TEXAS D.O.

The Journal of the Texas Osteopathic Medical Association

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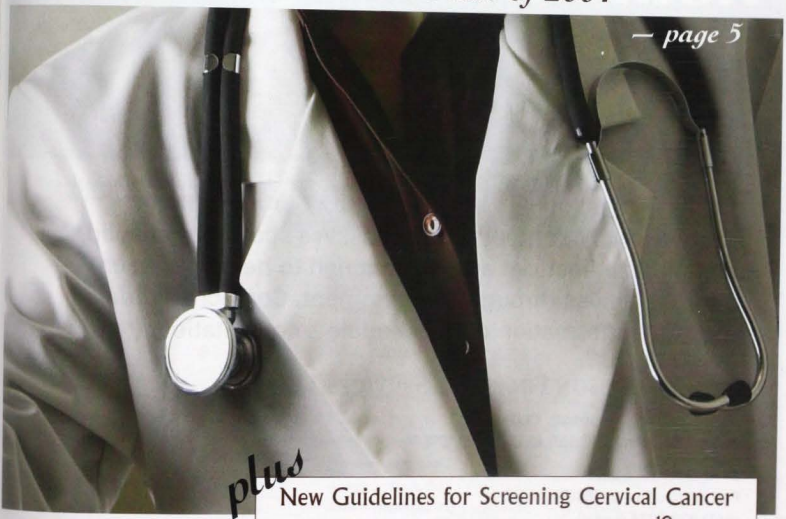
White Coat & Convocation Ceremony Welcomes TCOM Class of 2007



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OCTOBER 2003

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CALENDAR OF EVENTS

OCTOBER 12-16
"108 Annual AOA Convention & Scientific Seminar"
Sponsored by the American Osteopathic Association
Location: New Orleans, LA
Contact: AOA, 800-621-1773

OCTOBER 22-26
"ACOOG Postgraduate Course"
Sponsored by American College of Osteopathic Obstetricians and Gynecologists
Location: Renaissance Worthington Hotel, Fort Worth, TX
Contact: Jaki Holzer, ACOOG
800-875-6360 or 248-332-6360
FAX 248-332-4607
jbritton@acoog.com or <www.acoog.com>

NOVEMBER 6-9
"Primary Care Update"
Sponsored by the West Virginia Society of Osteopathic Medicine
Location: The Greenbrier, White Sulphur Springs, WV
CME: 25 hours category 1-A CME anticipated
Contact: Charlotte Ann Cales Pulliam
304-345-9836
FAX 304-345-9865 or wvdo@wvsominc.org

DECEMBER 3-7
"Principles of Manual Medicine"
Sponsored by the Michigan State University College of Osteopathic Medicine
Location: Kellogg Hotel & Conference Center
East Lansing, MI
CME: 40 hours category 1-A CME anticipated
Contact: Pamela Thompson, MSU-COM Office of CME
800-437-0001 or 517-353-9714
cme@comm.msu.edu
<www.com.msu.edu/cme>

DECEMBER 5-7
"22nd Annual Winter Update"
Sponsored by the Indiana Association of Osteopathic Physicians and Surgeons
Location: Crowne Plaze Downtown, Indianapolis, IN
CME 20 hours of category 1-A CME credit anticipated
Contact: Michael H. Claphan, IAOPS Executive Director
800-942-0501 or 317-926-3009
mclaphan@aol.com or <www.inosteo.org>

DECEMBER 13
"TOMA Board of Trustees Meeting"
Location: TOMA Building
Austin, TX
Contact: Lucy Gibbs, Associate Executive Director
800-444-8662 or 512-708-8662
FAX 512-708-1415
LucyG@txosteo.org

FEBRUARY 6-8
"TOMA 48th MidWinter Conference & Legislative Symposium"
Sponsored by the Texas Osteopathic Medical Association
Location: Omni Mandalay Hotel at Las Colinas
Irving, TX
Contact: TOMA
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CME CORRESPONDENCE COURSE
"Medical Ethics: Applying Theories and Principles to the Patient Encounter"
Sponsored by the University of Pennsylvania School of Medicine, the University of Pennsylvania Center for Bioethics and Clinical Consultation Services
CME: 60 hours category 2-B
Course Tuition: $1,200
Contact: 800-480-5542

Correction

The following intern/residency appointments were incorrectly listed in the July/August issue of the *Texas DO*

James P. McClay, D.O. – Dallas Southwest Medical Center

Matthew D. Thompson, D.O. – Dallas Southwest Medical Center

Pablo P. Zeballos, D.O. – Dallas Southwest Medical Center

White Coat & Convocation Ceremony Welcomes TCOM Class of 2007

Almost 130 new medical students from the Texas College of Osteopathic Medicine (TCOM) at the University of North Texas Health Science Center received their white coats at the annual White Coat and Convocation Ceremony August 22 at Will Rogers Memorial Auditorium in Fort Worth. The coats are donated each year by the Texas Osteopathic Medical Association.

