *Approved as Amended*
260 Wellness Parameters – *Disapproved*
261 Use of the Term "Fellow" by Osteopathic Physicians with Regard to Patient Communications – *Approved*
263 Yellow Ribbon Suicide Prevention Program – Light of Life Foundation - *Approved as Amended*
268 Board Certification Equivalency – *Approved as Amended*
271 Policy on Osteopathic Accreditation – *Substitute Resolution Approved*
279 Wellness Health Promotion Model – *Withdrawn and Combined with Resolution 302*
280 U.S. Postal Service First Class Osteopathic Medicine Recognition Stamp – *Approved as Amended*
292 Rotating Osteopathic Internship – *Withdrawn*
296 Professional Liability Insurance – *Withdrawn and Combined With Resolution 309*
301 Professional Liability – *Withdrawn and Combined With Resolution 309*
302 Wellness and Health Promotion Model – *Approved*
303 Anti-Bullying Law – *Approved as Amended*
306 Multi-Media Slide Facilitation in the AOA House of Delegates – *Approved*
307 Voting – AOA House of Delegates – *Approved as Amended*
309 Tort Reform – *Substitute Resolution Approved*
314 Restructuring of the Department of Education – *Approved as Amended*
315 Attendance of Non-Osteopathic Health Care Providers at CME Programs – *Approved*
316 Healthcare Wellness Promotion – *Disapproved*
317 Continuing Medical Education – *Disapproved*
322 End-of-Life Care – *Approved as Amended*
326 State Representation to AOA House of Delegates Annual Meeting - *Disapproved*
329 AOA House of Delegates' Code of Leadership – *Approved as Amended*

COMMITTEE ON PUBLIC AFFAIRS

203 Administrative Rule-Making Process - *Approved*
209 CPT Code Standardized Usage - *Deleted*
210 Denial of Payment of Pre-Authorized Medical/Surgical Services – *Approved*
213 Due Process in Agency Determination - *Approved*
215 Ethical Issues and Aspects of Managed Care - *Approved as Amended*
216 Ethical Issues in Managed Care - *Approved*
225 Health Maintenance Organizations (HMOs) Insurance – *Approved as Amended*
226 Home Healthcare Abuse - *Approved*
230 Mammography Accessibility - *Approved as Amended*
231 Medicare Resource Based Relative Value Scale (RBRVS) - *Approved as Amended*
232 Medicare - Assignment - *Deleted*
233 Medicare Fee Schedule – Competitive Bidding - *Approved*
234 Medicare Reimbursement Fairness – *Approved as Amended*
235 Medicare and Medicare Abuse- *Approved as Amended*
236 Medicare and Medicaid – Ethical Physician Arrangements - *Approved*

237 Medicare and Medicaid – Disproportionate Funding and Reimbursement of Pediatric Adolescent Care - *Approved*
238 Medicare Skilled Nursing Admitting Requirements - *Approved as Amended*
240 Reimbursement for Osteopathic Manipulative Treatment - *Approved as Amended*
246 Physical Fitness Program - *Approved as Amended*
248 Physician Reimbursement in Federal Programs - *Approved*
255 Senior Citizen - Freedom - *Approved*
258 Standard of Care - *Approved*
269 Discriminatory Reimbursement – *Approved as Amended*
270 Equitable Physician Reimbursement for Parental Medications - *Approved as Amended*
276 Team Physician – AOA Position Paper – *Amended and Referred*
278 Non-Generic Drugs - *Approved*
283 Influenza Vaccination Cost and Supply - *Approved as Amended*
284 Vaccination Costs and Supplies - *Approved as Amended*
288 Federally Funded Health Clinics - *Approved*
289 Medicare Policies - *Approved as Amended*
290 Prescription Drug Program - *Approved as Amended*
294 Disparities Between Rural and Urban Practice - *Approved as Amended*
298 Take Back Laws - *Approved as Amended*
299 Conversion Factor for Medicare Fee Schedule - *Approved as Amended*
308 Patient Safety - *Approved as Amended*
310 Equality of Patient Access for Structural Diagnosis and Osteopathic Manipulative Treatment - *Approved as Amended*
313 CPT Coding Policies - *Approved as Amended*
324 Family and Medical Leave Act (FMLA) Documentation - *Approved as Amended*
325 Formulary Changes - *Approved as Amended*

