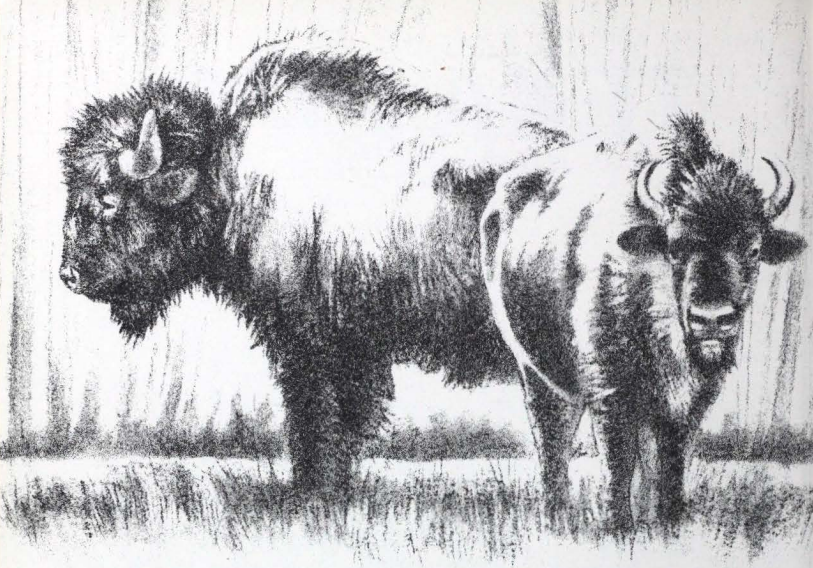
TEXAS DO

XXXIX, No. 10 TEXAS OSTEOPATHIC MEDICAL ASSOCIATION November, 1992

In This Issue:



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TOMA Malpractice Insurance Program:	
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TOMA Major Medical Insurance	1-800/321-0246
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Part A Telephone Unit	214/470-0222
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Profile Questions	214/669-7408
Provider Numbers:	
Established new physician (solo)	214/669-6162
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All changes to existing provider number records	214/669-6158
Texas Medical Foundation	512/329-6610
Medicare/CHAMPUS General Inquiry	800/725-9216
Medicare/CHAMPUS Beneficiary Inquiry	800/725-8315
Medicare Preprocedure Certification	800/725-8293
Private Review Preprocedure Certification	800/725-7388
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TOMA Med-Search	in Texas 800/444-TOMA
TEXAS STATE AGENCIES:	
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Drug Enforcement Administration:	
For state narcotics number	512/465-2000 ext 3074
For DEA number (form 224)	214/767-7250
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TEXAS DO

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

FEATURES

DEPARTMENTS

TEXAS DO

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

November, 1992

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Copy deadline — 10th of month preceding publication

Calendar of Events

DECEMBER

12

AIDS Conference
University of Osteopathic Medicine and Health Sciences
Location: 3200 Grand Avenue
Des Moines, Iowa
Hours: 5 Category 1-A
Contact: Gena Alcorn
Continuing Education Coord.
UOMHS
3200 Grand Avenue
Des Moines, IA 50312-4198
515/271-1480

JANUARY

27

"Allergy Seminar"
University of Osteopathic Medicine and Health Sciences
Location: 3200 Grand AVenue
Des Moines, Iowa
Hours: 5 Category 1-A
Contact: Gena Alcorn
UOMHS CME Coordinator
515/271-1480

FEBRUARY

2-3

Mid-Year Conference/Legislative Forum
Texas Osteopathic Medical Association
Location: Omni Hotel
Austin
Hours: 15 Category 1-A
Contact: TOMA
800/444-8662

4-6

Urgent Care Medicine
Kirksville College of Osteopathic Medicine
Location: Tropicana Resort
Las Vegas, Nevada
Hours: 20 Category 1-A
Contact: Rita Harlow
KCOM CME Coordinator
816/626-2232

21-26

Ski & CME Conference
Colorado Society of Osteopathic Medicine
Keystone Lodge & Resort
Keystone, CO
Hours: 38 Category 1-A
Contact: Patricia Morales
303/322-1752

MARCH

5-9

Ski-CME Seminar
Texas College of Osteopathic Medicine & Osteopathic Health System of Texa
Location: Lake Tahoe, Nevada
Hours: 20 Category 1-A
Contact: TCOM
CME Department
817/735-2539

31-April 4

Pan American Allergy Society Training Course and Seminar
Location: Doubletree Hotel-Post Oak
Houston
Contact: Ms. Ann Brey, Exec. Secy.
Pan American Allergy Societ
512/997-9853

APRIL

24-25

Sutherland OMT
Cranial Academy, Sutherland's Methods of Treating the Rest of the Body
Location: Bedford
Hours: 16 Category 1-A
Contact: Conrad Speece, D.O.
214/321-2673
fax: 214/321-4329
(Attendance is limited, so early registration is recommended)

MAY

13-16

94th Annual Convention & Scientific Seminar
Texas Osteopathic Medical Association
Location: Stouffer Hotel
Arboretum Blvd. - Austin
Hours: 30 Category 1-A (tentative)
Contact: TOMA
800/444-8662

Articles in the *"Texas DO"* that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the *"Texas DO"* is required by that law: Terry R. Boucher, Executive Director, TOMA, 226 Bailey Avenue, Fort Worth, Texas 76107.

Texas Hospitals Introduce New Interns and Residents

Recently graduated osteopathic physicians from osteopathic colleges throughout the nation have begun their training programs at Texas hospitals and medical centers.

Among new interns and residents already training for the 1992-93 year are:

BROOK ARMY MEDICAL CENTER
(Fort Sam Houston)

Bret T. Ackermann, D.O.
SEUHSCOM — *Intern*

Lynn M. Bergren, D.O.
NYCOM — *Intern*

Louise M. Bolton, D.O.
COMP — *Intern*

Carole A. Buckner, D.O.
OSU-COM — *GI Fellow*

Earl J. Campbell, D.O.
PCOM — *Intern*

Stephen M. Dentler, D.O.
TCOM — *Intern*

Kevaghn P. Fair, D.O.
UHS-COM — *Pathology Resident*

Carlos N. Hornedo, D.O.
KCOM — *Intern*

Brent L. Kutach, D.O.
TCOM — *Intern*

Craig E. McCoy, D.O.
KCOM — *Intern*

Christopher Pierce, D.O.
COMP — *Anesthesiology Resident*

Clyde A. Turner, D.O.
MSU-COM — *Emergency Medicine Resident*

Darius Yorichi, D.O.
OSU-COM — *Radiology Resident*

DALLAS/FORT WORTH MEDICAL CENTER
(Grand Prairie)

Ronda Beene, D.O.
TCOM - OB/GYN — *Resident*

Donald Brock, D.O.
UHS-COM — *Intern*

Kenneth Chan, D.O.
SEUHSCOM — *Intern*

Stephen Hall, D.O.
TCOM — *Intern*

Beverly Land, D.O.
TCOM — *Intern*

Michael "Skip" Landers, D.O.
UHS-COM — *General Practice Resident*

DALLAS MEMORIAL HOSPITAL
(Dallas)

David Graham, D.O.
UHS-COM — *Intern*

Jackie Miller, D.O.
KCOM — *Intern*

NORTHEAST COMMUNITY HOSPITAL
(Bedford)

Kamran Algilani, D.O.
OSU-COM — *General Practice Resident*

Victor Brown, D.O.
SEUHSCOM — *Orthopedic Surgery Resident*

Kathleen Cubine, D.O.
TCOM — *Family Practice Resident*

Steven Ellerbe, D.O.
TCOM — *General/Family Practice Resident*

Stephen Garner, D.O.
UHS-COM — *Orthopedic Surgery Resident*

Patrick Hurley, D.O.
UOMHS — *Orthopedic Surgery Resident*

Mary Dennis Kretzer, D.O.
UOMHS — *Intern*

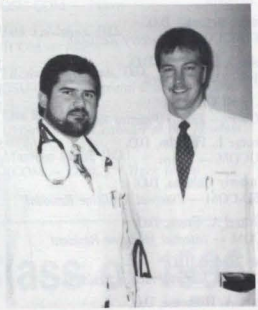
Sheila Page, D.O.
TCOM — *Intern*

Maurice Portilla, D.O.
TCOM — *Family Practice Resident*

Bessie Rogers, D.O.
TCOM — *Intern*

Felecia Waddleton-Willis, D.O.
PCOM — *Family Practice Resident*

DOCTORS HOSPITAL
(Groves)



L to R: Daniel Crain, D.O. and Chris Penning, D.O.

Daniel Crain, D.O.
TCOM — *Intern*

Chris Penning, D.O.
UHS-COM — *Intern*

MEMORIAL MEDICAL CENTER
(Corpus Christi)

Claire Zengerle, D.O.
TCOM — *Family Practice Resident*

OSTEOPATHIC MEDICAL CENTER OF TEXAS
(Fort Worth)

Douglas A. Albracht, D.O.
TCOM — *Intern*

Monte Allen, D.O.
TCOM — *Internal Medicine Resident*

Lyn M. Berutti, D.O.
TCOM — *Intern*

Daniel P. Conte, D.O.
NJSOM — *Manipulative Medicine Resident*

Burke DeLange, D.O.
SEUHSCOM — *Surgery Resident*

John J. Dougherty, D.O.
UHS-COM — *Intern*

L. Scott Fox, D.O.
COMP — *Family Practice Resident*

George L. Franklin, D.O.
OUCOM — *Intern*

Kimberly Galusha, D.O.
OSU-COM — *Internal Medicine Resident*

Michael A. Green, D.O.
TCOM — *Internal Medicine Resident*

Tony Hedges, D.O.
TCOM — *Family Practice Resident*

Renee A. Hillhouse, D.O.
UHS-COM — *Intern*

Janelle K. House, D.O.
UHS-COM — *Intern*

Scott Hughes, D.O.
TCOM — *Family Practice Resident*

Ellie Hryekewicz, D.O.
TCOM — *Manipulative Medicine Resident*

Robert Lopez, D.O.
TCOM — *Internal Medicine Resident*

Delbert McCaig, D.O.
TCOM — *Family Practice Resident*

Terry McDermott, D.O.
OSU-COM — *Urology Resident*

Mary K. Mills, D.O.
OSU-COM — *Intern*

Lisa Nash, D.O.
TCOM — *Family Practice Resident*

Ray Page, D.O.
TCOM — *Internal Medicine Resident*

M. Randy Ramahi, D.O.
UHS-COM — *Intern*

Daniel E. Rousch, D.O.
UOMHS — *Intern*

James W. Shuffield, D.O.
TCOM — *Intern*

Craig Spellman, D.O.
TCOM — *Internal Medicine Resident*

W. Craig Stevens, D.O.
CCOM — *Family Practice Resident*

Dana Wingate, D.O.
COMP — *Internal Medicine Resident*

Natalie Wright, D.O.
TCOM — *Intern*

Jerry Young, D.O.
TCOM — *Intern*

SOUTHSIDE COMMUNITY HOSPITAL
(Corpus Christi)

Peggy Weber, D.O.
KCOM — *Resident*

Dan Wilson, D.O.
KCOM — *Intern*

SOUTHWESTERN MEDICAL CENTER
(Dallas)

Fred W. Rohm, D.O.
TCOM — *Family Practice Resident*

WILLIAM BEAUMONT ARMY MEDICAL CENTER
(El Paso)

David H. Cyr, D.O.

Maryanne Gaffney, D.O.

Thomas W. Gibson, D.O.

James W. Howard, D.O.

Witold A. Wilk, D.O.

Mark D. Kalna, D.O.

Bret N. LeSueur, D.O.

J. D. Littleton, D.O.

Brent V. Nelson, D.O.

Gordon S. Olsen, D.O.

Nathan Tillotson, D.O.

Alfredo B. Tiu, D.O.

Erwina Q. Ungos, D.O.

David H. Cyr, D.O.
UNECOM — *Intern*

Maryanne Gaffney, D.O.
PCOM — *Intern*

Thomas W. Gibson, D.O.
PCOM — *Intern*

James W. Howard, D.O.
TCOM — *Intern*

Mark D. Kalna, D.O.
TCOM — *Intern*

Bret N. LeSueur, D.O.
KCOM — *Intern*

J. D. Littleton, D.O.
SEUHSCOM — *Intern*

Brent V. Nelson, D.O.
UHS-COM — *Intern*

Gordon S. Olsen, D.O.
OUCOM — *Intern*

Nathan Tillotson, D.O.
TCOM — *Intern*

Alfredo B. Tiu, D.O.
UOMHS — *Intern*

Erwina Q. Ungos, D.O.
COMP — *Intern*

Witold A. Wilk, D.O.
NYCOM — *Intern*

TEXAS A&M COLLEGE OF MEDICINE-SCOTT & WHITE (Temple)

John Hinze, D.O.
TCOM — *Resident*

Gerry Holland, D.O.
OSU-COM — *Resident*

Hermann Jonak, D.O.
TCOM — *Resident*

William Pieratt, D.O.
TCOM — *Resident*

Morey Price, D.O.
TCOM — *Resident*

James Stinson, D.O.
TCOM — *Resident*

Tommy Tarkenton, D.O.
TCOM — *Resident*

TRI-CITY HOSPITAL (Dallas)

Kathie Boyd, D.O.
OSU-COM — *Intern*

Michael Fulton, D.O.
KCOM — *Intern*

V. John Gonino, D.O.
TCOM — *General Practice Resident*

George R. Guntharp, D.O.
OSU-COM — *General Practice Resident*

Rita Hamilton, D.O.
OSU-COM — *Intern*

Jack LaManna, D.O.
TCOM — *Intern*

Elizabeth McKinnis, D.O.
OSU-COM — *General Practice Resident*

Lisa Reno, D.O.
UHS-COM — *General Practice Resident*

Maureen Ribail, D.O.
KCOM — *OB/GYN Track Intern*

■

Convocation Welcomes Class of 1996

Almost every seat in the Main Auditorium was filled Friday, September 25, as the 15th annual TCOM Convocation welcomed the Class of 1996.