During the ceremony, the health science center also awarded the prestigious Founders' Medal to L.L. LaRue, who served as its first fiscal officer in the late 1970s and early 1980s. The Founders' Medal is the institution's highest honor.

LaRue joined the staff of the Texas College of Osteopathic Medicine in 1976 as associate dean for administration to help the school through the transition from a private medical school to a state institution. As TCOM's first fiscal officer, he oversaw the development of institutional policies and procedures required for the school to meet state regulations. He also helped secure additional state funding for the medical school and later negotiated the purchase of more land for the growing campus. He served as president of the Retirees' Association for two terms and continues to be involved in institutional activities.

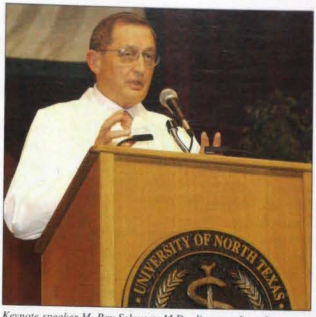
M. Roy Schwarz, M.D., president of the China Medical Board of New York, served as the keynote speaker for the ceremony. His presentation centered on the impact of globalization on the health professions.

"SARS reminds us that, because we live in a more global world, any disease that exists anywhere in the world exists everywhere," he said. "We can't ignore diseases because they originate somewhere else. Instead, the core curriculum and values of medicine must be the same around the world."

"This new global reality demands a new paradigm," Dr. Schwarz stated. "SARS screams at us that we must change how we think, live and behave. Medicine and public health must be fused. For them to be separate is intolerable and immoral."

Dr. Schwarz reminded students that by taking the professional oath of commitment, they could never again escape the responsibility that comes with it.

"Your white coat is a physical reminder of the oath and the demands accompany it," he said. "You are about to start an endless journey and begin a life-long, magnificent obsession with the art of medicine and science."



Keynote speaker M. Roy Schwarz, M.D., discusses how the practice of medicine has been impacted by globalization.

TCOM associate deans Michael Clearfield, D.O., and Don Peska, D.O., help a new medical student don her white coat.

The White Coat and Convocation Ceremony officially begins the new school year and welcomes new students to the health science center. Students are also presented with their white coats, symbolizing their entrance into the health professions.

This year, in addition to 127 new medical students entering as TCOM's class of 2007, 79 students joined the Graduate School of Biomedical Sciences, 28 new students entered the Physician Assistant Studies Program and 126 began their studies in the School of Public Health.

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NEW TOMA MEMBERS

The following physicians were approved for membership by the TOMA Board of Trustees at the September 13, 2003 meeting.

Gerald E. Brenton, D.O.
2500 N. Esplanade
Cuero, TX 77954
Dr. Brenton is a member of District 9. He graduated from The Texas College of Osteopathic Medicine in 1980 and is Certified in Orthopedic Surgery. Dr. Brenton is 3rd Vice-President of the American Osteopathic Association, and is a Past President of the Michigan Osteopathic Association.

David P. Klingensmith, D.O.
5005 N. Piedras Street
El Paso, TX 79925
Dr. Klingensmith is an Associate Military Member and a member of District 11. He graduated from The University of Health Sciences College of Osteopathic Medicine in Kansas City and is board certified in Anesthesiology.

Steven D. King, D.O.
523 South Santa Fe
Edmond, OK 73003
Dr. King is a Non-Resident Associate Member. He graduated from The Texas College of Osteopathic Medicine in 1999 and is board certified in Family Practice and Sports Medicine.

Kenneth A. Perez, D.O.
9131 Indianapolis Blvd.
Highland, IN 46322
Dr. Perez is a first year member. He graduated from the Chicago College of Osteopathic Medicine in 1992 and specializes in Family Practice.

TIOPA, Inc.
(Texas Independent Osteopathic Physicians Association)
3632 Tulsa Way
Fort Worth, TX 76107
TIOPA, Inc. joins as an Associate Member. The Executive Director is David Atkinson.

INTERN/RESIDENT/FELLOW MEMBERS

Adibeh Awaida, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving an internship at Bay Area Medical Center in Corpus Christi.

Layne S. Barnes, D.O. graduated from Western University of Health Sciences, Pomona, California in 2000. He recently completed a residency in Family Practice at the University of Wyoming and is currently practicing in Hereford.

Scott S. Carpenter, D.O. graduated from the University of Osteopathic Medicine and Health Sciences-College of Osteopathic Medicine and Surgery, Des Moines, Iowa, in 2003 and is serving an internship at Osteopathic Medical Center of Texas in Fort Worth.

Carena L. Chai, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving a residency in Obstetrics and Gynecology at Texas Tech University Health Science Center in Odessa.

Carl G. Chakmakjian, D.O. graduated from the Texas College of Osteopathic Medicine in 2000 and is serving a Fellowship in Oncology at Scott & White Memorial Hospital in Temple.