AD HOC COMMITTEE

200 Complementary and Alternative Medicine – *Adopted and Referred*
202 Abused Persons - *Approved*
204 Advanced Directives – *Approved As Amended*
211 Dispensing of Medication By Physicians – *Approved*
212 Drinking/Driving – *Approved*
219 Generic Drugs – *Approved as Amended*
220 Genetic Testing – *Approved as Amended*
223 Human Immunodeficiency Virus – Positive Status as a Disability – *Approved*
224 Human Immunodeficiency Virus – Clinical and Public Health Application – *Approved as Amended and Referred*
228 Human Cloning – *Approved as Amended*
229 Intractable Pain - *Approved as Amended*
247 Physician Assisted Suicide – AOA Position - *Approved*
250 Prescribing Pharmacists – *Disapproved*
251 Prescription Drug Samples – *Approved as Amended*
257 Smoking – Tobacco Products - *Approved as Amended*
262 PHARMA Code on Interactions with Healthcare Professionals, Revised – *Substitute Resolution Adopted*
264 Prescription Drug Usage Among the Elderly - *Approved as Amended*
265 Organ Donor Identification - *Approved as Amended*
266 Organ Donation – Opposition to Financial Incentives for Organ Donors - *Approved*
267 Office-Based Surgery, Policy Statement - *Approved as Amended*
272 Judicious Use of Antibiotics - *Approved as Amended*
273 Restraints for Children on Airplanes - *Approved as Amended*
274 Family Preparedness for Terrorism - *Approved as Amended*
275 Disability Medicine - *Approved as Amended*
277 Protection of the Public on the Internet - *Approved as Amended and Referred*
281 Treatment of Obesity - *Approved*
282 Yellow Pages – Directory Listings of Physicians - *Approved as Amended*
285 Osteopathic Representation on Composite State Medical Boards - *Approved as Amended*
286 Participation by Medical Providers in Services that Conflict with the Geneva Convention – *Substitute Resolution Adopted*
287 Co-Management of a Patient - *Approved*
291 On-Line Medicine - *Approved and Referred*
293 Dietary Supplements - *Approved*
295 D.O. Day on the Hill - *Approved as Amended*
297 Senior Prescription Drug Discounts - *Approved as Amended*
300 Code of Ethics of the American Osteopathic Association - *Approved*
304 Flame-Retardant Clothing for Infants & Children – Sleeping or Lounging - *Approved as Amended*
305 Obesity in Children and Adolescents - *Withdrawn*
311 Environmental Toxins and Children's Health - *Approved*
312 Controlled Substance Prescription Medicine Program - *Approved as Amended and Referred*
318 Healthcare Providers Right of Conscience - *Approved as Amended and Referred*
319 Breastfeeding Exclusivity - *Approved as Amended*
320 Promotion, Protection and Support of Breastfeeding - *Approved*
321 Breastfeeding Friendly Workplace - *Approved as Amended*
323 State Screening - *Approved as Amended*
327 Opposition to Use of Placebos in Pain Assessment - *Disapproved*
330 Illegal Dispensing of Pharmaceutical Agents - *Adopted and Referred*

If a resolution is of interest to you, the TOMA office has complete copies of all resolutions and will mail or FAX them to any TOMA member. Contact Terry Boucher, Executive Director, at 800-444-8662 or 512-708-8662. The resolutions are also available on the American Osteopathic Association website at <www.aoa-net.org>.

I remember when she was just a baby

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Acute Glenohumeral Dislocations

Diagnosis and Management

by S.N. Desai S/D

Hippocrates wrote;

"It deserves to be known how a shoulder which is subject to frequent dislocations should be treated. For many persons owing to this accident have been obliged to abandon gymnastic exercises, though otherwise well qualified for them; and from the same misfortune have become inept in warlike practices, and have thus perished. And this subject deserves to be noticed, because I have never known any physician [to] treat the case properly; some abandon the attempt altogether, and others hold opinions and practice the very reverse of what is proper."[1]

The glenohumeral joint is the most frequently dislocated major joint in the body, accounting for approximately 45% of all dislocations.[2] These lesions are very common, and nearly all medical professionals will encounter them at some point. For this reason, it is imperative that we understand the clinical presentation, anatomical relationships and rationale of management. The morbidity associated with failed diagnosis and improper treatment can be of much consequence. Functional disability very often ensues. Recurrent dislocations, chronic glenohumeral instability, sensory and motor insufficiency, and adhesive capsulitis are more serious outcomes.