President David M. Richards, D.O., and Vice President for Academic Affairs and Dean Benjamin Cohen, D.O., offered greetings and advice to the future osteopathic physicians. Salutations from TCOM's sister institution, the University of North Texas, were given by UNT Provost Blaine Brownell, Ph.D.

In his speech to the new class, Richards told them to take time for the part of their life outside medical school. "As you prepare yourself, please remember that there is a world outside of classes, study and examinations. Take time for your family, your friends and — most especially — take time for yourself," he said.

Cohen praised the class and commented on their collective goal to become physicians. "Your circuitous paths brought you to a common vision to travel the road to becoming a physician. Travel on this road will be arduous. In the process of becoming a giving, caring physician, the demands made on you and, to some extent, your loved ones, will be more encompassing that you ever imagined," Cohen said.

In the Class of '96 response, class President Michael Carrizal noted that the new students "represent the future of health care." He offered words of encouragement for his colleagues: "Remember that the success of our class lies not in the triumph of a few individuals, but in the shared success of the entire class."

William Jenkins, D.O., and Constance Jenkins, D.O., who retired from TCOM in 1991, were awarded Founders' Medals for their dedication and commitment to the college and the osteopathic profession. In words of praise for the couple, Richards noted that they are the "gold standard" by which role models are measured.

"They are counted among the distinguished pioneers who helped Texas' only college of osteopathic medicine grow into a medical school of the highest caliber," Richards said.

William Jenkins joined TCOM as a volunteer surgery instructor in 1971. He became chairman of surgery in 1978, a post he held until his retirement. The TCOM/UNT Board of Regents awarded him the rank of Professor Emeritus in 1991.

Connie Jenkins joined TCOM in 1978 and served as director of the G&FP Central Clinic for more than a decade. In 1992, the Texas Society of the American College of General Practitioners in Osteopathic Medicine and Surgery named her "General Practitioner of the Year."

The Jenkins told the new class to respect the osteopathic profession and to emphasize osteopathic principles. "The osteopathic profession and TCOM have given me a great deal of satisfaction," Connie Jenkins said. "Don't ever forget your osteopathic heritage."

"Stop along the way and give a little time to the osteopathic profession," William Jenkins said.

The Jenkins are the second husband-and-wife physician couple to receive TCOM Founders' Medals. John H. Burnett, D.O. and Mary M. Burnett, D.O., received medals in 1984.

The Founders' medal recipients and the Class of 1996 were honored at a reception in the Atrium following the convocation ceremony. ■

WARNING!!

NEW FEDERAL (OSHA) REGULATIONS

WENT INTO EFFECT MARCH 6th

LET US HELP YOU COMPLY WITH THE LAW

If your employees have occupational exposure to "blood or other potentially infectious materials" you will be required (29 CFR 1910.1030) to have and maintain a written, detailed Exposure Control Plan, WHICH MUST MEET SPECIFIC REGULATORY REQUIREMENTS or be prepared to pay fines of up to $70,000!

ADDITIONALLY, employees with occupational exposure must be provided with comprehensive Infection Control Training, during working hours, within 90 days of the effective date of the law, when assigned to exposure related tasks and annually thereafter.

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*Personal Protective Equipment
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*A Guide to the Use of Chemical Agents
*Employee Training Record
*Resource Information and more. . .

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Complete and simple to use as a staff training tool containing all required OSHA information including:

*Definitions
*Epidemiology
*Housekeeping
*Modes of Transmission
*Work Practice Controls
*Exposure Reduction Info
*Protective Equipment
*Disinfection/Sterilization Techniques
*A quiz. . .and much more

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_____ copies of: II. Infection Control in Healthcare: The Training Manual, $59.95 ea.

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Unfortunately, When You're Making Money Uncle Sam Is Always Just Around The Corner

In the September issue, we provided examples on how to invest your money and information as to why mutual funds are an excellent investment vehicle. Unfortunately, there are always two sides to a coin, and whenever you are making money you must consider the potential tax consequences. Uncle Sam is always just around the corner with his hands held out. Therefore, in order to maximize your investment earnings, you need to plan ahead. The following are some items you should consider before and after investing your money.

If you are like a lot of investors, you have been looking for higher rates of return than rates being offered on certificates of deposit. Therefore, you may be considering investing in mutual funds. Excellent idea, but before you cash in your certificates of deposit and purchase shares in a mutual fund, you need to get the answers to some important questions such as: When does the fund make its capital gain distributions? How much are the distributions likely to be? Does the fund have a high portfolio turnover rate? And finally, what is the fund's asset growth? Before looking at these questions keep in mind these basics:

1. Appreciation in value is not "realized" until the fund sells its investment.
2. "Unrealized" appreciation is not taxable.
3. "Realized" gains are distributed to the mutual fund's shareholders at which time the gains are taxable to those shareholders.
4. If you elect to reinvest those distributions, they are still taxable as if you received the distribution and then sent it back to the fund to buy more shares.
5. The value of "reinvested" dividends and gains does increase your tax basis in the fund.

Perhaps the first and most important question is "When does the mutual fund normally make its capital gain distributions?" This question is important because buying shares of a fund just before a distribution will result in a tax liability when the distribution is made. The value of the distribution is included in the purchase price but the gains will be taxed to those who receive the distribution, not those who enjoy the appreciation of their shares' value. The purchaser is in effect "buying" a taxable distribution. Since the ultimate goal is to save you money and unnecessary tax liability, the general advice is to buy a mutual fund after its capital gain distribution.

On the other hand, there are situations when it may not really matter if you purchase shares in a mutual fund just prior to the capital gain distribution. For example, let's say you have sold other investments during the current year and unfortunately you realized a loss on the sale of these investments. Under current tax law, your allowable capital loss deduction for any tax year is limited to $3,000. So when you purchase the capital gain distributions, you can use the gain to offset your other capital losses and not have a tax liability on these capital gain distributions.

The next logical question is "How can you determine how much the potential capital gain distribution might be?" This is a very difficult question. The future potential capital gain distribution can be estimated with ▶

limited accuracy. It depends on several factors, and generally those factors must be evaluated by a financial advisor or CPA who has the training and expertise to interpret these factors. Basically, what they will do is obtain the most recent financial report on the mutual fund. In the report, they are most interested in the undistributed net realized gain from investments. This is the amount that will be distributed the next time the mutual fund makes a capital gain distribution (assuming that the mutual fund does not incur other realized gains or losses on security transactions between the date of the financial report and the date of the capital gain distribution). Because of these future potential gains or losses, it is not possible to determine the exact amount of the capital gain distribution, but one can obtain a reasonable idea as to how much it might be next time. Once this calculation has been made, you will be better equipped to determine when to purchase shares in the mutual fund at which you are looking.

Another tax consideration in purchasing a particular mutual fund is the fund's portfolio turnover rate (how often the mutual fund buys and sells securities). A mutual fund which has a high portfolio turnover rate is generally expected to realize its capital gains faster than one which has a low portfolio turnover rate. To explain, if the mutual fund manager is constantly buying and selling securities (high turnover rate), he will generally realize the gains sooner than a manager who follows a longer buy-and-hold investment style (resulting in a low turnover rate). Either style of management can cause the value of the mutual fund to increase, but unrealized gains (the investments in the portfolio which have increased in value, but have yet to be sold) are preferable to realized gains since taxes do not have to be paid on the gains until they are realized.

Finally, you need to consider mutual fund's asset growth. Why? It affects the share of capital gains that each investor participates in based upon when the gains are realized and when the investor purchases shares in the mutual fund. This is a similar concept to the timing issue discussed earlier. If a fund becomes popular and grows by having new investors, those new investors must share in the tax burden when gains are distributed. This is good for those earlier investors whose shares have appreciated, tax deferred, while the realized gains are shared equally by the owners as of the date of the distribution.

Remember, there will probably always be some type of tax consequence with whatever investment you plan to make. You need to consider and plan ahead for this in order to maximize your investment return. This article is designed to present information on the subjects discussed in general terms and is not intended to be used as a basis for specific action without obtaining further professional advice. ■

This article is provided by Brian Jenke, Manager at Brantley, Frazier, Rogers & Company, P.C., an accounting firm founded in 1949 and located in Fort Worth.

Texas ACGP Update

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

Kathleen A. Buto, Director of the Bureau of Policy Development of HCFA, informed the AOA that osteopathic manipulative therapy (OMT), is considered to be a "procedure." She also stated that an evaluation and management (E & M) service, such as a visit or consultation, can be paid on the same day as OMT if the E&M service is a significant, separately identifiable E&M service by the same physician on the day of the OMT.

She went on to say that the CPT modifier 25 should be attached to the code for the E&M service. The CPT-4 code book states that the modifier 25 is to be used when a significant and separately identifiable evaluation and management service is provided by the same physician to the same patient on the same day the physician renders a "procedure."

Ms. Buto further stated that if the patient is scheduled to return, for example, the following week for another OMT and no separate E&M service is performed, (i.e., the sole purpose of the visit is for OMT), only the "procedure" can be paid.

In Texas, Blue Cross/Blue Shield, the Medicare carrier, has always recognized the current HCFA policy regarding OMT. However, the requirement of the modifier 25 is new. Dr. Godfrey, the Medicare medical director, has acknowledged that HCFA will require the use of modifier 25 if an evaluation/management service is billed on the same day as OMT. It is important that Texas ACGP members be alerted to the use of modifier 25 and encouraged to screen their Medicare claims to be sure they are getting reimbursed for an office visit and OMT on the same day.

HCFA requires the Medicare carrier to monitor the use of modifier 25. Dr. Godfrey is aware that there is a group of the osteopathic profession in Texas who uses OMT regularly, and this fact will be taken into consideration if any review is performed.

The modifier 25 is also required when an evaluation/management service is performed on the same day as a trigger point injection. The injection is considered to be a surgical procedure and will be referred to as such on the Medicare statement sent to the patient. The decision as to what codes are considered surgical, as far as requiring modifiers, is a national decision.

The Medicare Visit Code Comparative Performance Report Program provides physicians with information on their utilization of evaluation and management codes, when it is significantly higher than their specialty and locality peers, placing them in the 90th percentile or higher. High utilization may be a signal that CPT-4 codes are not being reported appropriately.

If you have received a Visit Code Comparative Report on services that you have reported more frequently than your peers, remember that at this time it is only informational. You should utilize all the appropriate E&M codes and not get locked into utilizing the same code all the time (i.e., code 99213). At some point in the future, the Medicare Visit Code Comparative Report will not just be informational.

I attended the Medical Care Advisory Committee (MCAC) of the Texas Department of Human Services in Austin, Texas on 9-11-92. There were several items on the agenda of interest to Texas ACGP members. First, the Department is changing the method of providing flu shots to Medicaid residents of nursing facilities. The current policy provides for reimbursement to the physician through the National Heritage Insurance Company (NHIC). Under the new policy, flu vaccine will be distributed free-of-charge to nursing facilities through local and regional Texas Department of Health offices.

Another item coming before the MCAC was the Vendor Drug Program Electronic Claims Adjudication rules. Interest in the development of a system for processing pharmacy claims electronically in the Texas Medicaid Vendor Drug Program had been expressed by pharmacy providers since the mid-1980s. The current billing system for Vendor Drug Program providers uses magnetic tapes and paper forms for claims submission. With implementation of the new system, only electronic submissions will be allowed. The implementation of the Electronic Claims Adjudication system is scheduled for January 1993. Will electronic billing by Texas physicians for Medicaid claims be a requirement in the future?

The most controversial item on the agenda was Medicaid payment of services performed by advanced nurse practitioners. Advanced nurse practitioners act independently and/or work in collaboration with other health care professionals in the delivery of health care. Currently, covered services provided by certified family and pediatric nurse practitioners, certified registered nurse anesthesists, and certified nurse midwives are reimbursed directly to enrolled providers. Currently, the Department does not reimburse all categories of advanced nurse practitioners. Advanced nurse practitioners are reimbursed at 70 percent of the rate paid to physicians.

After much discussion, the recommendation that the MCAC approve the proposed rule amendments, to include Medicaid coverage of services provided by all categories of advanced nurse practitioners at 85 percent of the rate paid to a physician for the same services, was voted down. This was to have included reimbursement for laboratory services, x-ray services, and injections at the same rate as physician reimbursement. It was a split vote, and this issue is expected to come back to the MCAC again and again.

In closing, don't forget to vote for the candidates of your choice in the upcoming general election. Please support TOMA-PAC if you can. It is a matter of economical and political survival. ■

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An Account of AAO President Judith A. O'Connell's Representation on the HCFA Panel to Evaluate Work Values

Following my testimony before the American Osteopathic Association's Board of Trustees and House of Delegates in July 1992, many of you have requested that I summarize my experience in representing the osteopathic profession before the Health Care Financing Administration's special panel to review comments on the RVUwork values assigned to manipulation codes. I am pleased to share with you my strategy, which was successful in convincing the panel to advocate higher work values for OMT. I hope that they will encourage you and help you in preparing for similar approaches to third party payors in your locality.

The HCFA implemented the Resource Based Relative Value Scale (RBRVS) on January 1, 1992, fully aware that adjustments would have to be made in the future on Medicare's program of physician reimbursement. HCFA provided a comment period on the work values associated with individual RBRVS procedure codes which would permit interested parties and groups the opportunity to challenge HCFA's decisions on these values. Following the deadline for comments, HCFA appointed panels to review all comments, including those regarding HCPCS Codes M0702-730, osteopathic manipulative treatment. The American Osteopathic Association nominated Wayne R. English, D.O. and me to represent the profession on this panel and designated me as the lead spokesperson for the osteopathic delegation.

Five days prior to the convening of the panel, I received from HCFA copies of all the comments submitted on M0702-M0730, along with instructions on how to rate the Relative Value Units (RVUs) on these codes. The comments generally were complaints that the RVUwork value for the M0-codes were too low. The stated purpose of the meeting was to decide if the RVUs in question truly were low, and, if so, then to assign appropriate work values. HCFA also provided for reference a set of CPT codes and their RVUwork values for comparison.

HCFA also had sent to me documents from the American Chiropractic Association (ACA) which essentially asserted that the code for chiropractic, A2000, was undervalued and restrictive. The ACA also proposed that the A2000 code be expanded into a "series of codes" based on the osteopathic M0-codes with the same RVUwork value. The ACA claimed that chiropractic manipulation was an equivalent service to OMT and, therefore, should be coded and reimbursed at the same level.