Annie Y. Chang, D.O. graduated from the Texas College of Osteopathic Medicine in 2001 and is serving a residency in Internal Medicine and Pediatrics at Scott & White Memorial Hospital in Temple.

Adriana H. Cheever, D.O. graduated from the Texas College of Osteopathic Medicine in 2002 and is serving a residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Yee-Ru (Amy) Chen, D.O. graduated from Nova Southeastern University-College of Osteopathic Medicine, Fort Lauderdale, Florida in 2000 and serving a residency in Family Practice at Christus St. Joseph Hospital in Houston.

Linda K. Christensen, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving a residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Norman T. Crabb, D.O. graduated from The University of Health Sciences College of Osteopathic Medicine in Kansas City in 2003 and is serving an internship at Bay Area Medical Center in Corpus Christi.

Clinton D. Damron, D.O. graduated from Arizona College of Osteopathic Medicine in 2003 and is serving an internship at Bay Area Medical Center in Corpus Christi.

Garry Todd Davis, D.O. is a first year member. He graduated from the University of Health Sciences College of Osteopathic Medicine in Kansas City in 2000. He completed a residency in Family Practice at Osteopathic Medical Center of Texas and is now practicing in Rotan.

Amy M. Delorie, D.O. is a first year member. She graduated from the University of New England College of Osteopathic Medicine in 1999. She completed a residency in Emergency Medicine at St. Barnabas Hospital in Bronx, New York, and is now practicing in Lubbock.

Tejas D. Desai, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving a residency in Internal Medicine at Scott & White Memorial Hospital in Temple.

Christine M. Estrada, D.O. graduated from Arizona College of Osteopathic Medicine in 2003 and is serving a residency in Obstetrics and Gynecology at the Osteopathic Medical Center of Texas in Fort Worth.

Charles C. Gregory, D.O. graduated from the University of Health Sciences College of Osteopathic Medicine in Kansas City in 2002 and is serving a residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Jay W. Harvey, D.O. graduated from Kirksville College of Osteopathic Medicine in 2001 and is serving a residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Peggy A. Johnson, D.O. graduated from Ohio University College of Osteopathic Medicine in 2002 and is serving a residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Steven P. Johnson, D.O. graduated from the University of Osteopathic Medicine and Health Sciences-College of Osteo-

pathic Medicine and Surgery, Des Moines, Iow,a in 2001 and is serving a residency in Family Practice at Wellmont-Holston Valley Medical Center in Kingsport, Tennessee.

Christine H. Le, D.O. graduated from Touro University College of Osteopathic Medicine-San Francisco in 2001 and is serving a residency at Memorial Hermann Hospital Southwest in Houston.

Matthew H. Lyman, D.O. graduated from Kirksville College of Osteopathic Medicine in 2003 and is serving an internship at Osteopathic Medical Center of Texas in Fort Worth.

Peter T. Marta, D.O. graduated from the University of Medicine and Dentistry of New Jersey-School of Osteopathic Medicine in 2001 and is serving a residency in General Surgery at Osteopathic Medical Center of Texas in Fort Worth.

Thomas J. May, D.O. graduated from the Texas College of Osteopathic Medicine in 2003; and is serving an internship at Plaza Medical Center in Fort Worth. He will then serve a residency in Anesthesiology at University of Texas Southwestern Medical Center in Dallas.

James P. McClay, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving an internship at Dallas Southwest Medical Center in Dallas.

Megan E. McDonald, D.O. graduated from Ohio University College of Osteopathic Medicine in 1998 and is serving a fellowship in Pediatric Radiology at Fannin Medical Center in Houston.

Ositadinma O. Opara, D.O. is a first year member. He graduated from Philadelphia College of Osteopathic Medicine in 1999. He finished a residency in Internal Medicine at Detroit Medical Center and is now in practice in Dumas.

Kartik N. Patel, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving an internship at the University of Texas Health Science Center in San Antonio.

Daniel J. Sabol, D.O. graduated from Arizona College of Osteopathic Medicine in 2002 and is serving a residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Nisha M. Saran, D.O. graduated from The University of Health Sciences College of Osteopathic Medicine in Kansas City in 1999 and is serving a residency in Internal Medicine at Henry Ford Hospital in Detroit.

Kirk S. Smith, D.O. graduated from Western University of Health Sciences, Pomona, California, in 2003 and is serving an internship at Bay Area Medical Center in Corpus Christi. He will then serve a residency in Anesthesiology at the University of Chicago.

Melissa Ruiz-Cady Sneed, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving an internship at the University of Texas Health Science Center in San Antonio.

Steven T. Solby, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving an internship at Plaza Medical Center in Fort Worth.

Frances S. Spiller, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving an internship at the University of Texas Health Science Center in San Antonio.