Anatomic considerations must be observed while managing these injuries. Several factors predispose the glenohumeral joint to displace: (1) the shallowness of the glenoid fossa; (2) the humeral head has a diameter 1.5 to 2.0 times, and a surface area three times that of the glenoid. Approximately 30% of the humeral head articulates with the glenoid at any given arm angle [3]; (3) the thinness, laxity, and redundancy of the joint capsule; (4) the dependence on atmospheric pressure to preserve contact of the articular surfaces; and (5) the long length of the humerus, which provides a significant lever arm for displacement.

Anterior dislocations (humerus relative to the glenoid) are the most common form of glenohumeral dislocation, constituting 95 to 97% of such injuries.[3] The acromion, coracoid, and coracoacromial ligaments provide anterosuperior, posterosuperior, and superior restraint respectively. No significant structures exist anteriorly or anteroinferiorly to prevent the humeral head from displacing in these directions. Indirect or direct stressors easily overcome the little restraint provided by the anteroinferior capsule.

Posterior dislocations are much more infrequent, and particular attention must be paid to these lesions. The literature reports that these injuries are missed approximately 60% of the time.[4,5] Significant morbidity is associated with these injuries thus appropriate management is of utmost importance. There are several anatomical reasons for the scarcity of posterior dislocations.[6,7] First, the spine of the scapula and the acromion process both act as posterior blocks. Second, the scapula is angled in a manner which places the posterior portion of the glenoid behind the humeral head. Given these anatomic barriers significant force must be applied to the glenohumeral joint in order for it to displace posteriorly. This force most often occurs through electric shock or seizures, both of which involve significant muscle contraction.

Patient History

Patient history is imperative in the primary evaluation. The mechanism of injury, amount of force applied to the arm, and location of the force should be sought. Dislocation most commonly occurs through an indirect mechanism. A position of abduction, extension, and external rotation of the arm favors anterior dislocation. At this position the forces on the arm are transferred to the weaker anterior capsule and ligaments. The humeral head easily prevails over these structures and is able to displace anteriorly. Although rare, a direct blow to the posterior proximal humerus can also produce an anterior dislocation. A history of axial loading of the adducted internally rotated arm, seizures, electric shock, or direct blow to the anterior shoulder all support the diagnosis of posterior dislocation. Most often electric shock or seizure provides the violent muscle contraction that results in the humeral head displacing posteriorly. The internal rotators of the arm provide a stronger force than the external rotators and displace the humeral head posteriorly.

Physical Exam

Physical exam is essentially diagnostic. The lesion is extremely painful and analgesia should be provided. Anterior dislocations present characteristically with the arm held in a position of slight abduction and external rotation. The patient is unable to internally rotate or abduct the injured extremity. The humeral head is often palpable anteriorly and a depression is noted below the acromion. An assessment of neurovascular integrity must be performed. The brachial plexus and axillary

artery lie just inferior, anterior and medial to the glenoid rim. Neurologic injury occurs in approximately 10% of acute anterior shoulder dislocations.[8,9,10] The nerve travels anterior to the subscapularis muscle, and both structures are put under traction as the humeral head is displaced. Given the anatomic dilemma, motor function of the axillary nerve is difficult to assess. This is better evaluated after reduction. Sensation just above the deltoid insertion on the lateral shoulder tests axillary sensory nerve function. Generally axillary nerve injuries are traction neuropraxias. These injuries are usually transient and full function should return 3 to 5 months after the dislocation.[9] The radial pulse should be palpated and the capillary refill of the fingers should be less than three seconds. If either of these parameters is abnormal further evaluation should ensue. Posterior dislocations generally present with the arm adducted and internally rotated. The injured extremity is limited in external rotation and abduction. A prominent coracoid and flattening of the anterior shoulder can be visualized. Posteriorly, a prominence and rounding may be noticed. Again, neurovascular status must be assessed.