As head of the osteopathic delegation, I had the responsibility for compiling reference material to be used in documenting our support for increased RVUwork values and defending osteopathic manipulation as a separate and distinct medical procedure.

As President of the American Academy of Osteopathy (AAO), I was aware that AAO's Medical Economic Committee and its Ad Hoc Committee on Federal Regulation of Osteopathic Manipulative Medicine had been studying the RVUwork values for osteopathic manipulation codes. I relied heavily on these committee's work which found:

1. HCPCS Codes M0702-730 for osteopathic manipulation were undervalued. I was able to compare the M0-codes to the reference codes provided by HCFA to illustrate the work involved and prepared myself to defend and increase in the RVUwork values for the M0-codes based on that comparison. (Since the RVUwork values are not stable, any discussions you may have with third party payors should be based on current data. In my opinion, the best reference at this time is the RVUwork values assigned to the Evaluation and Management (E&M) codes since these values are the product of the Harvard University study upon which the RBRVS system is based.)

2. The RVUwork values for M0-codes are inconsistent, since the value assigned to M0706 (treatment of up to six body regions) is higher than M0708 (treatment of up to eight body regions.) We addressed this inconsistency by pointing out that this series of codes is constructed on the progressive treatment of body regions in groups of two. Logically, the work involved in treating a higher number of regions increases and the RVUwork values for the higher codes should reflect that increased complexity. We proposed that the basic unit of increase should be the value for M0702 (treatment of up to two body regions) since the codes progressed in that fashion, i.e. M0704 is twice the work of M0702; M0706 is three times the work, M0708 is four times the work, etc.

▸

3. The RVUwork values for M0702-710 (office based OMT) should parallel the values for M0722-730 (hospital based OMT.) This approach allows for consistent, logical reimbursement.
4. The work involved in OMT necessitates evaluation, diagnosis, treatment plan and selection of appropriate OMT modalities, and the appropriate application and re-evaluation of the OMT. This work calls for a high degree of medical judgment and decision-making and, therefore, necessitates the use of an E&M code in addition to the procedure code (M0-code). The HCFA panel agreed.

We are successful in communicating this message to the panel. They agreed that the RVUwork values for the M0-codes were undervalued, that our proposal was more realistic, and that the values should be increased. The HCFA leadership agreed to take this recommendation to the next level and advocate an increase in the RVUwork values for OMT codes.

The next issue was the ACA's proposal for an expansion of the chiropractice code (A2000), using a system based on the osteopathic manipulation codes (M0702-730.) The ACA's documents submitted to HCFA asserted the following:

1. Chiropractic treatment is equivalent to OMT because both treat the musculoskeletal system.
2. Chiropractic and osteopathic techniques are the same.
3. We both hold the same belief that disease comes from malalignments of the spine.
4. Chiropractic manipulation is more specific because it treats spinal subluxations and is therefore better than OMT.
5. In light of all of these assertions, chiropractic treatment is equivalent to OMT and should be reimbursed and coded as such.

I had to be prepared to counter these assertions; hence, I read chiropractic literature in order to understand their position. What I discovered is that the chiropractic profession is in turmoil whether to remain classical (proponents are called "straights") or to embrace medicine (advocates are termed "mixers"). The ACA stance is that classical philosophy of disease is caused by malalignment of the spine, and appropriate treatment is directed to chiropractic subluxations. In most states, the scope of practice for chiropractic limits practitioners to "straight" chiropractic and chiropractors are considered "limited license practitioners."

Knowing that the panel would consider the ACA stance as a basis for its discussions, I prepared cases that would illustrate the osteopathic integrated approach to medicine. I purposely stressed the diagnostic and visceral components with an emphasis on treating the system in dysfunction, not just the axial skeleton. I chose two cases for presentation:

1. piriformis syndrome with sciatica; and
2. congestive heart failure with peripheral edema.

In the treatment plan for piriformis syndrome with sciatica, I stressed the treatment of muscle spasm with medication, physical therapy and osteopathic manipulative treatment. This allowed me to demonstrate that OMT is part of a total medical treatment plan and that OMT is *not* physical therapy. I also described techniques that are muscle specific, not axial skeleton specific.

In the second case, I described lymphatic and vascular techniques coupled with medication, hospitalization and testing. I stressed that OMT is an integral part of osteopathic health care and is disease specific, not spinal specific.

Our preparation paid off. By using the above clinical cases for the basis of my advocacy for higher work values, the ACA also had to address these cases to substantiate their claim of equivalency. In their presentation and discussion of chiropractic care for these cases, it became obvious to the panel that there was no support for their claim of equivalency. The panel found that chiropractic manipulation was not equivalent to osteopathic manipulation. Therefore, the chiropractors could not use the M0-codes as a basis for an expansion of their own code.

In summary, we were able to convince the HCFA panel that the work involved in osteopathic manipulation was greater than the present RVUwork values reflect; that the RVUwork values should increase by a unit value reflective of the increased work involved in treating additional body regions; that the in-patient and out-patient RVUwork values should be parallel; that an E&M charge is appropriate in addition to a charge for OMT; that chiropractic is not an equivalent service to OMT; that OMT is disease specific, not spinal specific; and that the M0702-730 codes are not templates for chiropractic codes.

I hope that this synopsis of the HCFA panel's discussions and findings are helpful to you in your local and national negotiations with all third party payors. In order to be successful, we must act in unison. The American Academy of Osteopathy is working for you. Through your support as a member, we can continue to make a difference. If you need help or wish to share information with the rest of the profession, please contact the Academy.

Judith A. O'Connell, D.O., President
American Academy of Osteopathy

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ATOMA NEWS

ATOMA District II

By Myra Schussler

ATOMA District II began the year with a membership drive held on July 1, 1992 at the home of Anny Buchanan. Our membership vice president, Tulisha Buchanan, and our president, Teri McFaul, did a fine job organizing the Hawaiian Luau. There were about 50 people present, many potential members of our district, and fun, food and prizes were abundant!

Here is the official outcome of all the hard work that went into the planning of the 1992 Wintercrest Charity Ball. This year, the Ball was aptly called the Bandana and Boots Ball and was held at the Yellow Rose Saloon in the Texas Exhibit of the Fort Worth Zoo. There was authentic barbecue as well as fajitas, dancing, and, of course, a fun-filled casino night and auctions. The evening was lovely and we were able to enjoy the outdoor area as well as the saloon itself. The bottom line is that ATOMA District II, because of the work of many, was able to give $10,000 to osteopathic scholarships and $7,300 to the chosen local charities. The remaining 10 percent of the profits is held as seed money for the following year's Ball. Congratulations to everyone who helped to make this endeavor the huge success it was!!

National Osteopathic Medicine Week was celebrated October 4-10. Among the many things planned for the week was a magic show that was brought to the schools, telling the history of osteopathic medicine and preventive medicine.

There was an SAA family dinner and swim get-together at Mark and Rita Baker's house on August 29, and a fun time was had by all. Thank you, Bakers, for your hospitality!

At this time, I'd like to congratulate the following families on their new additions (if I've left anyone out, please let us know and I'll include them in the next issue): Jackie and Larry Sharp, Randy and Lori Phillips, Mitzi and Al Hulse and Staci and Burke DeLange.

The following is a list of the ATOMA and TOMA District II dinner meetings and where they are to be held. Coctails are at 6:30 with dinner at 7:30. Please remember that interns and residents and their spouses are invited to attend as our guests for dinner. Try to attend and try to bring either a new or a potential member with you. We have a great district — but we need to keep working to keep it great! If you have any news that you would like to see in this column, send it to me or call: Myra Schussler, 3712 Myrtle Springs Road, Fort Worth, 76116; (817) 737-7370.

November 12	— Rivercrest Country Club
January 21	— Ridglea Country Club
March 18	— Dos Gringos Restaurant
May 20	— Mira Vista Country Club

President's Corner

By Peggy Rodgers, ATOMA President

NOM Week always slips up on me. This year we have done so much that it's hard to put forth more effort. The AAOA has a wonderful cookbook to be used by the districts as a fund raiser and it brings out a very positive image of D.O.s to the public. As a district, it might be best to start planning for NOM Week in the spring. In the fall, too many times NOM Week is upon us before we have a chance to prepare. You can still place the coloring books in offices, etc., even though NOM Week is over.

Shirley Bayles may be contacting your districts to see if you would like me to come and visit. If your district is not organized, it would be fun to get together anyway. Think of something we could do together. It does take some effort to plan activities. These activities may be separate from the physicians' meeting. I must admit, it does take some work to get a tradition started or a group together. All of us usually have a full schedule already, so in the planning stages, find someone to help you if you are trying to get together. This way, you don't burn yourself out. All of you are important to ATOMA; we need you all. As an organized district, give someone a phone call to come to meetings or to become a member. Everyone loves personal contact to feel like they are a part. Begin thinking of ways we could get together when Shirley contacts your district. I'm looking foward to seeing you.

Our midyear meeting was held at the TOMA office on Saturday, September 12, from 9 a.m. to 3 p.m. We have a lot of new members on the board and they are doing an excellent job. We had reports from each office and committee. We are considering setting up a scholarship fund from ATOMA contributions and fund raisers. We will continue to contribute to the national scholarship funds, but we are interested in a state scholarship fund we would be able to keep in Texas. We are also looking into different price ranges for tee shirts and golf shirts.

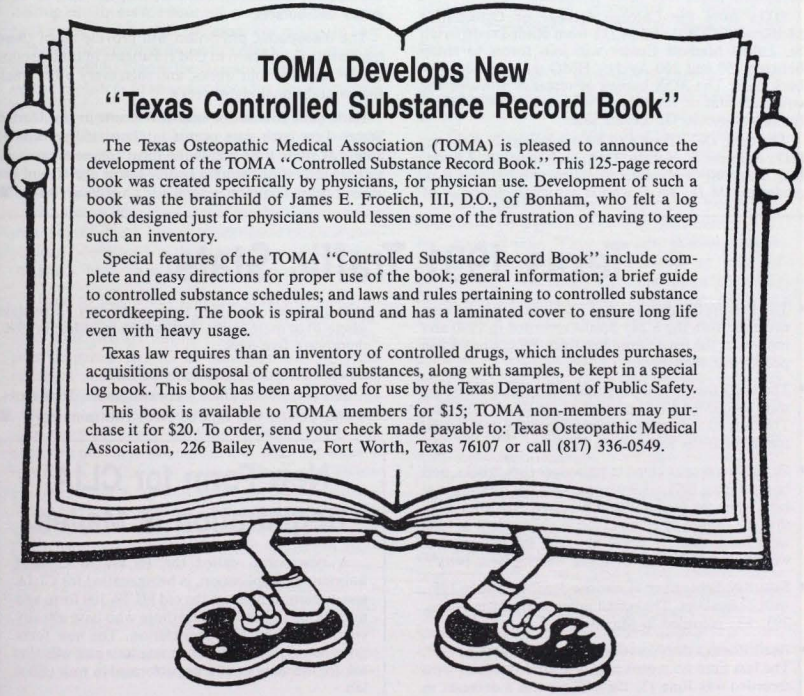
The national convention is being held November 1-4 in San Diego, California. We have been preparing for passing the additional clause (resolution) in the Associate

Membership category to include others interested in supporting the Auxiliary, for instance: widows of D.O.s. Our Public Relations Chairperson will be handling the sales of tee shirts and golf shirts. They will also place the orders and handle the budgeting of those funds. We had a very productive meeting.

Our membership drive is beginning this month. Please help us by encouraging others to join. We do have a budget set up each year for operating expenses and our dues go toward this. In order to continue all the wonderful things we are doing, we need your membership to make these things happen. So please, help us this fall by joining the auxiliary.

We would love to hear from each and every one of you. Please send articles to the *Texas DO* by the 10th of the month preceding publication, of what is happening in your district. You do not have to be organized to be doing great things. We would also like to know of weddings, grandkids, and new additions to your own family. We all would like to know of your activities for our own districts to draw on. So please, let us know what's happening across the state by sending in your articles to the state office.

I would like to extend a special thanks to District II for all the work and financial support extended to the SAA. They are instrumental in providing the SAA with luncheons, open houses and tours of the school. District II, you're doing a great job! Thanks from all of us. ■



TOMA Develops New "Texas Controlled Substance Record Book"

The Texas Osteopathic Medical Association (TOMA) is pleased to announce the development of the TOMA "Controlled Substance Record Book." This 125-page record book was created specifically by physicians, for physician use. Development of such a book was the brainchild of James E. Froelich, III, D.O., of Bonham, who felt a log book designed just for physicians would lessen some of the frustration of having to keep such an inventory.

Special features of the TOMA "Controlled Substance Record Book" include complete and easy directions for proper use of the book; general information; a brief guide to controlled substance schedules; and laws and rules pertaining to controlled substance recordkeeping. The book is spiral bound and has a laminated cover to ensure long life even with heavy usage.

Texas law requires than an inventory of controlled drugs, which includes purchases, acquisitions or disposal of controlled substances, along with samples, be kept in a special log book. This book has been approved for use by the Texas Department of Public Safety.

This book is available to TOMA members for $15; TOMA non-members may purchase it for $20. To order, send your check made payable to: Texas Osteopathic Medical Association, 226 Bailey Avenue, Fort Worth, Texas 76107 or call (817) 336-0549.

M.D.s and D.O.s Team Up To Study Most Effective Back Pain Treatment

D.O.s and M.D.s are teaming up to find the most effective way to treat low back pain.

A study has been launched in Chicago to determine if osteopathic manipulative treatment (OMT) has benefit to low back patients over and above that of other traditional treatments.

"This research will help quantify the contribution of osteopathic manipulative treatment to patient care," said Howard M. Levine, D.O., chairman of the American Osteopathic Association bureau of research. "The outcome of this project is very important to our profession. Our students are asking for scientifically acceptable proof that OMT is effective."

D.O.s from the Chicago College of Osteopathic Medicine (CCOM) and M.D.s from Rush-Presbyterian St. Luke's Medical Center will join forces to study between 150 and 200 Anchor HMO patients with low back pain. The AOA bureau of research provided the entire amount of funding — in excess of $400,000 — for this research, Dr. Levine said.