Marci L. Troxell, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving an internship at John Peter Smith Hospital in Fort Worth. She will then serve a residency in Neurology at Baylor College of Medicine in Houston.

Phillip A. Ward, D.O. graduated from the Texas College of Osteopathic Medicine in 2001 and is serving a residency in Family Practice at Bay Area Medical Center in Corpus Christi.

Carol A. Wood, D.O. graduated from the Texas College of Osteopathic Medicine in 2002 and is serving a residency in Family Practice at the University of Texas Southwestern Medical Center in Dallas.

Christine M. Zalucki, D.O. graduated from the Texas College of Osteopathic Medicine in 2003 and is serving an internship at Madigan Army Medical Center in Tacoma, Washington.

WEST NILE VIRUS IN TEXAS

As of September 17, 2003, the Texas Department of Health had recorded 205 human cases of the West Nile virus in 49 Texas counties this year, including eight deaths.

Human cases have occurred in Andrews (2), Angelina (3), Bexar (4), Brazos (2), Caldwell (1), Cameron (5), Collin (1), Dallas (33), Deaf Smith (1), Denton (3), Donley (1), Ector (2), Ellis (3), El Paso (5), Falls (1), Galveston (1), Gregg (5), Hale (2), Harris (28), Harrison (1), Hemphill (1), Hidalgo (8), Hockley (1), Jefferson (4), Johnson (2), Kaufman (1), Lamb (1), Lubbock (17), Maverick (1), Midland (6), Montgomery (17), Moore (1), Nueces (1), Oldham (1), Orange (3), Panola (2), Randall (4), Shackelford (1), Smith (5), Starr (1), Swisher (2), Tarrant (6), Taylor (1), Terry (1), Travis (8), Waller (1), Webb (1), Wichita (2) and Willacy (1) counties.

The eight deaths were in residents of Ellis, Hidalgo, Lubbock (2), Montgomery, Taylor, Travis and Wichita counties.

(Source: Texas Department of Health. News Update-<www.tdh.state.tx.us/updates.htm>)

New Guidelines for the Screening of Cervical Cancer

by Ryann McClennen, MSII, Jenny Wiggins, MSII, Ray Page, D.O., Ph.D.

Background

In 2003, the projected incidence of invasive cervical carcinoma will reach 12,200 with an anticipated mortality of 4100 patients. However, cervical cancer mortality has been on the decline since the mid-nineteen forties including a decrease of 74% in the years between 1955 and 1992.[1,2,3] This reduction can be attributed to the introduction and mass screening using the Papanicolaou (Pap) test, better known as the Pap Smear. Cervical cancer, once the number one cancer killer of women, now ranks 13th in cancer deaths for women in the United States.[4]

The previous American College of Obstetrics and Gynecology (ACOG) and American Cancer Society (ACS) guidelines, followed since 1987, have suggested that women receive initial Pap tests three years after first sexual intercourse or at age 18, whichever occurs first.[5] Those patients deemed "low risk" (late sexual intercourse, single partner) could have less frequent screenings, while those considered "high risk" (early sexual intercourse, multiple partners) would need to continue annual screenings.[6] The new set of guidelines are a reflection of the refined understanding that we have on the pathogenesis of Human Papilloma Virus (HPV) in cervical cancer and the contribution of newer sophisticated technologies such as liquid based Pap tests and HPV testing.

Epidemiology

The mean age of developing cervical cancer is 52, with a peak age of 47.[2,6] Among those diagnosed with cervical cancer, 47% are under the age of 35, and 10% are over the age of 65. Those over 65 are more likely to die of the disease due to their more advanced stage at diagnosis.[2]

Patients from lower socioeconomic classes are more likely to be affected by cervical cancer, along with those in geographic locations without access to medical care and routine screening.[2] Also, the disease is most common in women of Latin American and Western European origin.[7] Among women under or at the age of 30, cervical cancer incidence for Hispanic women was approximately twice that for non-Hispanic women.[8]

Etiology and Risk Factors

Human Papilloma Virus (HPV) infection is an important factor in the pathogenesis of cervical cancer. Nearly all degrees of cervical intraepithelial neoplasia and invasive carcinomas have been associated with HPV infections.[6] An international biological study of cervical cancer found that 93% of invasive cancer specimens had PCR-revealed DNA evidence of HPV infection.[9] Human Papilloma Virus has been classified according to its oncogenic risk. Those with low oncogenic risk include types 6 and 11, types considered high oncogenic risk include 16, 18, 45, 56, and 58.[9] Conversely, a negative HPV test is associated with a decreased risk of cervical neoplasia.[10] Many individuals may harbor the virus for years without any symptoms, and in most cases of HPV infections of younger women the immune system defeats the virus without any permanent effects.[11]