Radiography

Radiographs are important in evaluating patients with possible shoulder dislocations. A radiographic trauma series, including an anteroposterior view, a trans-scapular lateral view, and an axillary view, should be taken. A true anteroposterior should be taken in the plane of the scapula and not in the plane of the body. The scapula lies on the posterolateral chestwall at an angle of 30-45 degrees; therefore the beam should be angled 90 degrees to this plane. The critical view to obtain in the radiographic evaluation of the injured shoulder is the axillary view. The axillary lateral view is obtained with the radiographic cassette on the superior aspect of the shoulder. The injured arm is then abducted enough to allow the beam to pass through the axilla perpendicular to the cassette. The interpretation of the axillary view is not difficult. The radiographic should be placed with the coracoid pointing superiorly and the humerus in the direction of the affected side. Four important anatomical relationships should be noted. The coracoid, acromion, glenoid, and humeral head should be identified. The relation between the humeral head and the glenoid should be apparent if the film is of adequate quality. Impression fractures of the humeral head, glenoid rim fractures, and fractures of the lesser tuberosity should also be identified. This view is absolutely essential in evaluating for posterior dislocations. This lesion is often missed because appropriate films are not ordered. If an axillary view is unattainable a scapular lateral film should be taken. This view is adequate, but is only second best to the axillary view. The beam is shot in a plane parallel to and down the spine of the scapula. The projection forms the shape of the letter "Y". The body is formed be the body of the scapula. The two short arms are formed by the coracoid anteriorly and the scapular spine posteriorly. The intersection of the three limbs is the location of the glenoid fossa. The humeral head should be centered in the fossa. If anterior or posterior, an anterior or posterior dislocation respectively could be present.

There are certain radiographic findings on an anteroposterior film that can aid in diagnosing a posterior dislocation. (1) The humeral head is superimposed over the glenoid forming an elliptical shadow on a normal shoulder film. This relationship is lost with posterior dislocations. (2) The humeral head is no longer centered in the glenoid producing an "empty glenoid" sign. (3) With posterior dislocations the humerus is internally rotated and the humeral neck will no longer be seen in profile.[1]

Treatment

Closed reduction is most commonly the treatment of choice for stable anterior and posterior dislocations. Anterior dislocations can be reduced using the traction and countertraction method. Narcotics and muscle relaxants can be used to aid reduction. A folded sheet should be placed under the axilla and serve as countertraction. Gentle traction in line with the deformity should be applied to the injured extremity. An assistant provides countertraction with the sheet under the axilla. Internal or external rotation can be provided along with traction to aid in reduction. If the head is impacted in the glenoid this may facilitate disengagement. An audible clunk may be heard when reduction is successful. Radiographs should be used to confirm reduction. The arm should then be immobilized in a sling in a position of slight adduction and internal rotation. The patient will generally be able to move the extremity with little difficulty. Posterior dislocations are also treated with closed reduction. Narcotics and muscle relaxers should be given to the patient. With the patient supine, traction in line with the deformity should be provided, and the humeral head should be gently lifted into the glenoid fossa. Countertraction can be used with a folded sheet under the axilla if needed. Again, an audible clunk may be heard upon successful reduction. Once reduction is achieved a trauma series should be taken for confirmation. If appropriately reduced the arm should be immobilized in a position of neutral rotation and slight extension.

Postreduction Care

The injured arm should be immobilized for 2 to 5 weeks. Early range of motion is encouraged. Isometric exercises focusing on the internal and external rotator muscles are most important. The strengthening of these muscles serves to regain stability, and preserve the biomechanical integrity of the glenohumeral joint.

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Self's Tips & Tidings

By Don Self

It's Okay to Have Multiple Fee Schedules

Once again, someone is running around the country teaching seminars to physicians and saying that you cannot "discriminate" by having multiple fee schedules. Once again they are WRONG. Every time this has come up, I've asked for an official source that says you cannot have multiple fee schedules and so far not one attorney has been able to provide me with one BECAUSE IT DOESN'T EXIST.