The three D.O.s from CCOM are Robert E. Kappler, D.O.; Kenneth E. Nelson, D.O.; and James A. Lipton, D.O. The study's principal investigator is Gunnar B. J. Anderson, M.D., Ph.d. who is associate chairman of orthopedic surgery at Rush-Presbyterian-St. Luke's. Frederick N. Schwartz, D.O. and Andrew M. Davis, M.D. are co-investigators.

Patients who have experienced low back pain for at least three weeks, but not longer than six months will be randomly assigned to standard care and standard care with OMT. They will be treated for up to three months and results will be compared between the two groups.

Patients seen by an M.D. will be treated with analgesics, anti-inflammatory medication, exercise, therapy and conservative treatment methods such as ultrasound, diathermy, biofeedback, hot and/or cold packs and corsets.

The osteopathic physicians will provide all of these treatments in addition to OMT. Patients in both groups will be seen for four weeks, and then every other week for an additional eight weeks.

Back pain is a major health concern in the United States. Low back pain occurs in almost 80 percent of adults at some time and is the most frequent cause of activity limitations among people below age 40 and the second most common reason for physician visits. ■

Texas 1991 Traffic Stats

- The 1991 traffic death toll of 3,079 was a five percent decrease from the 3,243 deaths recorded in 1990 and represents the fewest fatalities since 1974, when 3,046 people lost their lives.
- The 1,622 motor vehicle fatalities in rural areas of the state accounted for 53 percent of the state's fatalities. This is a nine percent decrease from the 1,777 rural traffic fatalities recorded in 1990.
- Of all the persons killed in passenger cars, trucks, and buses during 1991, 68.9 percent were not wearing seat belts when the fatal accident occurred. Statistics show that the chance of being killed in an accident in 1991 were more than 11 times as great for persons not wearing seat belts as for those wearing seat belts.
- Saturday, September 14 was the deadliest day in 1991, with 22 fatalities. The largest number of traffic deaths, 293, was recorded in March.
- April 16 was a deathless day on Texas highways in 1991. The last time no motor vehicle traffic fatalities were recorded was June 13, 1989. There was a decrease in the number of days where 20 or more traffic deaths were recorded. In 1991, there were only three days where 20 or more traffic deaths were recorded; in 1990, there were five days.
- Based on reported accidents in 1991:
  One person was killed every two hours, 51 minutes.
  One person was injured every two minutes. ■

New Form for CLIA Registration is Mailed

A new form, called the HCFA-116 Clinical Laboratory Application, is being mailed for CLIA registration. It replaces the old HCFA-109 form and must be completed even by those who have already completed the CLIA registration. The new form gives new directions for counting tests and will also ask for the number of tests performed in your office lab.

Letters To The Editor

Dr. John Boyd Speaks to TMF Board

Dr. John Boyd, of Eden, addressed the TMF Board on July 12, 1992 and below is a copy of his remarks:

You have abdicated your responsibility for review and allowed your authority to be applied and abused by non-physician reviewers. Your physician reviewers are accepting the dominance of non-physicians with check lists in hand and those aggressive physician-baiting employees are destroying our promises to the health care professionals of Texas. The quality of care is thereby standardized and diminished. Before long, Tuesday will be Green Tie Day and God help any of you so foolish as to wear a red or blue tie on Tuesday!

The strength of American Medicine has been built on the patient's right to choose a physician whose style of practice and philosophy made him or her feel secure, well, and cared-for. Anyone who believes he knows the only right way to treat a particular illness needs to clean his glasses. All of you had better realize that if those check lists represent good medical care, you can be replaced by those non-physicians holding the check lists. Then God help the poor patient!

I want to talk about some observations based on my experience and the experience of other rural physicians. We are having problems with inflexible practice parameters in the hands of non-physician reviewers and with the outcome of review. We are hearing from experienced hands in TMF and in the review program that many of our physicians are intimidated by the non-physician reviewers. I think you need to take some soundings and find out what is happening. I think that many times our review program is not according weight properly to clinical judgment and experience. We apparently have an inflexible approach to style of practice and philosophy. I have been told that you, the Board, would not know a quality issue if you saw one. We have created a new elite. In the thirties it would have been called a Gestapo. We have physicians destroyed by people they may not face and respond to, and this is frightening!

There is a great deal of confusion of purpose in the conduct of review. We are having people criticized because available procedures are not used. Availability is not a basis for ordering procedures or tests! Need, indications are the bases.

We have a system of medicine that is economically bankrupt because of procedures — because of wasteful application of personnel, materials, and procedures.

We are burdened by programs and devices planned by specialists, people who treat a little piece of the human machinery, and we are taking those programs and those requirements and laying them against those physicians who treat the whole human being, who do the triage and see patients in the rural setting.

I realize our machinery is efficient. It works well. Sometimes perhaps too well. I helped develop it... I am proud of that. When you start making rules or laws and applying them because of ease of enforcement, you have gone from the principles of democratic society, and we have gone down that road. I think there is in our machinery a tendency to be self satisfied. We are all good at that! I remarked to someone — someone asked about bringing cases here and I said, "Oh, Hell no!" There are cases, obviously or I wouldn't have the squawk. They are not all mine, but there are cases. But I don't want to talk about cases with you. But I thought some of the remarks I got from individuals in review — not just one, but several — were revealing. They indicated an underlying belief that the concept of quality medical care is foreign to this Board as a group. I don't believe that is true. I think that the devices for policing quality medical care may not be well-known to many of you. That is no problem! But I still think you should know individually and collectively what is being done in your name. And I shall tell you it is almost impossible to get a physician to come into a rural hospital to practice. Most of them can't face the heat, and a great many of them aren't willing to face you.

News from the TMF

CHAMPUS Preadmission/Preprocedure Authorization

As part of its regional contract with the Department of Defense, the Texas Medical Foundation reviews inpatient services provided to CHAMPUS beneficiaries in acute-care civilian hospitals and rehabilitation units, including hospitals participating in coordinated care networks and children's hospitals in Texas.

While most of TMF's review activities are initiated through case selections obtained from CHAMPUS fiscal intermediary claims data, preadmission/preprocedure review actually begins with the physician or his/her designee.

In preadmission/preprocedure review, TMF determines the medical necessity and appropriateness of the setting for inpatient admissions for selected principal diagnoses (except abortions; see codes list) and for selected procedures, regardless of whether the procedure is principal or secondary. The need for preadmission/preprocedure authorization applies regardless of whether the beneficiary's CHAMPUS coverage is primary or secondary.

For these selected diagnoses and procedures, the CHAMPUS program requires that a physician (or the physician's designee) call TMF to obtain a treatment authorization number prior to the physician's admitting the beneficiary or performing the procedure. The list of ICD-9-CM diagnosis and procedure codes which require preadmission/preprocedure authorization is on the following page.

Physician Responsibility

To receive a treatment authorization number for a selected diagnosis/procedure, the physician (or physician's designee) must call TMF prior to the admission, before the procedure, or within two working days of an urgent/emergency admission/procedure. The toll free number for TMF's preadmission/preprocedure authorization line is 1-800-299-3627. If the physician has any question regarding whether or not a diagnosis or procedure requires preauthorization, he or she is encouraged to call the TMF general inquiry number for CHAMPUS cases. The CHAMPUS general inquiry number is 1-800-299-8963.

The physician (or designee) must give the following information to the TMF nurse reviewer:

- the beneficiary's full name, CHAMPUS identification number, age, and date of birth;
- date of admission/procedure;
- hospital name and provider number;
- physician's name, UPIN number, and telephone number;
- and pertinent medical information which substantiates the beneficiary's medical need for the admission/procedure.

Preadmission/preprocedure authorization may be requested for an admission/procedure up to 30 days before the scheduled date. The treatment authorization number assigned by TMF remains valid for up to 30 days from the date the admission/procedure is originally scheduled.

The physician (or designee) must notify TMF if the hospital, surgical setting, or physician changes from what was originally submitted to TMF. When the admission/procedure does not occur within 30 days of the originally scheduled admission/procedure date, the original treatment authorization number is invalid. The physician (or designee) must call TMF to reinitiate review and consideration of a new treatment authorization number.

If a CHAMPUS admission/procedure takes place outside of this date window and TMF is not notified, the CHAMPUS fiscal intermediary will pay the claim but the case will be selected for TMF's retrospective review of the medical record. A canceled procedure does not have to be reported to TMF. Cases for which a treatment authorization number is not obtained as required will also be selected for retrospective review.

CHAMPUS Diagnoses and Procedures which require preadmission/preprocedure authorization

(effective 5/15/92)

Simple Pneumonia

485 Bronchopneumonia, organism unspecified
486 Pneumonia, organism unspecified
487.0 Influenza with pneumonia

Bronchitis/Asthma

466.0 Acute bronchitis
466.1 Acute bronchiolitis
490 Bronchitis, not specified as acute or chronic
491.0 Simple chronic bronchitis
491.9 Unspecified chronic bronchitis
493.00 Extrinsic asthma w/o status asthmaticus
493.10 Intrinsic asthma w/o status asthmaticus
493.90 Asthma, unspecified w/o status asthmaticus
493.01 Extrinsic asthma w/ status asthmaticus
493.11 Intrinsic asthma w/ status asthmaticus
493.91 Asthma, unspecified w/ status asthmaticus

Coronary Artery Bypass Graft

36.10 Aortocoronary bypass for heart revascularization, not otherwise specified
36.11 Aortocoronary bypass of one coronary artery
36.12 Aortocoronary bypass of two coronary arteries
36.13 Aortocoronary bypass of three coronary arteries
36.14 Aortocoronary bypass of four or more coronary arteries
36.15 Single internal mammary-coronary artery bypass
36.16 Double internal mammary-coronary artery bypass
36.19 Other bypass anastomosis for heart revascularization

Angioplasty/Endarterectomy

36.01 Coronary (balloon) (single vessel)
36.02 With thrombolytic agent infusion
36.05 Multiple vessels
38.12 Endarterectomy - head and neck

Cardiac Catheterization

37.21 Right heart cardiac catheterization
37.22 Left heart cardiac catheterization
37.23 Combined right and left cardiac catheterization
88.55 Coronary arteriography - single catheter
88.56 Coronary arteriography - two catheter
88.57 Other and unspecified arteriography

Gastritis/Dehydration

276.5 Dehydration
535.00 Acute gastritis w/o hemorrhage
535.30 Alcoholic gastritis w/o hemorrhage
535.50 Unspecified gastritis and duodenitis w/o hemorrhage
552.3 Diaphragmatic hernia with obstruction
553.3 Diaphragmatic hernia
558.9 Other and unspecified noninfectious gastroenteritis and colitis

Abortion

Two ICD-9-CM codes must be provided, one for the diagnosis and one for the procedure. Both codes must appear on the list of codes which require prior authorization; if not, the case does not require preprocedure review. The diagnosis code may be primary **or** secondary.

ICD-9-CM Diagnosis Codes

635.0x - .9x Legally induced abortion
636.0x - .9x Illegally induced abortion
637.0x - .9x Unspecified abortion
638.0x - .9x Failed attempted abortion
V61.7 Other unwanted pregnancy

ICD-9-CM Procedure Codes

69.01 Dilation and curettage for termination of pregnancy
69.02 Dilation and curettage following delivery or abortion
69.51 Aspiration curettage of uterus for termination of pregnancy
69.52 Aspiration curettage following delivery or abortion
74.91 Hysterotomy to terminate pregnancy

NOTE: CHAMPUS coverage for abortions is prohibited by law except where the life of the mother would be endangered if the fetus were carried to term.

Biliary Tract Operations

51.22 Total cholecystectomy
51.23 Laparoscopic cholecystectomy

C-Section/Removal of Fetus

74.0 Classical cesarean section
74.1 Low cervical cesarean section
74.2 Extraperitoneal cesarean section
74.4 Cesarean section of other specified type
74.99 Other cesarean section of unspecified type

Other Uterine Incision or Excision

68.4 Total abdominal hysterectomy
68.5 Vaginal hysterectomy

In Memoriam

SHARON L. DIXON, D.O.

Sharon L. Dixon, D.O., of San Antonio, passed away on July 7, 1992. She was 39 years of age. She was buried in Fort Sam Houston Cemetery.

Dr. Dixon graduated from L.D. Bell High School in Hurst in 1971 and attended the University of Texas at Arlington. She received her D.O. degree in 1984 from Texas College of Osteopathic Medicine and interned at the Osteopathic Medical Center of Texas in Fort Worth.

Dr. Dixon was on active duty with the U.S. Air Force. She was a member of TOMA District XVII.

Survivors include a sister, Sandra Jenkins, of Palestine.

A. ROSS McKINNEY, D.O.

A. Ross McKinney, D.O., of Texarkana, passed away in September. The exact date is not known. He was 86 years of age.

A 1928 graduate of Kirksville College of Osteopathic Medicine, Dr. McKinney served an internship at the Laughlin and KCOS Hospitals. He practiced in Louisiana for one year and then returned to Texarkana, where he was raised. He operated his general practice in Texarkana until his retirement in May of 1991.

He was active in TOMA affairs as well as those of TOMA District III. He was a life member of TOMA and the AOA, and held membership in the American Academy of Osteopathy and the International Academy of Preventative Medicine.

Dr. McKinney served on the first board of directors of the Texarkana Jaycees and was a member of the Texarkana Chamber of Commerce and the Texarkana Rotary Club.

In 1978, Dr. McKinney completed his 50th year of practice. During a phone interview with TOMA at that time, he stated, "I'm forever grateful for being able to study osteopathic medicine, even if I hadn't been able to make a living at it, because of what it has taught me about myself."

H. GEORGE GRAINGER, D.O.

H. George Grainger, D.O., FAAO, of Tyler, passed away October 6. He was 88 years of age. Funeral services were held October 8 at the First Baptist Church in Tyler, with burial in Rose Hill Cemetery, also in Tyler.

Following his 1929 graduation from Kirksville College of Osteopathic Medicine, Dr. Grainger moved to Tyler. He practiced for 63 years, with 56 of them in Tyler. He had announced his retirement as of June 1, 1992.