Early onset of sexual activity can take part in the later development of cervical cancer. During the time of menarche, the transformation zone of the cervix is more susceptible to oncogenic agents such as HPV. Therefore it is postulated, that beginning sexual activity before 16 or women who are sexually active within 1 year of menarche are at an increased risk for cervical carcinoma. Additionally, the increased number of sexual partners is also associated with increased risk, with a higher risk associated if there are multiple partners before age 20 years.[2]

Historically, women who use oral contraceptives are more sexually active than women who do not use oral contraceptives. It is thus controversial whether oral contraceptive use constitutes an independent risk factor for cervical carcinoma.[2]

Cigarette smoking, due to diminished immune function secondary to systemic effect and/or local effects of tobacco-specific carcinogens, also has been identified as a risk factor for cervical carcinoma.[2] Studies have shown a history of current or prior smoking significantly correlates with biopsy-proven CIN 2 or greater.[12]

Data demonstrates that immunocompromised patients, either due to medications or human immunodeficiency virus (HIV), have an increased risk of invasive cervical carcinoma. It is postulated that the suppression of normal immune response to HPV, makes patients more susceptible to malignant transformation.[2]

New Recommended American Cancer Society Screening Guidelines (Table 1)

Age of Initial Screening

Data suggests that there is little risk of missing an important cervical lesion until 3-5 years after initial exposure to HPV; thus, cervical cytology screening before the 3 year-period may result in over diagnosis of cervical lesions that may regress spontaneously.[13] Additionally, The National Cancer Institute's Surveillance, Epidemiology, and End results (SEER) program from 1995-1999 reported no cases of invasive cervical carcinoma for patients age 10-19 years and only 1.7/100,000/year for ages 20-24.[14] Due to this rationale, cervical cancer initial screening should begin 3 years after a woman begins having vaginal intercourse, but no later than 21 years of age.[15]

Age to Discontinue Screening

The general consensus is that the incidence of cervical cancer in mature women is almost entirely confined to the unscreened and under screened, not an age related risk factor. In fact, there is a decreased risk factor for 50+ women in countries with regular

Table 1. New Recommended Guidelines for Early Detection of Cervical Cancer

Patient Population	Frequency
<21 years, or 3 years after first sexual intercourse	Initial Pap
21-30 years	Annually, or every 2 years with liquid-based Pap with HPV screening not exceed every three years
30+ years	If normal cytology 3 successive years, then screening every 2 to 3 years
70+ years	If 3 or more normal Pap tests and no abnormal results in the last 10 years may choose to stop screening
Partial Hysterectomy (w/cervix)	Benign reasons: routine screening to age 70, then may stop if screenings normal
Total Hysterectomy (w/o cervix)	Benign reasons: screening not indicated History of CIN2/3: Annually until 3 successive normal smears and/or no abnormal cytology within 10 years
In Utero DES exposure	Annually, while in reasonably good health
Immunocompromised (HIV+, etc.)	Annually, while in reasonably good health

screening programs. Cervical cancer among older, screened women in the United States is rare. Therefore, it is now recommended that women 70 years and older who have had 3 consecutive normal Pap tests in the last 10 years may choose to stop cervical cancer screening. However, women who have a history of cervical cancer, in utero exposure to diethylstilbestrol (DES) and/or who are immunocompromised (including HIV) should continue screening as long as they are in reasonable good health.[13]

Screening Intervals

While the difference in relative risk of an important lesion progressing to invasive disease between 2 or 3 year screening intervals when compared to 1 year interval is significant; it is important to note that the probability of disease is quite small even among women screened every three years.[13] While frequent screening increases sensitivity, it also greatly increases patient harm and costs. Additionally, estimations of absolute risks of cervical cancer following 1, 2, and 3 or more consecutive negative cytology smears as 3.09, 2.56, and 1.43 per 100,000 women.[16] Cervical screening should be performed annually with conventional cervical cytology smears or every two years when using liquid-based cytology up until age 30 years. At or after age 30, women who have had three normal tests may be screened every 2-3 years. However, women with a history of in utero DES exposure and/or are immunocompromised (including HIV) are suggested to continue annual screening.[5,13] Age of onset of sexual activity or multiple sexual partners, and smoking should not be used as rationale for more frequent screening.[13]

Screening After a Hysterectomy

Vaginal cancer incidence rate is 1-2/100,000/year making it an uncommon malignancy; thus, vaginal cytology tests following total hysterectomy (with removal of cervix) is not indicated.[4,13] Additionally, for women with a total hysterectomy for benign reasons, cervical cancer screening is not recommended. Women who have had subtotal hysterectomies should continue cervical cancer screening as per above guidelines. However, women who have had hysterectomies due to invasive cervical carcinoma should be screened until three documented, consecutive normal cervical cytology tests are reported and/or no abnormal cytology test are reported in a 10 year period.[13]

HPV DNA Testing with Cytology Screening

With the FDA approval of HPV testing for screening purposes[11], women aged 30 and over in conjunction with cervical cytology and/or liquid-based cytology HPV DNA testing should be performed not more frequently than every three years. Counseling and education is critical when HPV infection is indicated.[13]