Once in a while, someone will say that Medicare has a regulation saying you cannot charge anyone less than Medicare, but that isn't accurate either. Medicare says you cannot routinely charge more to Medicare than you charge everyone else. I don't know anyone who does this (except for the physicians in the Northeastern part of the country who have foolishly signed contracts with managed care companies to pay LESS than Medicare). Then, the question of "it's not moral or ethical to charge more for one person than another occurs". OK, let's look at this: You go to a theater and see a movie and the 70-year-old to your left side paid less for his seat since he is a senior citizen. Do you want to kick him out? The 7-year-old kid eating popcorn and spilling Dr. Pepper on your right paid less. OK, mom, get that kid outta here! I don't think so. So, if you want to charge everyone differently you can, even though I don't recommend it. I recommend you charge everyone your highest fee and then make discounts as the carriers pay or as the patient pays. Oh, yes, so you don't get confused, I still recommend a QUICK-PAY discount to anyone paying the bill in full (not just part of the bill, but the entire thing) at the time of service. That's legal, too, and I challenge anyone to prove it's not.

You Don't Have to Have a Different Diagnosis

Doctor, do not let anyone make you believe that Medicare or CMS (formerly known as HCFA) requires you to have one diagnosis for an office visit and a different diagnosis for the procedure being done on the same day, in order to bill for both and to be paid for both. It's not so. Now, there are some managed care plans using this as an excuse to keep YOUR money. Just remember to let them know that the plan the patient has is probably employer-provided and if so, that means that ERISA (Employee Retirement Income Security Program) applies which means the carrier has to abide by the national standards of coverage as set forth by the Federal Government or they can be fined $10,000 per claim for which they do not. (Make sure you also send a copy of the appeal letter to the nearest Federal Courthouse, attention ERISA compliance officer as that gets the carrier's attention as well.) Don't be afraid to use ERISA to help you. But first become educated on ERISA. It probably applies to at least 85% of all insurance claims you file and it gives you a much bigger sword with which to fight the carriers than the pocket knife you now wield.

When Do You Collect Co-Pay?

You are allowed to collect the co-pay from the patient PRIOR to the patient being shown to the examination room, as long as you know what the co-pay is. If your patient has Blue Cross insurance and the co-pay is a flat $15.00, why not collect it prior to taking the patient back to the exam room? If the patient doesn't have it, do you still have to see them then? Of course not, unless it's an emergency. If the patient doesn't have the co-pay, you can know about it up-front, rather than later. That gives your office staff the opportunity to explain that the doctor is running a few minutes later than expected, so the patient has time to run down to an ATM and get some cash.

The same thing holds true for Medicare patients, with one exception. You usually do not know what level of service the doctor is going to provide on the office visit, so you have to wait until the patient starts to leave before asking for the co-pay. Remember, if the patient walks out the door owing you money, the chance of you collecting all of it is less than 100%, and many times it will then cost you money to collect it (statements, phone calls, postage, envelopes, bills, etc.). It's always better to get it up front. Remember the theater scenerio I mentioned earlier? You always pay before you see the movie, not afterwards.

Doctors Need to Match Diagnosis with Procedure Codes

In many offices, the doctor will mark off 3 to 5 diagnosis codes on the bottom of the form (or write them in, if the practice forms need updating) and then mark off the office visit, a lab test or two and any procedures done. The form is then taken to the front office to be entered into the computer. Someone who has absolutely no clinical training at all is being required to "figure out" which procedure code gets matched with which diagnosis code. In some cases, it's easy to figure them out, i.e., ear wax impaction goes with ear irrigation, Somatic Dysfunction with the OMT, or chest pains get matched with EKG – but it's not always so easy.

Does that clerical person know why YOU ordered the CBC or Lipid panel? Do they know the reason you gave the patient the Depo-Getbetter? What happens if they match the wrong diagnosis with a procedure code in the computer? The claim form is not completed properly and you don't get paid. It's really that simple. Doctor, why not draw a line from procedure to diagnosis code on the superbill or use an alpha character with a circle to denote which procedure goes with which diagnosis. Remember, you don't want that clerical person making clinical judgments. It took you how many years of school and internship to learn it?

continued on page 28

Your TOMA benefits just got BETTER!