Dr. Grainger had been a TOMA member since the 1930s, serving as TOMA president from 1948-49. He was also a life member of both TOMA and the AOA. He was the founding president of TOMA District III, serving as its secretary for numerous years, and writing the District III news for the *Texas DO.*

He was a member of the founding board of directors of Texas College of Osteopathic Medicine in the years before it became state supported in 1975. In 1986, TCOM awarded him a Founder's Medal, the highest award the college gives for contributions to medical education.

Dr. Grainger was founding president of the Texas Academy of Applied Osteopathy. In 1963, fellowship in the American Academy of Osteopathy (AAO) was conferred, only the second year the earned fellowship program was in operation. He had been a member of the AAO since 1949, and their 1973 Academy Yearbook was dedicated to Dr. Grainger.

In 1967, Dr. Grainger was chosen as the "General Practitioner of the Year" by the Texas Society of ACGP and in 1986, he was awarded a 50th anniversary medallion by his alma mater, KCOM.

A poet and artist as well as a physician, he was a founding member and poet laureate of the American Physicians Poetry Association. He served as president of the Tyler Art League in 1966 and edited the *Journal of the Osteopathic Cranial Association* for four years.

He was a major in the medical corps with the Texas State Guard during World War II.

He was a longtime member of the First Baptist Church in Tyler, Order of the Rose, Willow Brook, and Tyler Museum of Art.

Survivors include his wife, Geneva Grainger of Tyler; two sons and daughters-in-law, Richard and Corinne Grainger of Tyler, and Dr. Jack and Doris Grainger of Houston; a daughter and son-in-law, Jill and Charles Milstead of Houston; a sister, Geraldine Meckel of Denver, Colorado; five grandsons, Rick and Greg Grainger, and Charlie, Mark and Lyle Milstead; two granddaughters, Amy and Gigi Grainger; and one great-grandson, Richard Blake Grainger.

Memorials may be made to the Henry George Grainger Memorial Scholarship Fund in care of Texas College of Osteopathic Medicine Foundation, 3500 Camp Bowie Boulevard, Fort Worth, Texas 76107 or to the Tyler Day Nursery.

In Memoriam

PHYLLIS WIMAN

Phyllis Wiman of Wichita Falls, wife of Thomas D. Wiman, D.O., passed away August 15. She was 49 years of age. Funeral services were held August 18 at Bell-Cypert-Seale Funeral Home in Snyder, Texas, with burial in Hillside Memorial Gardens in Snyder.

Mrs. Wiman had lived in Wichita Falls the past 15 months, moving from Fort Worth where she had worked at the Osteopathic Medical Center of Texas. She lived in Snyder from 1975 to 1986, working at Cogdell Memorial Hospital and with her husband in his medical practice from 1983.

Mrs. Wiman attended Howard County R.N. School, received her B.S.N. Degree from Northeast Missouri State University, graduating Suma Cum Laude, and received her Master of Nursing Science Degree from the University of Missouri, Columbia, graduating Magna Cum Laude. She was a member of the American Nurses Association, Texas Nurses Association, Nursing Association of North Texas, and an elected member of the Florence Nightingale Society, an international honor society in nursing.

Survivors include her husband; a son, Del Vickers of Lubbock; a daughter, DeLena Jones of Tanzania, Africa; her parents, Art and Iva Pyle of Andrews, Texas; two stepsons, David of Abilene, Texas, and Chris of Palo Alto, California; a stepdaughter, Shanda of Abilene; two brothers, Roy Lee Pyle of Midland, and Jerry Pyle of Pauls Valley, Oklahoma; and six grandchildren.

The family suggests memorials be made to the Phyllis Wiman Memorial Nursing Scholarship Fund at Western Texas College in Snyder.

CHAMPUS News

CHAMPUS Publishes New Handbook for Families

The new CHAMPUS Handbook has been published, and will soon be available to service families.

The 156-page handbook has been completely updated with the latest information about the standard CHAMPUS program's benefits, procedures and eligibility requirements, including new provisions for some service members who leave active duty, and their families. The book was last published in 1990.

Also discussed in the handbook are the uniformed services' Active Duty Dependents Dental Plan and CHAMPVA, a program similar to CHAMPUS that is operated by the Department of Veterans Affairs for the families of disabled veterans.

The cover of the new handbook is green with white lettering. The red-white-blue 1990 handbook and all previous editions are outdated, and should be discarded immediately. The new handbook is being shipped to the military services' distribution centers, to the U.S. Public Health Service, the U.S. Coast Guard, and to the headquarters offices of all CHAMPUS claims processors.

Requests for supplies of the handbook may be forwarded to the appropriate publication distribution centers. Navy requesters should use this stock number: SN 0510-LP-209-3800. Other requesters should refer to CHAMPUS Handbook 6010.46H, dated July 1992, when ordering from their distribution centers.

Individuals who want copies of the new handbook should contact their nearest Health Benefits Advisor.

CHAMPUS Won't Accept Old HCFA Form

CHAMPUS claims processors will not accept obsolete versions of the HCFA 1500/CHAMPUS 501 claim form from providers of care after December 31, 1992. Obsolete forms are those dated earlier than December 1990.

Versions of the form dated before December 1990 will be accepted by CHAMPUS contractors only through December 31, 1992, regardless of when the services listed on the form were provided.

Claims received after the end of the year on the obsolete forms will be returned with a letter saying that they must be resubmitted on a HCFA 1500 dated December 1990 or later.

The "CHAMPUS 501" designation, which appeared on the old forms, has been deleted from the December 1990-and-after versions of the HCFA 1500. However, the HCFA 1500 remains the proper billing form for all individual professional provider and supplier services, including those of institution-based providers. ■

TCOM Tops State Medical Schools In Percentage Of Graduates In Family Practice Residencies

Texas College of Osteopathic Medicine leads the state's eight medical schools in the percentage of 1991 graduates entering family practice residency programs.

In a report published in the September-October issue of *Family Medicine*, a national publication of the American Academy of Family Physicians, TCOM ranked 14th out of the 140 medical schools in the nation in 1991 graduates entering American Council on Graduate Medical Education-approved family residency programs.

Including American Osteopathic Association-approved general and family practice residencies, TCOM ranks third in the number of 1991 graduates entering residencies compared to the 125 allopathic medical schools.

"When TCOM became a state-supported school, our charge from the Texas Legislature was to prepare primary care physicians," said TCOM President David M. Richards, D.O. "In the 22 years that we have been helping meet the health care needs of Texas, more than 80 percent of our graduates have entered primary care medicine."

More than 75 percent of TCOM's 1991 graduates entered primary care graduate training programs. Primary care physicians include those in general and family practice (G&FP), pediatrics, obstetrics and gynecology and internal medicine.

In the Texas Health Policy Task Force report issued at the end of August, experts say that a major crisis facing health care in Texas is the lack of primary care physicians. The report says that "there is an ongoing need for more primary care practitioners . . . within underserved areas and populations."

The report goes on to say that primary care accounts for more than 90 percent of the health services people receive, and that preventing illness and meeting basic health care needs is crucial to the well-being of Texas residents.

According to Benjamin Cohen, D.O., vice president for academic affairs and dean, recruiting individuals interested in primary care fields is crucial to producing a higher percentage of family medicine physicians. "We actively recruit students who are interested in primary care medicine, and our curriculum is specifically designed to emphasize it. The students' clinical rotations spotlight family medicine and broaden the students' experience. Even though we have the smallest number of clinical faculty of all Texas medical schools, we produce the largest percentage of general and family practice physicians," Cohen said.

TCOM encourages students to pursue careers in primary care medicine in the following ways:

- Students complete 630 classroom hours in general and family practice courses. The next highest number of hours required by a Texas medical school is 340.
- Students complete 16 weeks in general and family practice clinical rotations. The national average for students in G&FP clinical rotations is less than five and one-half weeks.
- TCOM's Department of General and Family Practice is a constant fixture in the lives of students. In the first two years, students are required to take four different G&FP courses. First-year students are placed in health-related agencies throughout Fort Worth for a broad exposure to community health. Second-year students work in the offices of local osteopathic physicians to experience general practice first-hand. The last two years include 19 required clinical and hospital primary care and specialty rotations.
- More than half of TCOM admissions committee members are practicing primary care physicians which, according to the Texas Health Policy Task Force report, increases the likelihood of recruiting students interested in becoming general practitioners. ■

Worker's Compensation Law Cuts Chiropractic Costs

Chiropractors have suffered a stinging loss of revenue since the passage of Oregon's 1990 workers' compensation law, when they lost the ability to become attending physicians. Roseburg Lumber Products has completed a before-and-after analysis of medical costs. The result: chiropractic expenditures have dropped by 77 percent. In 1989, Roseburg Lumber paid out $191,818 to chiropractors for injured worker claims. Those costs dropped to $35,239 in 1991. During that same time, physician expenditures went down, by 32 percent, from $641,308 in 1989 to $437,494 in 1991. Roseburg Lumber has 3,500 employees.

Managed care plans cannot take the credit for the cost savings, said John Clemons, workers' compensation manager. Medical costs came down because injured workers filed fewer claims and Roseburg Lumber took over the administration of claims.

(Reprinted from the July 1992 "Oregon D.O.")

D.O.s IN THE NEWS

Editor's Note: *TOMA districts are encouraged to send in any news regarding TOMA members for submission in the "Texas DO." Send us information about awards, positions, items from your local papers and/or hospital newsletters, etc., and we'll make every effort to print them.*

Local Doctor Went Extra Mile

Words are so inadequate to express how thankful my husband and I are for Abilene's only neonatologist, James R. Marshall, D.O. Our newest little daughter, Jordan, was born prematurely in April of this year and was in the Humana Hospital Neonatal ICU for one week due to severe apnea and bradycardia episodes.

During this time, she had two separate surgical procedures and a multitude of tests. The compassion and professionalism shown us by Dr. Marshall was so exceptional and real that, as parents of a critical newborn, we felt assured that our child's life was in the best of hands.

Dr. Marshall is still treating Jordan for other problems she is experiencing. And what is so amazing is that while he is not only helping us he is improving the lives of many other newborns as well.

We just wanted to let the city of Abilene know how great a doctor they have in Dr. Marshall. He absolutely will go the extra mile for you because that is what his heart guides him to do. He truly cares.

Steve & Denise Simmel
Eastland

(Reprinted from the Abilene Reporter News, September 4, 1992)

Note: Dr. Marshall has since relocated to Fort Worth.

Dr. John Cegelski Appointed to Public Health Group

John J. Cegelski, Jr., D.O., FACGP, of San Antonio, has been appointed the Public Relation Officer of the United States/Mexican Border Public Health Association. This is an active organization dedicated to the unique public health problems of the U.S./Mexican border. He will be acting as program chairman during the organization's December meeting.

As chairman of the TOMA Environmental Health and Preventive Medicine Committee since 1989, Dr. Cegelski has been actively involved with the U.S./Mexican Border Public Health Association for a number of years. ■

Rural Health Factline

• The average U.S. doctor in active practice earned $164,300 net income before taxes in 1990, worked 59.1 hours a week and took five weeks off. Rural physicians averaged about one fifth less overall than their urban colleagues, for an average net income before taxes of $131,440.*

• Nearly one in four children in Texas lives in poverty. According to 1990 U.S. Census data, 24 percent of Texas children were below the poverty line. That's an increase of about 33 percent over the 1979 rate of 18.7 percent.@

•Metropolitan areas of Texas have higher birth rates, lower death rates, and higher levels of migration than do rural areas of Texas.†

**Austin American-Statesman, June 2, 1992. From the American Medical Association's annual compendium of the social and economic characteristics of medical practice.*

@Austin American-Statesman, May 21, 1992.

†The Changing Face of Texas, a publication of the Texas Comptroller of Public Accounts, August 1992.

Reprinted from the Rural Health Reporter, Summer 1992.

AOA Washington Update

EKG Fight Retains Steam: Enactment Likely

With at least four bills pending in Congress to repeal the ban on reimbursement for an electro cardiogram (EKG) interpretation, the outlook on repeal of the OBRA 90 language is excellent. The Omnibus Budget Reconciliation Act of 1990 (OBRA 90) eliminated the payment for interpretations done in conjunction with an office visit or consultation based on the rationale that an EKG test is like any other laboratory test and therefore, physicians should not be paid to interpret the results.

The AOA has been an active member of a coalition of organizations including the American Medical Association (AMA), the American Society of Internal Medicine (ASIM) and the American College of Cardiology (ACC), working to restore the payment for interpretation and eliminate the unfair assessment of the benefits of an EKG.

In fact, the coalition was instrumental in developing a compromise proposal which has been included in four bills currently pending in Congress. On August 3, the House passed H.R. 3837 which included an amendment drafted by Congressman Tom McMillen (D-MD) who has long been a supporter of restored EKG interpretation payment. Further, legislation pending in the Senate (S.2914) also includes almost identical language and has been discussed at length by the Senate Finance Committee. Finally, the Democratic health care reform bill (H.R. 5502) which was passed by the Health Subcommittee of the Committee on Ways and Means and H.R. 5748 passed by the Energy and Commerce Committee on August 5 also includes language which would repeal the ban on interpretation payment.

The EKG compromise will repeal the ban on payment without damaging the integrity or the implementation of the new Medicare Fee Schedule (MFS). Repealing the measure will create additional MFS implementation problems because the MFS has already begun its phase-in and a simple return to prior law is not possible. To further complicate the issue, the MFS law requires budget neutrality. Therefore, the legislation stipulates that the Health Care Financing Administration (HCFA) should reinstate payments for the interpretation of EKGs by redistributing the relative value units that HCFA added on to visits and consultations in an effort to "cover" EKG interpretation. Many of the services which received add-ons are in transition, however, and a nominal and declining reduction in payment amounts for those services would be necessary between 1993 and 1995. The 35 percent of office visits and the 21 percent of surgical services which are already at the full payment schedule would be unaffected by the reduction. Similarly, the reduction will phase-out as the full fee schedule amount phases in by 1996. In this respect, the small reduction is temporary but achieves the reinstatement of payment for EKG interpretations at an appropriate level.

All indications from the staff and members of the pertinent Committees are that at least one of the EKG measures will be enacted by the end of the 102nd Congress which should occur in early to mid-October.