Conclusion

The changes for the new guidelines support data stating that continued annual screening in younger women may result in false-positive tests and invasive procedures that outweigh the benefits of annual screening. In fact, with the development of more sophisticated technologies, such as liquid-based Pap tests and a new HPV test, it is critical that women not be screened too frequently so that these tests sustain sensitivity. Over-screening may result in positive results for viruses that eventually resolve.[3]

Changes made to the screening guidelines are unlikely to have a significant impact on the mortality for cervical cancer or the relatively low incidence of cervical cancer in the United States. However, there is a potentially large impact for a reduction in health care costs and invasive procedures, resulting in a reducing in patient discomfort, anxiety and inconvience.[13]

The largest gain in continued reduction of cervical cancer incidence and mortality would be achieved by increasing rates among women who are unscreened or under screened.[13] Texas is currently below national average for all age categories for percentage of recent Pap screening.[17] Clinicians, public health officials, hospitals and health care plans should seek to improve screening for these women, improving access to medical care and routine screening. With the new guidelines, the benefits outweigh the costs.

continued on next page

These guidelines continue to emphasize the importance of flexibility for women and their health care providers. Screening should be based on discussion of the benefits, risks, and limitations of cervical cancer screening.

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22 Million in U.S. Suffer from Substance Dependence or Abuse

In 2002, an estimated 22 million Americans suffered from substance dependence or abuse due to drugs, alcohol or both, according to the newest results of the Household Survey released today by the Substance Abuse and Mental Health Services Administration in the Department of Health and Human Services (HHS). There were 19.5 million Americans, 8.3 percent of the population ages 12 or older, who currently used illicit drugs, 54 million who participated in binge drinking in the previous 30 days, and 15.9 million who were heavy drinkers.

The report highlights that 7.7 million people, 3.3 percent of the total population ages 12 and older, needed treatment for a diagnosable drug problem and 18.6 million, 7.9 per cent of the population, needed treatment for a serious alcohol problem. Only 1.4 million received specialized substance abuse treatment for an illicit drug problem and 1.5 million received treatment for alcohol problems. Over 94 percent of people with substance use disorders who did not receive treatment did not believe they needed treatment.

There were 362,000 people who recognized they needed treatment for drug abuse. Of them, there were 88,000 who tried but were unable to obtain treatment for drug abuse in 2002. There were 266,000 who tried, but could not obtain treatment for alcohol abuse.

"There is no other medical condition for which we would tolerate such huge numbers unable to obtain the treatment they need," HHS Secretary Tommy G. Thompson said. "We need to enact President Bush's Access to Recovery Program to provide treatment to those who seek to recover from addiction and move on to a better life. That is what Recovery Month is all about."

Findings from the 2002 National Survey on Drug Use and Health are available at <www.DrugAbuseStatistics.samhsa.gov>.

News from the Texas Medical Foundation

Mediation Now Available to Resolve Medicare Beneficiary Complaints

As of September 15th of this year, the Texas Medical Foundation (TMF) began offering a new option to resolve Medicare beneficiary complaints about the medical care they receive under the Medicare program. For beneficiary complaints that do not involve quality of care issues, voluntary and confidential mediation services will be offered as an alternative to the current physician peer review process.

"We are pleased to offer a new tool to resolve complaints from beneficiaries. Mediation is ideal for complaints that stem from communication problems with patients and can head off a more lengthy legal or investigation process," said Grey McLeod, Vice President of Administration for the TMF, a physician-led, non-profit organization that is the Medicare quality improvement organization for Texas. In addition to its quality improvement activities, TMF is responsible for reviewing the necessity and quality of medical care provided to Medicare beneficiaries in Texas.

Professional mediators will bring both parties together in a neutral and confidential environment. The process allows each side to hear the other party's viewpoint..

The federal Centers for Medicare & Medicaid Services, a division of the U. S. Department of Health & Human Services, piloted the mediation program in six states across the country from 1998 to 1999. The success of the mediation process in those states was the impetus for launching it nation-wide this fall through the quality improvement organizations in each state.

"Mediation will not be available if a quality of care concern appears to be involved," said McLeod. "However, up to 80 percent of complaint cases are driven by lack of communication or patients' concerns about their interaction with physicians. In these cases, mediation may provide a more satisfactory outcome than the traditional review process."

Currently, each Medicare beneficiary complaint goes through a medical record review process at Texas Medical Foundation that can last anywhere from 85 to 165 days. "Mediation is not the time-consuming process some people think it is. The actual mediation discussion may only take a few hours. When a settlement is reached the patient's dissatisfaction is relieved and the physician is saved from more time-consuming processes, such as lengthy investigations or litigation," adds McLeod.