The Texas Medical Foundation is offering complimentary membership

The Texas Medical Foundation (TMF) is now offering TOMA members a complimentary one year membership for the 2002-2003 membership year (June 1 through May 31).

TMF is a physician-led organization that relies on the leadership and guidance of physicians like you. By joining TMF, you express your support for continued health care quality improvement efforts in Texas.

As a TMF physician member, you:

- Join an organization endorsed by TOMA which includes a network of physicians and other health care professionals committed to quality health care;
- Are invited to attend medical ethics lectures and continuing education programs for physicians and staff;
- Receive special physician tools for monitoring disease prevention and treatment;
- And much more!

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TMF membership is available to licensed Texas physicians. To qualify for membership, each physician must be a current TOMA member in good standing.

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TxACOFP Update

by Joseph Montgomery-Davis, D.O.

Well, folks, the TxACOFP got side-tracked for a while, but it is now back on track and ready to roll. There have been changes to insure future financial stability and accountability. Once again there is a strong working relationship with TOMA.

The 45th Annual Clinical Seminar, in conjunction with the TCOM Alumni Weekend, took place at the Arlington Wyndham Hotel in Arlington, Texas, from August 1– 4, 2002. A big thank-you goes out to Ronda Beene, D.O., Program Chair, for an excellent CME update for primary care physicians.

On Friday, August 2nd, the Keynote Luncheon speaker was Representative Jim Keffer (R-Eastland), who is the next-door neighbor of Robert DeLuca, D.O. Representative Keffer stated that because there are so many trial lawyers in the Texas Legislature, it would take a united effort on the part of all non-trial lawyers to bring about tort reform in Texas. He also emphasized the importance of establishing a working relationship with your Texas legislators through eyeball to eyeball contact, noting that sight recognition is just as important as name recognition.

On August 3rd, the annual TxACOFP membership-business luncheon was held. The president-elect of the National ACOFP, Jay Porcelli, D.O., from Pomona, California, was the guest speaker at the luncheon. He talked about the four 50's: 1) Dr. Porcelli was born in 1950; 2) The National ACOFP was started in California 50 years ago; 3) It has been 50 years since California has had a president of the National ACOFP; and 4) Dr. Porcelli will be the 50th president of the National ACOFP.

Following Dr. Porcelli's speech, the election of officers took place, and are as follows:

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Later that evening during the President's Banquet, Dr. Porcelli introduced his daughter, Adrianne. She is a fourth year student at TCU in Fort Worth, and is majoring in film and cinematology. The master of ceremonies for the evening was T. Eugene Zachary, D.O., who is a member of the AOA Board of Trustees. Also in attendance were: R. Greg Maul, D.O., vice president of the National ACOFP; Robert L. Peters, D.O., a member of the AOA Board of Trustees; Rodney Wiseman, D.O., speaker of the house for the National ACOFP; Robert Maul, D.O., a past president of the National ACOFP; Jim Froelich, III, D.O., TOMA president; Terry Boucher, TOMA executive director; and Paula Yeamans, TOMA associate executive director.

Jerry Smola, D.O. and his wife, Joan, were the special guests for the evening.

Dr. Smola spoke about his plans for the TxACOFP in the upcoming legislative year, and of the need for tort reform in Texas.

Physicians in the Lower Rio Grande Valley of Texas have been hit hard by frivolous lawsuits. State Attorney General John Cornyn made comments in Santa Rose on August 7 regarding insurance. He said he favored "loser pay deals" and caps on jury awards for non-economic damages such as pain and suffering. Valley doctors drew nationwide attention when they staged a day of awareness in April to protest skyrocketing malpractice insurance premiums.

A recent report by the Texas Department of Insurance (TDI) to the state House Insurance Committee confirmed that Rio Grande Valley physicians are paying the highest premium rates in Texas. Insurance companies have put the blame on a runaway increase in malpractice lawsuits.