E&C Medicare Amendments: *Good and Bad*

Legislation passed by the Energy and Commerce Committee and reported to the full House makes a number of changes in Medicare policy that includes both improvements and detriments to the Medicare Fee Schedule (MFS). Among other items, H.R. 5748, the Miscellaneous Medicare Amendments, includes measures to: improve the payment for new physicians; update the geographic adjustment factor (GAF) with the most recent data; enhance payment for graduate medical education of primary care residents; and, enforce Medicare's extra-billing limits.

One improvement included in the measure would eliminate the current reductions in Medicare payment for physicians in their first five years of practice. Under current law, physicians in their first through fourth year of practice receive 80, 85, 90, and 95 percent of the MFS amount respectively. A number of organizations, including the AOA, have urged Congress repeatedly to repeal these reductions based on the intent of the MFS to pay all physicians equally based on the relative work associated with a service.

H.R. 5748 also includes provisions which would require the Health Care Financing Administration (HCFA) to utilize the most up-to-date information in developing the geographic adjustment factor (GAF) under the MFS. For many states, the fee schedule GAF levels are inadequate because the Agency used old data to develop the geographic practice and malpractice cost indices. Because an earlier version of this provision specifically stated that HCFA should consult with the state medical societies in the development of the GAF, the AOA contacted cosponsors of the legislation to ensure that the osteopathic medical societies were included in the consultative effort. The final provision of the bill as passed by the Committee makes no reference to contact either allopathic or osteopathic medical societies. Instead, the provision requires the Secretary to consult with *the appropriate representatives of physicians* and to use the most up-to-date geographic information.

To enhance graduate medical education (GME) and encourage primary care medical education, the bill would weight primary care residents at 1.1 for the purposes of Medicare reimbursement. Primary care residents are defined as a resident being trained in a distinct program of family practice medicine, general internal medicine, general pediatrics or emergency medicine. Residents who are not primary care residents but who specialize in

internal medicine, pediatrics or obstetrics and gynecology would be weighted at 1.0 while all other residents would be weighted at .85. Further, the weighting factor for residents beyond the initial period of their residency would be increased from .5 to .75.

Finally, the Committee's legislation would enforce Medicare's balance billing requirements for non-participating physicians. The legislation clarifies Medicare law in cases where payment is made on a non-assignment basis. Under the bill, no beneficiary would be liable for payment of any *amounts in excess of* the limiting charge. The bill stipulates further that if the physician collects amounts in excess of the limiting charge, the physician must provide the individual charged a refund within 30 days of being notified of the excess charge. Further, if the physician knowingly and willfully bills for services in violation of the excess charge limits, HCFA may apply sanctions.

CLIA: The Nightmare Continues

There is only one problem with the Health Care Financing Administration's (HCFA) September 1, 1992 deadline which required all laboratories performing tests on human specimens to possess a CLIA certificate: HCFA did not meet it! The Agency maintained throughout July and August, even while physicians' offices were waiting up to four months for their CLIA bills, that the deadline was hard and fast and physicians must at least register to be in compliance with the law. Furthermore, the Agency threatened non-payment of laboratory claims for unregistered labs and noted that all labs must include their CLIA registration number on their claims.

As the deadline approached however, HCFA conceded that many labs that had met HCFA's deadlines and submitted registration applications still had not received bills for payment or the final registration certificates due to the huge backlog at the Agency. Even more distressing for physicians however, was the fact that offices who attempted to contact the spanking new CLIA hotline waited endlessly on hold or called repeatedly to no avail getting only a constant busy signal. Finally, the Agency has backed down and has said it will continue to pay all claims for lab services *with or without* a CLIA registration number until December 1, 1992. Assuming the Agency can make this deadline, all labs should be registered and should have received a number by then. In the meantime, however, all labs must still be in compliance (as of September 1, 1992) with all the personnel, quality control and quality assurance standards of the February 28, 1992 regulation. For further information on these standards, please contact the AOA Washington Office.

Final Accrediting Bodies Rule Issued

On a related CLIA note, the final regulation which establishes program requirements for private organizations seeking "deemed status" to accredit laboratories for HCFA under CLIA was issued July 31, 1992. Like other implementation dates of this law, the "accrediting bodies" rule is extremely late and has put pressure on organizations, including the AOA, to apply for deemed status as soon as possible. The regulation also stipulates requirements for states which have enacted their own CLIA laws and wish to apply for a state exemption to CLIA.

Administration Pushes Health Reform Plan

The Bush Administration firmly assured its plans to move forward its own health care reform package despite apparent gridlock of the Democratic Congress. At a show down on the health care issue during a press conference held September 9, Department of Health and Human Services Secretary Louis Sullivan and Bush Health Policy Advisor Gail Wilensky demanded a floor vote on the Bush package. The meeting was held in response to leaked reports about statements made in late July during the Democratic Caucus on health reform which attested to the high political stakes of enacting health reform legislation before the November elections. The Bush package includes small insurance market reforms, malpractice reform including caps on attorneys fees and damages for pain and suffering, and an increase in the self-employed tax deduction for health insurance premiums. The Democrats have several proposals varying from the Conservative Democratic Forum proposal which is similar to the Bush plan, to establishment of a global cost containment system.

HHS Secretary's Recommendations on VPS Will Stand

Congress currently has no intention of eliminating the surgical/non-surgical volume performance standard under the new Medicare Fee Schedule. The VPS and physicians' success at meeting the target determine the annual update for the MFS conversion factor. Lawmakers are expected to allow the recommendations of the Department of Health and Human Services to take effect. Under the HHS recommendation, the 1993 conversion factor would increase by 2.6 percent for surgical services and 0.3 percent for non-surgical services.

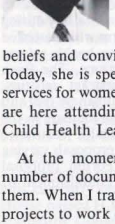
D.O.s To Testify at AHCPR Meeting on Low Back Pain

Osteopathic physicians Steven Blood and Robert M. Mandell will testify at an upcoming meeting of the Agency for Health Care Policy and Research (AHCPR) panel on low back pain. The panel which was established last spring, is charged with developing practice guidelines for the treatment of acute low back pain conditions. Dr. Blood will testify as a representative of the American Academy of Osteopathy. Dr. Mandell will make a statement on behalf of the American Osteopathic Association and the American Osteopathic Academy of Orthopedics. Their statements will encourage the panel to develop guidelines which are flexible enough to ensure physicians' judgement and expertise in the care and treatment of their patients are not compromised. The testimony further attests to the conservative, non-invasive treatment of low back conditions and the optimum use of osteopathic manipulative treatment (OMT). ■

Public Health Notes

Achieving Improved Health In Our Communities

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



I am writing this article from a hotel room in the Georgetown section of Washington, D.C. Shortly, I will have the pleasure of hearing the Surgeon General of the United States for the second time in four days. This is an unusual honor. Antonia C. Novello is a gifted speaker who communicates her beliefs and convictions with great vigor and sincerity. Today, she is speaking on the need to improve health services for women and children. The audience members are here attending the national Urban Maternal and Child Health Leadership Conference.

At the moment, however, I am surrounded by a number of documents, and I'm trying to make sense of them. When I travel on business, I often take additional projects to work on, if there are a few spare hours here or there.

It appears that every interest group in the nation has concluded that it has the solution to the health care access problems that we face or at least that it has something to contribute to the discussion. I think that this is as it should be in a discussion of such important issues in a democratic society. One of the documents I've just read is an article in a respected business journal. The writer challenges both Republican and Democratic health care proposals as being bad for business, the insurance industry in particular. He suggests that universal coverage may not be desirable and the elimination of pre-existing condition limitations will destroy our health care funding structure. He goes on to suggest, it seems, that there is some innate value in paying an insurance company a direct premium for health insurance.

This is rather an amazing line of thought even from a journal in the business of promoting business. It appears to me that here is a fundamental issue yet to be settled. That issue is: do we, as a society, accept the concept that all citizens of this advanced society deserve some basic level of health services regardless of income? It's really quite simple. If the answer is yes, as the majority of Americans now seem to be saying, then we must set about designing a system that makes adequate health service available to all. Health insurance, in my opinion, should be taken away from Wall Street and returned to the citizens.

Financing health services is too important to the future of this country to leave it in the hands of those who are primarily interested in producing dividends and capital appreciation for their stockholders. Financing health services should be about providing the best mix of services in the most efficient and cost effective manner. I suggest that publicly held insurance corporations or insurance corporations which are units of large national corporations have other priorities. This may hold true for certain "non-profit" health insurance organizations as well, but for those the story is not quite so clear. In any event, those who hold interests in such companies/corporations can make their money in other ways, and should.

I am also reviewing another amazing document. It is called the Draft Report of the Texas Health Policy Task Force. This task force was created by Governor Ann Richards last November. It consists of six State Senators, six State Representatives, thirteen public members and four ex officio state agency representatives. It is charged with proposing a basic health services plan for the state along with funding and structural options.

The amazing thing is that for such a potentially important document, it has been rather low key. I received a copy of the draft on September 9 and comments are due before September 17. Since it is now September 14 and I will not return from Washington until September 17, I will miss the deadline but plan to submit my comments nevertheless. If it had not been for a local hospital executive, I would probably not have seen the document at all. So, I doubt that many of you have seen it.

This draft report deals with many areas in health services which I suspect many of you would find of interest. They include: physician education, supply of primary care providers, Medicaid acceptance, and disciplinary procedures of the Texas State Board of Medical Examiners.

Since I am limited as to the length of these articles, I cannot expand on each area. There is one, however, which I will touch on in more detail; that is the role of prevention services. In its recommendations, the task force states that primary care and prevention services are top priorities. It then goes on to define primary care as "the first contact in a given episode of illness that leads

to a decision regarding a course of action to resolve the health problem." There are a number of definitions of primary care and this may serve as an adequate working definition. Things become somewhat confusing, however, when in the next line preventive services are defined as "a component of primary care."

Public health/preventive medicine is usually understood to encompass health promotion, health education, immunizations, wellness evaluations, screening and other measures designed to prevent disease or arrest it before illness occurs. If that is the case, prevention services cannot by any stretch of the imagination be considered primary care if the above definition of primary care is accepted. Prevention services compliment primary care and ultimately reduce the need for illness care. They, however, are not the same nor is one a subset of the other.

Finally, I'll attempt to tie these two issues together in a way that at least in part justifies the title I have given this article. We have heard over the past several months, a great deal of talk about health care reform, some coming from me. As we move ever closer to taking actions on the state and federal levels, we must make sure they are the best possible actions. Reforming the health financing system alone will not achieve our desire for a healthier Texas and America. This is true whether the financing is singlepayer, "play or pay," multiple payer, and so on.

In order to achieve a truly healthier America, we must change our entire emphasis. The change in emphasis which I propose will take time. It cannot occur overnight, but we must commit to it today. If we believe prevention is the key to a healthier, more productive society, then any comprehensive health services plan must place its major emphasis on that prevention effort. If what we say over, and over again, that prevention reduces cost and leads to a healthier society, is what we really believe and not merely empty rhetoric, then we will place primary emphasis on disease prevention and not the treatment of episodic and chronic illnesses. We will make the provision of screening mammography as important in our funding as a mastectomy. We will make the provision of hepatitis B vaccine more important than the treatment of chronic active hepatitis and hepatoma. We will place greater emphasis on funding prevention research. We will adopt the health model and not the sickness model.

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News From the Food and Drug Administration

Treatment IND Ok'd for Ovarian Cancer Drug

FDA has authorized a treatment protocol for the experimental drug taxol to treat certain patients with advanced metastatic ovarian cancer. The protocol was submitted by the National Cancer Institute (NCI).

Only those patients who have not responded to standard chemotherapy or whose treatment is no longer effective are eligible for the approved protocol. They must have been treated with at least two standard cancer regimens before beginning treatment with taxol. One of those treatments must have included a platinum-containing cancer drug, such as cisplatin.

Under FDA's Treatment IND (Investigational New Drug) regulations, promising experimental drugs can be made available to patients with certain serious or life-threatening conditions before final data for marketing approval have been submitted to the agency. Taxol was approved for experimental use under a "Group C" protocol, which enables NCI to make new experimental treatments available through a network of cancer treatment centers.

Uncontrolled clinical studies of patients with advanced ovarian cancer who were resistant to standard chemotherapy demonstrated a tumor response rate of 20 percent to 30 percent. Responses lasted an average of six months, with some lasting considerably longer. Taxol's side effects are similar to those of other toxic cancer drugs. It is not yet known whether taxol prolongs life.

Since taxol is derived from the bark of the Pacific yew tree, supplies are limited. Therefore, taxol will be available only at NCI-designated cancer centers. Physicians should contact NCI at (301) 496-5725 for more information on locations of these cancer centers.

NCI is working with Bristol-Myers Squibb of New York, New York, to find new sources of the active ingredient in the drug. Taxol is now being manufactured in Mayaguez, Puerto Rico.

Rapid AIDS Test Licensed

FDA has licensed a single-use, rapid, HIV-1 screening test for use by health professionals in a variety of settings.

The SUDS (Single Use Diagnostic System) HIV-1 test is an enzyme-linked immunosorbent assay (ELISA) sensitive to HIV-1 antibodies that can be manually performed and visually read in about 10 minutes.

In clinical trials involving 8,714 serum or plasma specimens at 11 test sites, the SUDS test had an estimated sensitivity of 99.9 percent to the presence of HIV antibodies. The SUDS test also had an estimated specificity rate of 99.6 percent for HIV-1 antibodies. These figures are comparable to those for other currently marketed test kits used by clinical laboratories.

The SUDS test device is a small plastic cartridge that displays a blue color in its center hole when a blood specimen contains HIV-1 antibodies. Any specimen that reacts by producing a blue color in the cartridge should be retested twice with the SUDS test. If the specimen tests positive a second time, the result should be confirmed through additional tests, such as the Western immunoblot or an immunofluorescence assay.

A negative test result at any point in the testing procedures does not exclude the possibility that exposure to or infection with HIV-has occurred.