The mediation process is purely optional and either party can withdraw at any time and the case would then revert to the traditional medical record review process. Another key factor in the mediation process is confidentiality. No records are kept of the actual discussion and nothing stated in mediation can be used in any legal proceedings. If the parties reach an agreement, Texas Medical Foundation will then follow-up and ensure the terms of the agreement are implemented.

For more information about the mediation process, call the Texas Medical Foundation at 512-329-6610 or go to <www.tmf.org>.

Check Out the TSBME Web Site For Agency Changes

The Texas State Board of Medical Examiners (TSBME) has recently made many changes in the way it regulates Texas physicians, and you need to be aware of these changes in order to remain in compliance with the law and with TSBME regulations.

The agency no longer mails its twice-yearly newsletter, *The Medical Board Report*. A new publication, called the *Texas Medical Board Bulletin*, is published on the agency web site. It has all the latest news with links that provide additional information and contains a list of disciplinary actions taken by the board and Formal Complaints filed since the previous issue.

Other sections of the site that are of interest to physicians include physician registration, proposed rules and rule changes, information for deployed military physicians, and the latest news in the form of press releases.

The site is <www.tsbme.state.tx.us>. Don't take chances on being unaware of regulatory changes you need to know.

Self's
Tips & Tidings

By Don Self

Updating Your Fees

While performing fee, code and charge analysis for physician practices around the country, I'm coninuously amazed at some of the misconceptions people have about their fees. Some offices have not raised their fees in five years or longer, while others increase their fees twice a year. Some people use Medicare's fee as a base and then multiply that base times some odd calculation to come up with a fee they will charge non Medicare. Some offices charge everyone the same as the Medicare allowed amount (definitely not recommended), while others may have 14 different fee schedules. "Yes ma'am, we have one fee schedule for your husband since he's on Medicare with a BCBS Texas secondary policy, yet we are going to charge you 2.6 times that amount since you have Monk Insurance with a Hezakiah policy as supplemental."

What's next? Putting a bar code on the forehead of patients so you can charge them appropriately? "Sir, please lean over here so we can scan you and make sure we bill you correctly. Of course, if you brought in any coupons today for one of our injections or specials we're offering in the paper, we need those before we scan you."

Okay, where have we come from and where are we going concerning physician fees? In the 80s, we had a change in this country when physicians decided it was better to accept assignment on insurance claims and get some of the money today, instead of waiting for patients to get their insurance checks and then pay the physician (if the patient had not already spent it on something else). Physicians made a huge mistake back then by not educating their patients as to what accepting assignment meant. Actually, it only meant asking the carrier to pay the physician instead of the patient and the patient still owed the balance – but 99% of the physicians refused to spend a little money educating their patients to this effect, such as sending newsletters to their patients or having a notation on their patient statements, so patients believed what they heard from their carrier. So did many physicians, unfortunately.

Before long, we saw physicians signing contracts with insurance carriers and turning to them for payment instead of holding the patient responsible. Then, in '92 and '93, physicians again refused to educate their patients. Headlines in the papers routinely stated "Physicians overcharging patients" or "Doctors Abusing Medicare," yet physicians relied solely on their associations to defend them, rather than taking a pro-active stance in educating patients. About the same time, physicians started charging multiple fee schedules based on different things.

My recommendation is that you have one fee for everyone. Charge one fee and then make whatever adjustments that need to be made AFTER the carrier pays. Do not charge what you THINK Medicare allows. Make it easier on yourself and your staff and less confusing to the patient. Determine what each service is worth and then charge that. If you want to give a break to a patient whose husband has run away and joined the circus and didn't leave her money to take care of the 40 kids she has at home, then it's okay give her a discount. There are no laws stating you cannot give someone a break or a discount for paying in full at the time of service. There are no fairness laws stating you have to charge everyone the same. Even Medicare doesn't prohibit you from charging less for some patients than you charge them, as long as you don't ROUTINELY and SUBSTANTIALLY charge Medicare more. (CMS officials have stated that "routinely" is more than 40% of patients and "substantially" is 30% more money.) So, unless you're giving more than 40% of your patients a discount of more than 30% less than the fee you charge to Medicare, I wouldn't worry about any serious response from Medicare. As to the claims that your neighbor's mother-in-law's hairdresser says that you can be fined by someone for charging them more or less than someone else, give it as much credence as you give to an email telling you that Microsoft will send you a check if you forward emails, or that the wife of the deposed leader of Costra Libra wants you to keep $15 billion of their money in your bank account and will deposit it if you will just give them your bank account information.

The next logical question is "How do I decide what fees to charge for each service?" That one is a little more complicated. There are fee schedules published by Unicor Medical, PMIC and others, but which one is accurate? Do you use the 50th percentile? How about the 75th or the 90th? How accurate are the percentiles? Why can't you just call around and ask other physicians what they charge? You can, but be aware that the Federal Trade Commission frowns upon "price-fixing." Of course, to be convicted of price-fixing, you must have collusion between parties and as long as there is no collusion, how could they convict you? Yes, many physicians will utilize a consultant to review their fees, codes being used, charging patterns, etc and follow their advice. In fact, many D.O.s throughout Texas have done exactly that with our service. One advantage is that some consultants guarantee their services so that if you're not pleased with it, you pay nothing. Our guarantee is this plus the fact that if we cannot increase your income by at least $5,000 per month, you still owe us nothing.