TDI's report revealed that almost the entire increase in claims frequency occurred in the Rio Grande Valley, where the number of claims filed has been growing at a rate of 60 percent per year, primarily in Hidalgo County.

Rate changes showed increases of as much as 119 percent over the last four years, as in the case of the Texas Medical Liability Trust. The department's report showed a wide variation in premiums between specialties, but in all cases the Valley ranked at the top in Texas. The insurance department referred to a National Association of Insurance Commissioner's 2000 report that said Texas was the least profitable state for insuring physicians out of 15 similar states. Texas was the number one money-losing state, before Maryland, Florida, and Illinois.

Governor Rick Perry has stated that "for predatory trial lawyers who for years have skirted the bounds of ethical practices and refined the art of intimidation, my message is clear: Texans will no longer allow you to hold their health care hostage." His health care proposals are as follows:

- To pass meaningful tort reform for the health care profession that caps non-economic losses to plaintiffs at $250,000 and limits plaintiffs' attorney fees to a prescribed schedule based on the size of the award. More than 20 other states have capped non-economic damages, resulting in significantly lower liability insurance rates. California, for example, limits non-economic damages to $250,000 and has the 47th lowest medical liability rates in the nation.
- To create special courts or designated special judges to hear medical malpractice claims. These judges would have expertise in malpractice issues and would be better able to toss out frivolous lawsuits. Encourage the special courts to sanction lawyers and award litigation costs in frivolous cases.
- To improve the Texas State Board of Medical Examiners' ability to police the medical profession and safeguard patient care through enforcement of licensing laws and consistent disciplinary enforcement actions.
- In concert with doctors and hospitals around the state, develop clear procedures for reducing medical errors, and for clear and swift disciplinary actions against the relatively few bad doctors.
- To extend tort immunity to health care providers who treat low-income patients under contract with the state.
- To provide a form of temporary emergency malpractice insurance coverage for doctors who have been denied coverage solely for economic reasons.
- To expand the TDI's ability to review insurance companies' rates and help ensure that malpractice premiums are commensurate with losses.

TOMA and the TxACOFP back bipartisan legislation introduced in the U.S. House of Representatives that calls for a $250,000 cap on non-economic damages. The bill also calls for limits on attorneys' fees and three-year statute of limitations in most cases.

One of the things Texas physicians must do is elicit the support of their patients in solving the medical insurance liability crisis in Texas. Your patients are constituents of politicians who make the laws. "All politics are local." Your patients can help decide who represents your area in the 78th session of the Texas Legislature.

In the Rio Grande Valley, physicians are having patients sign petitions to send to their legislators in Austin asking for tort reform. A sample copy of this petition can be obtained in English or Spanish from the TxACOFP or TOMA upon request.

Texas physicians must realize that they are in a war. They are under attack by personal injury lawyers. In these tort battles, there will only be room for combatants and casualties; there will not be any room for spectators.

UNT Health Science Center Welcomes Future Medical Professionals

The University of North Texas Health Science Center faculty welcomed its newest class of students at the annual Convocation and White Coat Ceremony, held August 16th at the Will Rogers Memorial Auditorium in Fort Worth.

The White Coat ceremony is a rite of passage for students entering the academic health community. During the ceremony, students receive gifts signifying entry into their respective health professions. The incoming students are literally "coated" for the first time with a white coat to symbolize humanism and professional ethics in medicine.

For the fourth year, TOMA purchased the white coats provided to the incoming medical students. TOMA President Jim Froelich, D.O., and TOMA Executive Director Terry Boucher also presented each first year student with a TOMA lapel pin to wear on his or her new white coat.

This year, the UNT Health Science Center welcomed 127 incoming medical students to the Texas College of Osteopathic Medicine, 84 students of the Graduate School of Biomedical Sciences, 26 new students in the Physician Assistant Studies Program and 100 in the School of Public Health.

Michael E. Whitcomb, M.D., senior vice president for the division of medical education at the Association of American Medical Colleges, presented the keynote address. Dr. Whitcomb is also editor-in-chief of Academic Medicine, a scholarly journal devoted to issues related to academic medicine. The AAMC is a national organization representing U.S. medical schools, teaching hospitals and faculty in many different professional medical societies. The AAMC strives to strengthen the quality of medical education and training, enhance the search for biomedical knowledge, advance research in health sciences, and integrate education into the provision of effective health care.