Murex Corp., the manufacturer of the SUDS HIV-1 test has included a "training panel" to help new users gain proficiency performing the test and interpreting the results. The panel consists of five specimens with a range of reactivities. Health professionals who need additional information can contact a Murex Corporation technical services representative at (404) 662-0660 or (800)826-8739. ■

Blood Bank Briefs for Physicians

Idiopathic CD4+ Lymphocytopenia (ICL)

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

The VIII International Conference on AIDS in Amsterdam is the spring board for the sudden recognition that, between 1989 and the end of July, 1992, 21 cases of unexplained CD4+ T-lymphocyte depletion in persons without evidence of HIV infection had been reported in the medical literature. These reports include persons who reside in the United States and six other countries.

On July 31, 1992, the CDC issued through the AIDS Surveillance section the definition for what is named "Idiopathic CD4+ T-Lymphocytopenia - ICL": Patients who have (1) CD4+ T-lymphocyte depletion (absolute CD4+ T cell level less than 300 cells/mL or less than 20 percent on more than one determination (2) no serologic evidence of HIV infection and (3) no defined immune deficiency or therapy associated with T-cell depletion.

The cause of this condition remains unknown. One of the most striking things about the new syndrome (ICL) is its heterogenicity. Particularly important is the fact that there is "no readily apparent linkage, or clustering of cases." They are widely scattered geographically and no evidence of illness or lymphocytopenia in patients' contacts who have been tested so far. The 14 persons reported to CDC from 1985 to 1992 reside in ten states; the ages range from 31 to 70 years (median 48 years), eight are males, 12 are white, one black and one Asian. One person died from AIDS defining illness and the other 13 are alive.

On August 18, 1992, blood bankers from the American Association of Blood Banks, American Red Cross and Council of Community Blood Centers met with representatives of CDC, FDA and the Public Health Service to discuss implications of this "new syndrome" for the United States blood supply. All agreed that the issues raised by any putative new infectious agent cannot be ignored.

Carter Blood Center is monitoring this new syndrome closely and with the three blood group organizations are in a state of alertness but not a state of alarm.

1. CDC. Unexplained CD4+ T-Lymphocyte depletion in persons without evident HIV infection — United States. MMWR 1992; 41:541-544.

2. CDC. Update CD4+ T-Lymphocytopenia in persons without evident HIV infection — United States. MMWR 1992;41:578-579.

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NHANES III Selects Texas Sites

The National Center for Health Statistics is conducting a major study of the health of persons living in the United States aged two months and older. Beginning December 4, 1992 through April 12, 1993, Tarrant, Cameron and El Paso Counties have been selected as survey locations during the third National Health and Nutrition Examination Survey (NHANES III). Residents of these counties, randomly selected, will have the opportunity to undergo extensive physical examinations and respond to questions on health-related issues.

This survey is part of the U.S. Public Health Services' continuing study of the Nation's health. During the past 27 years, similar surveys have been successfully conducted on various segments of the U.S. population. Important health data are collected through household interviews and standardized medical examinations in a mobile examination center. Effective national health research, education and health promotion programs rely on information from this survey.

NHANES III is designed to learn more about and prevent such major diseases as heart disease, hypertension and diabetes. The survey will gather information on the dietary habits and nutritional status of Americans, and on their blood pressure, serum cholesterol, height, weight, and other physiological and body measurements. The extent of asthma, liver disease, arthritis and other major chronic conditions will also be measured.

Before the survey ends in 1994, about 40,000 people living in 88 communities across the country will have been asked to participate. All information collected in the survey is confidential. ■

Military Retirees and Families Benefit from Osteopathic Plan

"In an effort to continue the ongoing relationship with military personnel and to bridge the gap of health care services during the downsizing of the Carswell hospital and after its closing, Osteopathic Health System of Texas has developed a unique program of health services," announced Jay Sandelin, chairman of OHST, at a special reception August 18.

U.S. Representative Pete Geren, whose district includes Carswell, was on hand to praise the new program. "You are making tremendous sacrifices to go the extra mile and make the quality of life better for the military retirees and their families," Geren said.

Sandelin explained that the program's mission is "to help close the gap between the closing of the Carswell hospital and the implementation of the planned CHAMPUS managed care plan."

Ron Stephen, senior vice president of Osteopathic Medical Center of Texas, OHST's largest affiliate, spearheaded and coordinated the development of the Carswell Osteopathic Medical Plan, or COMP. Mr. Stephen is a retired colonel in the Air Force and former administrator of the Robert L. Thompson Strategic Hospital at Carswell Air Force Base.

"By providing an alternative health program, we can both retain our current military retiree population in Fort Worth, and continue to attract others to our community," said Mr. Stephen, who outlined the features of COMP at the reception.

The Carswell Osteopathic Medical Plan is free to all military retirees and their family members and is also available to dependents of active-duty personnel who remain in the area.

Members of the plan will have access to the following services:

- Physician-finder services
- Access to a discount pharmacy network, including OHST's Medical Center Pharmacy
- Pharmacy-by-Mail services, with free delivery for those persons living in the greater Fort Worth area
- Access to a pre-paid discount dental health care plan
- Free subscription to the *Sentinel*, the news source for military retirees in the Metroplex
- Special health promotion lectures and programs which focus on military retirees and their family members
- Discount membership at the Fitness Connexxion
- Health benefits advisor services

Director of COMP will be Floyd J. Cantu, who comes to OHST from Carswell Air Force Base. Floyd is a retired Air Force master sergeant and worked as superintendent of patient administration at the Carswell hospital.

Brochures explaining the COMP program are now available, and may be obtained by calling Floyd Cantu at 735-4466. ■

TOMA's Mid-Year Meeting/Legislative Conference to be Held in Austin February 2-3, 1993

We have a new program lined up for this year's Mid-Year meeting. Rather than the usual continuing medical education programs, we are focusing toward the business side of your practice.

This program will provide information about topics such as "Marketing Your Osteopathic Practice," "Everything You Wanted to Know About Computers But Were too Embarrassed to Ask Your Children," "Investments During the Recession... Putting Your Money to Work," "Your Medicare Coding Questions Answered," "Medicare Rules & Regulations," "Ways to Protect Your Medical License," "How to Play the Insurance Game," "Tax Savings Through Estate Planning" and "Four Pillars of Accounts Receivable Management."

The registration fee for this seminar is $99 per physician and $49 each for spouses and office personnel. Watch your mail for registration information or call 1/800/444-TOMA.

FYI

OBTAINING PRESCRIPTION DRUGS FOR NEEDY PATIENTS

The Pharmaceutical Manufacturers Association (PMA) has made it easier for physicians to locate programs for needy patients who must be treated with prescription drugs.

A pilot program consisting of two components has been created by the PMA. First, a directory entitled "1992 Directory of Prescription Drug Indigent Programs" is available to physicians. Listing 59 prescription drug indigent programs, it is available, only in writing, from the PMA, 1100 15th Street NW, Washington, D.C. 20005.

Secondly, physicians with questions about the program can call 1-800-PMA-INFO.

ADA TECHNICAL ASSISTANCE MANUAL PUBLISHED BY EEOC

Additional guidance on the Americans with Disabilities Act (ADA) has been published by the Equal Employment Opportunity Commission. The act became law in July for many employers. The new *Technical Assistance Manual* provides more guidance in areas such as identification of the essential functions of a job, reasonable accommodation obligations, and issues associated with workers' compensation. The new manual includes a resource guide listing public and private agencies and organizations that provide help on issues of employing persons with disabilities. For a copy, write to EEOC Communications and Legislative Affairs, 1801 L Street, N.W., Washington, D.C. 20507.

TEXAS SUBSTANCE ABUSE TAB IN BILLIONS

A new study by the Texas Commission on Alcohol and Drug Abuse says that substance abuse is costing Texas billions of dollars a year in health care, lost earnings and crime-related expenses.

Although the difficulty of estimating dollar losses from substance abuse is pointed out in the study, an analysis estimated $12.6 billion in costs for 1989. Of this total, $7.9 billion was due to alcohol abuse; $3.7 billion to illegal drug abuse; and $1 billion to both combined.

Approximately two million adult Texans have alcohol or illegal drug problems, according to the study.

TDH TO DISTRIBUTE FOLIC ACID

The Texas Department of Health will begin distributing folic acid tablets to low-income women in Cameron and Hidalgo counties in hopes that this will help reduce the higher than average incidence of neural-tube birth defects. In 1990-91, the rate of neural-tube defects in Cameron County was 26.8 per 10,000 live births, more than three times the average U.S. rate.

The TDH recommends 0.4 milligrams of folic acid daily for women of childbearing age as a preventive measure against neural-tube birth defects. Although folic acid is an essential nutrient, it is not known how it works to prevent such defects.

EMPLOYERS TAKE ACTIVE ROLE IN PROMOTING GOOD HEALTH

A Washington consulting firm has found that more companies are paying for annual physicals. The most recent poll showed 47 percent of the companies surveyed were footing the bill for physicals. That number is up from 42 percent in 1990. Similarly, wellness programs have become popular among employers. Wellness programs emphasize prevention of poor health habits. The most popular programs of this nature include well-baby and prenatal care, offered by 43 percent of the companies polled.

GAP NARROWS BETWEEN MEN AND WOMEN FOR JOB HOPPING

A recent study by the Bureau of Labor Statistics indicates that women are becoming more likely to stay longer with their employers. During the period from 1983 to 1991, the study showed average job tenure rose from 3.3 to 3.8 years for women, but remained at 5.1 years for men.

MEDICAL SUPPLIES NEEDED

Heart-to-Heart, of the American Medical Students Association, at the University of Texas Southwestern Medical Center, is collecting medical supplies (stethoscopes, otoscopes, blood pressure cuffs, laboratory supplies, etc.) to be personally delivered to developing nations with limited resources. If you would like to make donations, please contact either Kalyani Raja (214/948-7016) or Adam Kaplan (214/522-1619). Thank you for your support.

TOMA Supports Caring for Children Program of Texas

In Texas, over 100,000 children ages 6 through 18 come from families who have no health care protection whatsoever. Victims of the Medicaid gap, their families cannot afford private health insurance, but earn too much money to qualify for Medicaid.

These children left outside of America's health safety net must often go without basic medical attention. The tragedy is that such basic care can prevent an illness from becoming crippling, or even fatal.

In an innovative effort to change this situation, the Caring For Children Program of Texas has been launched. Designed for children ages 6 to 18, the program provides basic preventive and outpatient health care services to eligible children of parents who earn too much to qualify for Medicaid but cannot afford private health insurance.

Administered by Blue Cross and Blue Shield of Texas at no charge, the program is a private sector initiative funded solely through private sector donations. It is not an insurance product and 100 percent of all contributions go directly to health care benefits. No government funds are involved in this program. The program works with volunteer community steering committees in raising funds for sponsoring eligible children. Every $312 collected buys a child one year of outpatient medical care. Donations raised in a county are designated for that county unless otherwise specified.

For only $26 per month per child, the annual benefits include: doctor's office visits for illness and well care; outpatient diagnostic care; outpatient emergency room care for illness or accident; routine immunizations; outpatient surgery; and prescription drugs with a $5 copayment. Parents of the enrolled children pay nothing for these health care benefits, other than the prescription drug copayment, when these medical services are provided through the Blue Cross and Blue Shield of Texas statewide network of over 16,000 physicians or Member Hospital Outpatient Facilities.

The Caring for Children Program of Texas is the eighteenth such program providing these services for children since 1985. All of the programs have been developed and are administered by Blue Cross Plans. The Texas program was launched in Hays and Comal counties and was expanded to Collin County. Areas targeted for launching local programs during 1992 are Midland, Odessa, San Antonio, Austin, Corpus Christi and the greater Dallas, Fort Worth and Houston areas.

To make a donation or for more information, contact: Craig Jeffery, Executive Director, Caring for Children Foundation of Texas, Inc., P.O. Box 655488, Dallas, Texas 75265-5488; or call 1-800-258-KIDS (in Dallas: 669-5306). ■

New Guidelines Issued for Medical Examinations

Many Texas employers use medical examinations to determine if potential employees can fulfill the requirements of certain job descriptions. However, the *Americans With Disabilities Act* (ADA) places new and numerous restrictions on requesting applicants to submit to medical examinations. The new federal ADA guidelines on medical exams have recently been released.

Employers can require a medical exam only *after* an offer of employment has been made, and only if the exam is required of all employees in that job description.

However, an employer can require an employee to take a medical exam if he exhibits behavior or a physical problem that indicates job performance or safety could be jeopardized. To require the exam, an employer must be able to show the exam is job-related and consistent with business necessity. If an examination reveals a disability protected under the ADA, the employer must be willing to make a reasonable accommodation to ensure the individual can be employed. An accommodation is considered unreasonable when it imposes an undue hardship on the employer.

Information from medical exams must remain confidential and must be kept separate from an employee's personnel file.

Employers who use medical exams in the hiring process should re-evaluate each aspect of their procedures and policies to ensure compliance with the ADA.

For more information about the ADA and medical examinations, contact the Equal Employment Opportunity Commission at 1-800-669-3362, or the Texas Commission on Human Rights at 512-837-8534.

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ATOMA
OSTEOPATHIC CENTENNIAL MERCHANDISE ORDER FORM

GOLF SHIRT: 100% cotton, interlock knit by Dolphin Cove.
Osteopathic Centennial logo embroidered on left chest
Available in Royal Blue and Red.
Adult sizes: Sm/Med/Lge/XL/XXL
Small - XL $35.00 ea. XXL - $37.00

GOLF CAP/Solid: Poplin, cloth strap, 3-1/2" high crown, matching bolo card, embroidered Centennial patch
$15 Royal Blue or Red

GOLF CAP/Mesh: 60/40 poplin cap featuring nylon mesh back, matching bolo cord, embroidered Centennial patch
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New President-Elect and Board Members for AOA

Laurence E. Bouchard, D.O., a Narragansett, Rhode Island, Osteopathic physician, was elected president-elect of the American Osteopathic Association during the AOA House of Delegates meeting held in Dearborn.

Dr. Bouchard, a general practitioner, is a police surgeon and town and school physician in Narragansett. He serves on the board of trustees of both the Rhode Island Society of Osteopathic Physicians and Surgeons and the New England Foundation of Osteopathic Medicine. He is the past assistant regional dean of clinical affairs for the University of New England College of Osteopathic Medicine.

He has served the AOA as chairman of the task force on certifications and of the graduate medical education committee, and is the past chairman of the department of professional affairs and of the bureau of small states. He has served as the chairman of the American Association of Colleges of Osteopathic Medicine. He is also a member of the American Academy of Osteopathy.

Dr. Bouchard is currently a member of the AOA bureau of finance, the committee on administrative personnel and the president's advisory council.

A 1962 graduate of the Kirksville College of Osteopathic Medicine, Dr. Bouchard completed his internship at Cranston General Hospital in Cranston, Rhode Island. He received his undergraduate degree from the University of Buffalo.

Five physicians were elected to the AOA Board of Trustees during the AOA House of Delegates meeting. They are as follows:

John A. Strosnider, D.O.

A general practitioner specializing in geriatrics, Dr. Strosnider is from Kansas City, Missouri. He is an active staff member at Park Lane Medical Center in Raytown, Missouri, and an associate staff member at Lees Summit Hospital in Lees Summit, Missouri.

Dr. Strosnider is the associate dean for academic affairs/clinical sciences at the University of Health Sciences College of Osteopathic Medicine (UHSCOM) in Kansas City, and is an associate professor of general practice at UHSCOM. He is the past president of the Missouri Association of Osteopathic Physicians and Surgeons, and the past Chief of Staff at Lakeside Hospital in Kansas City.

Dr. Strosnider is a national board diplomat and member of the Jackson County Osteopathic Association, and is a member of the American College of General Practitioners in Osteopathic Medicine and Surgery, and the Missouri Association of Osteopathic Physicians and Surgeons.

A 1975 graduate of UHSCOM, Dr. Strosnider completed his internship at Lakeside Hospital. He received his undergraduate degree from Northeast Missouri State University in Kirksville.

Martin Diamond, D.O.

A general practitioner from Amityville, New York, Dr. Diamond is also a part-time clinical assistant professor in the Department of Family Practice at New York College of Osteopathic Medicine in Old Westbury, New York.

Dr. Diamond is on the board of directors and trustees of the University of Osteopathic Medicine and Health Sciences in Des Moines, Iowa. He served as both president and director of the New York State Osteopathic Medical Society. He has served the AOA as a member of the Council on Federal Health Programs and as a member of the House of Delegates since 1983. He also served as the site chairman of the Eastern Regional Osteopathic Convention Exhibits.

Dr. Diamond is a member of the Long Island Society of Osteopathic Physicians and Surgeons, the New York State Osteopathic Medical Society, and the American College of General Practitioners in Osteopathic Medicine and Surgery.

A 1962 graduate of the University of Osteopathic Medicine and Health Sciences College of Osteopathic Medicine and Surgery in Des Moines, Iowa, Dr. Diamond completed his internship at Delaware Valley Hospital in Bristol, Pennsylvania. He received his undergraduate degree from Queens College, New York.

Darryl A. Beehler, D.O.

Dr. Beehler, of Mesa, Arizona, is a general practitioner who specializes in cardiology. He is the medical director of Health Choice Arizona in Mesa and an emergency room physician at Mesa General Hospital.

Dr. Beehler is an Arizona delegate to the American College of General Practitioners in Osteopathic Medicine and Surgery and is the past president of the Minnesota Osteopathic Medical Society. He is the former program chairman of the 1980 national convention of AOA delegates, and is active in the American College of Physician Executives.

In addition to the AOA, Dr. Beehler also holds professional memberships in the Arizona Osteopathic Medical Association and the American College of General Practitioners in Osteopathic Medicine and Surgery. ▶

A 1975 graduate of the Kirksville College of Osteopathic Medicine, Dr. Beehler completed his internship at Carson City Hospital in Carson City, Michigan. He received his undergraduate degree from St. Cloud State University in St. Cloud, Minnesota.

Eugene A. Oliveri, D.O., FACOI, FACG

Dr. Oliveri, of Farmington Hills, Michigan, is the director of the gastroenterology fellowship program at Botsford General Hospital in Farmington Hills. He is board certified in internal medicine and gastroenterology.

Dr. Oliveri serves on the ethics committee and the committee for physician competency for the Michigan Association of Osteopathic Physicians and Surgeons. He is a clinical professor of medicine at Michigan State University College of Osteopathic Medicine, and also serves on the board of directors of the Oakland County Osteopathic Association, a position he has held for 11 years.

He represents the AOA on the advisory panel to the Department of Health and Human Services, and serves on the Federal Health Council, Bureau of Governmental Affairs. He is also the vice-chairman of the committee on post-doctoral training for the AOA.

Dr. Oliveri is a former member of the American Society of Gastrointestinal Endoscopy and the American College of Osteopathic Internists. He is also a diplomat of the American Osteopathic Board of Internal Medicine.

A 1964 graduate of University of Health Sciences College of Osteopathic Medicine in Kansas City, Missouri, Dr. Oliveri completed his internship at Detroit Osteopathic Hospital. Prior to receiving his undergraduate degree, Dr. Oliveri served in the U.S. Army Medical Corps for nearly two years.

Donald E. Kotoske, D.O., FACGP

Dr. Kotoske of South Bend, Indiana, was elected third vice president of the AOA Board of Trustees. A graduate of the University of Notre Dame and the Chicago College of Osteopathic Medicine, he is a board certified specialist in general practice and surgery.

His professional achievements include being named Physician of the Year in 1991 by the American College of General Practitioners in Osteopathic Medicine and Surgery. He was also named national public relations director for the ACGP and he received the Indiana Osteopathic Physician of the Year Award in 1990. He is currently a member of the AOA committee on constitution and bylaws.

Dr. Kotoske is on the staff of Michiana Community Hospital and St. Joseph's Medical Center of South Bend and St. Joseph's Hospital of Mishawaka. He is also director of a medical-surgical diagnostic and treatment center in South Bend.

Dr. Kotoske is currently the host of the radio talk show "Ask The Doctor," which airs on WAMJ-AM in South Bend and is director of public relations for the Indiana Association of Osteopathic Physicians and Surgeons. ■

Non-Surgical Procedure Opens Blocked Peripheral Arteries

Hardening of the arteries, a serious and potentially fatal condition, can be successfully treated 80 percent of the time without surgery.

The procedure is called Peripheral Percutaneous Transluminal Angioplasty (PTA) and it is similar to the angioplasty or the "balloon procedure" used on heart disease patients to open coronary arteries during an attack.

Peripheral disease treated by this procedure most commonly affects arteries in the legs, arms and kidneys. Patients with restricted or closed arteries leading to the arm or leg experience pain in the affected limb and, if left untreated, the impairment can result in disability or amputation. If the damaged artery leads to the kidney, the result can be uncontrollable high blood pressure and if the artery leads to the brain, it can cause a stroke.

Before PTA, open surgery was the only option. "The PTA procedure has been in use for more than 15 years," explained Lloyd Brooks, D.O. Director of the Fort Worth Heart and Vascular Institute and a staff physician at Osteopathic Medical Center of Texas.

"When I treated large numbers of patients with peripheral artherosclerosis (hardening of the arteries) at Riverside Methodist Hospital in Columbus, Ohio, we saw the benefits of the procedure," explained Dr. Brooks, the only cardiologist in Fort Worth currently performing PTA.

PTA is performed in the hospital with the patient sedated but awake. A local anesthetic is administered at the site of the puncture, where Dr. Brooks inserts a wire into the artery and guides it to the obstructed area. A balloon catheter is passed into the area of blockage and inflated, stretching the artery. The balloon is later removed, leaving the artery enlarged and open, allowing blood to flow through the artery unimpeded. The patient usually goes home the next day and can resume normal activities almost immediately.

However, a small percentage of arteries revert back, blocking blood flow again. On some patients, Dr. Brooks uses a stent, or metal ring, which he places at the point of the narrowed artery after stretching it, to hold it open.

Dr. Brooks explained that the non-surgical revascularization procedure is quite successful and carries little risk compared to open surgery, but he recommends addressing the underlying cause.

"There is a very high correlation between peripheral disease (disease of the peripheral areas such as the arms and legs) and coronary heart disease. Whatever caused the obstruction in the first place, needs to be addressed," Dr. Brooks explained. "But the obstructed artery also must be treated because it can lead to severe consequences such as amputation. With this procedure, the affected artery and the quality of life can be restored very quickly with less trauma to the body." ■

UR Regulations Adopted

Effective August 7, the Texas Department of Insurance adopted regulations applicable to utilization review (UR) activities occurring after June 1, 1992. These regulations implement the utilization review legislation passed in 1991 in House Bill 2, the 72nd Texas Legislature's insurance reform bill.

These regulations establish standards for conducting UR by UR agents, HMOs and insurance companies, and attempt to "foster greater coordination and cooperation between health care providers and utilization review agents."

Certification and Operation of UR Agents

UR agents must obtain certification from the Texas Department of Insurance, such certification to be renewed every two years. In order to seek certification or recertification, UR agents must follow specific requirements, which include:

- All UR activities must be conducted under the direction of a licensed physician;
- Only appropriately trained or qualified (and licensed, where necessary) personnel are to be employed to conduct UR;
- Any type of compensation or incentives to employees based on the amount or volume of adverse determinations is prohibited;
- Each UR agent should provide written and medically acceptable screening criteria and review procedures, to be periodically evaluated and updated with appropriate involvement from physicians and other health care providers;
- UR agents are prohibited from making unnecessary or unreasonable repetitive contacts with patients or health care providers;
- UR agents are to establish and maintain a complaint system that provides reasonable procedures for the resolution of complaints by patients and health care providers;
- Appropriate personnel must be reasonably available by toll-free telephone at least 40 hours per week during normal business hours in Texas;
- The confidentiality of individual medical records, as required by law, must be maintained by UR agents.

Health Care Providers' Rights

The regulations state that health care providers are entitled to the following:

- Reimbursement for the reasonable costs of providing medical information in writing, including copying and transmitting any requested patient records or other documents;
- In the event of an adverse determination, notification by the UR agent must include the principal reasons for the adverse determination, a description or the source of the screening criteria that were utilized as guidelines in making the determination, and a description of the appeals procedure;
- A formal appeal of an adverse determination, including, if necessary, appeal to licensed physicians and specialists;
- A reasonable opportunity to discuss a patient's plan of treatment and the clinical basis for the UR agent's decision with a physician before issuance of an adverse determination. ■

AAOPP Formed

The American Association of Osteopathic Postgraduate Physicians (AAOPP), a group specifically focused on osteopathic physicians in postdoctoral training, has been established. Designed for interns, residents and fellows, the AAOPP was formed through the work of a group of concerned house staff and with the guidance of Mitchell Kasovac, D.O., AOA Past President.

One of the many goals set by the AAOPP is to continue improving the educational experiences of osteopathic postgraduate physicians. Other important issues include student loans and interest deductibility, improving the mechanism for approval of non-osteopathic training programs, medical licensing, malpractice insurance, stress management, spouse involvement and governmental and legislative affairs.

For AOA members, there is no charge for AAOPP membership. For AOA non-members, the AAOPP membership fee for physicians in postdoctoral training is $25. For information, contact: AAOPP, 142 East Ontario Street, Chicago, Illinois 60611; (312) 280-5800.

Opportunities Unlimited

PHYSICIANS WANTED

FULL AND PART-TIME PHYSICIANS WANTED — for two primary care/minor emergency clinics in the D/FW area. Flexible schedule, excellent potential for growth and financial success. Please send resume or contact: Karen Grizzle, Business Manager, Ready-Care Medical Clinic, 4101 Airport Freeway, Suite 101, Bedford, 76021; 817/540-4333. (19)

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

POSITION OPEN IN HOUSTON — Established solo practitioner specializing in OMT seeks associate with like interest to join practice. Please call Reginald Platt, III, D.O., 6815 North Hampton Way, Houston, 77055. 713/682-8596. (04)

FORT WORTH — Clinic seeking energetic general practitioner to work full-time and act as medical director. Salary open. Contact: Bill Puryear, D.O. or Jim Czewski, D.O. at 817/232-9767. (27)

SAN ANTONIO — Seeking a BE/BC Internist to join a busy internal medicine office. Partnership available, salary negotiable, situation flexible. Please send resume to: Shane Carter, 4411 E. Southcross, San Antonio, 78222. (34)

BUSY THREE-PHYSICIAN PRACTICE IN WEST CENTRAL TEXAS — being operated by two aging osteopathic physicians, needs third to share the load. Salary commensurate with training and experience. Opportunity for partnership after one year. No obstetrics or major surgery. Twenty-bed district hospital, 80 bed nursing home, and 500-bed detention center for federal detainees. Call 915/869-6171. (40)

PART-TIME PHYSICIAN — needed from 9-12 Saturday for office sick call. $200 per shift. Call Mark D. Hughes, D.O., 903/432-2707. (22)

D.O. AMBULATORY FAMILY PRACTICE FOR SALE. No hospital, no call. Grosses $400,000+, nets $200,000+. Cash practice, no Medicaid, Medicare; very little private insurance. Extremely desirable northeast Houston suburb. Physician retiring. Malinda Hale, ProHealth Consulting. 800-444-2720. (25)

PRACTICE FOR SALE IN HOUSTON — Osteopathic clinic approximately 1,700 square feet. Majority workmans compensation and insurance practice. Equipment includes EKG machine 100MA; traction table; ultra sonic. Doctor to retire. Call 713/862-4105. (44)

PRIMARY CARE PHYSICIANS — needed and appreciated. Locum tenens, practice trials, and permanent placements available throughout TEXAS. INTERIM PHYSICIANS large enough to offer you options. . .small enough to care. Call Jamie Butler or Janice Hawkins at INTERIM PHYSICIANS, 1/800/531-1122. (06)

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

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

POSITIONS DESIRED

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

OSTEOPATHIC GENERAL PRACTITIONER — looking for full-time employment; available immediately. Prefers Dallas-Fort Worth metroplex. Write to Don Dunlap, D.O., 2701 West 15th Street, Suite 284, Plano, 75075, or call 817/481-9565. (02)

ANESTHESIOLOGIST — available to work locums. If you need someone or want to work Locums. Call FAST DOC, INC., a D.O. ONLY permanent and locums agency, placing osteopathic physicians of all specialties. Call 1/800/241-STAT. (21)

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