"Self's Tips & Tidings" continued from page 24

MDM Doesn't Have to Be One of the Two Components

You know that your progress note (documentation) has to have at least two of the three key components (history, exam & medical decision-making) clearly indicated in order to bill any carrier for an established patient visit. You also know that new patients and consults require all three be done and documented. Most of you reading this have purchased the pocket-sized E&M sliderule and you know that it doesn't matter which two of the three you document (even though the history and exam are usually easiest). The problem is that some folks are publishing in magazines (not this one) and teaching in seminars that the medical decision-making (MDM) has to always be one of the two. That isn't the case. If you're good with documentation, MDM can be one of the clearest to show, but it's not required on all visits. Here's a tip that will help you if you're ever audited for your documentation (and you probably will be, when you least expect it): If you have rule-outs that you're considering, always put that in your progress notes. No, you cannot use it on a HCFA 1500 claim form, but it really shows the MDM, so include them in your progress notes.

GERD Now Included in Results of LEAP

You've heard me talk about the fantastic results we're having with the Mediator Release Test (food sensitivity test on patient blood) and LEAP program on migraine patients, IBS patients, Fibromyalgia and join pain, but now we're seeing more than 80% of patients with severe GERD being helped by simply using the MRT & LEAP program to identify which foods cause reactions with the patient's blood and taking those foods out of the patients diet. It might be something as simple as peanuts or Red Dye # 3 or spinach that the patient ate three or four days before the symptoms show up. There is a HUGE difference in food sensitivities and food allergies, so let us help you help your patients. If you haven't checked into these food sensitivities, check out <www.donself.com/LEAP> and then let us know what you think. We have physicians all over the country helping patients who have been told by their other doctors "just live with it." When a patient is having 12 to 14 bowel movements a day or two or three migraines a week, there is a better than 75% chance that that patient can be helped. The insurance plans are paying $1500 to $1850 per patient for the program, so check it out.

Handling and/or Conveyance

If you are preparing a specimen (blood, urine, stool, skin, pap, or other), taken from the patient and having a local lab or delivery service pick it up from your office to transport to the pathologist or lab, be sure to bill for 99000. No, Medicare doesn't pay for it, but just about everyone else does. No, contrary to what some may have told you or your staff, you do not have to have expense involved in the actual transport of the specimen to the lab. The pick-up person can be an employee of the lab and they pick it up at no expense to you and you can still use this code.

Discharge and Admit – Same Day –

If you discharge a patient from a hospital and place them into a skilled nursing facility, bill for two charges. You have the 99238 (or 99239, if you documented more than 30 minutes spent on the day of discharge) and the SNF admit (99303) you can use. Be sure to put them on different claim forms since box 32 for Place of Service is different and you can't fit both into one box on a claim form.

Two Office Visits – Same Day _

If you have a patient in your office this morning for one problem who then comes back this afternoon for a different problem, you can bill for both office visits (use the 25 modifier on each). The claim may be automatically denied but you will probably win on an appeal, even with Medicare.

Does Your Office Appeal Every Time?

In seminars, I'll ask for a show of hands of how many offices appeal every claim that isn't paid properly and every hand will go up (As Gomer would say, Surprise, Surprise, Surprise!). When I come out to your office and do an analysis on your fees, codes, charging patterns and collection practices, I find that less than half actually do appeal the claims. LESS THAN HALF!

When I have a discussion with the doctor and explain how we're increasing their net income by $10,000 or $20,000 a month through the analysis/report, the physicians are astounded and disbelieving when I point out how many claims are not appealed. In every one of them, I hear the same thing: "You are mistaken as my staff do appeal claims when they're not paid properly." Oh how naïve. Doctor, your office may be one of the 45% of offices that do appeal every claim not paid properly, but you better make sure. If they are not, it's your money being completely lost. I am of the firm belief that every carrier denies a certain number of claims for no reason, because they know the majority of doctors won't appeal and they keep the doctor's money to show as profits.

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