We know of some consultants that recommend a flat rate above Medicare (twice Medicare's allowed or 2.5 times Medicare, etc.). However you calculate your fees, be sure to remember one thing:

If the carrier is ever allowing your full fee, it may be time to increase your fee.

Which Seminars to Attend

There are many fine companies out there, such as McVey & Associates, Terry Fletcher Seminars, Conomikes and others. Before spending your money on any seminar about fees and business financial management, check the Better Business Bureau or even go to the CMS website and do a name check. You may be surprised.

Needle EMG with NCV

As you know if you've been reading this column for the past 15 years, we are constantly looking for revenue enhancement opportunities for our clients. Before we can recommend any diagnostic or therapeutic service, it must first meet our criteria. That includes being clinically efficacious for the patient, applicable for the type of practice and profitable. There is another company out of Houston we are now recommending that will send certified technicians to your office (wherever you are) to perform Needle EMG with NCV on your patients with their own equipment. You schedule those patients that qualify for this service on one or two dates a month, and this compnay comes in and performs the diagnostics. You bill for the professional component for interpreting the results and they bill for the technical. Then, when you refer a patient with radicular pain, tingling or numbness for a consult, you'll be sending a quality consult. When you combine this service with the holters & EMGs we are placing into offices at no charge to the clinic or physician with the LEAP disease management program for weekly migraine or IBS-D patients, you're talking about services that can make a huge difference for the patient and the practice's monthly deposits increase substantially.

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Letter to the Editor

Dear Mr. Boucher:

Please convey my sincere thanks to the Officers, Board of Trustees and the House of Delegates for honoring me with a Life Membership. It came as a very pleasant surprise!

I began my profession in Texas following graduation from the Philadelphia College of Osteopathic Medicine in 1962. I did my internship and residency at the Fort Worth Osteopathic Hospital and practiced there for 10 years. I was there for the founding of the Texas College, saw it move from the unfinished fourth floor of the hospital to the bowling alley, and became part of the early faculty of the College as well as serving on the Admissions Committee. I have very fond memories of my professional beginnings and colleagues in TOMA.

I left Texas in 1974 to join the Navy. However, I maintained my membership throughout the past 29-plus years because I like to keep up with what is going on within the association as well as the membership

Again, thank you very much for the honor and I hope to continue to follow TOMA business and members for many years to come!

Warmest regards,

James H. Black, D.O.
Norfolk, Virginia
and Lauderdale Lakes, Florida

Who's in the News?

Samuel T. Coleridge, D.O., New TAFP Treasurer

Dr. Samuel T. Coleridge of Fort Worth was elected treasurer of the Texas Academy of Family Physicians during its 54th Annual Session and Scientific Assembly. Dr. Coleridge assumed his duties July 26 at the annual Installation of Officers and President's Gala.

Dr. Coleridge is a graduate of the University of Akron and the Kansas City College of Osteopathic Medicine. He has extensive teaching experience and is currently professor and chair in the Department of Family Medicine at the University of North Texas Health Science Center at Fort Worth.

Actively involved in TAFP, Dr. Coleridge has held numerous positions including vice president and parliamentarian. During his year as treasurer, he will serve as chair of the Finance Committee and will review income and expenditures of the Academy.

As an officer and member of the Executive Committee, he will meet with state legislators and testify before legislative hearings as an advocate of family doctors and the patients they serve.

Larry Price, D.O., Elected Vice President of TSBME

Dr. Larry Price of Temple was elected vice president of the Texas State Board of Medical Examiners during its June board meeting.

Currently, Dr. Price is an assistant professor at the Texas A&M University Health Science Center College of Medicine and senior staff cardiologist at Scott & White Clinic in Temple. He is board certified in Internal Medicine, Cardiology, Critical Care Medicine and Cardiac Electrophysiology. He is a 1980 graduate of the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine.

In the spring of 2002, Dr. Price was reappointed to the board for another six-year term, which expires April 13, 2009. The other D.O. members of the board are David E. Garza, D.O., and Roberta M. Kalafut, D.O.

Influenza Vaccine Supply Expected to Meet Demand

Sufficient supplies of flu vaccine should be available during the coming influenza season. The Centers for Disease Control and Prevention (CDC) predicts that everyone wanting to get a flu shot to avoid influenza, regardless of age or health status, should be able to get vaccinated as soon as vaccine becomes availableas early as October.

CDC estimates that vaccine manufactures will produce approximately 85.5 million doses of influenza vaccine during the 2003 influenza season. This projection represents 9.5 million fewer doses than were produced last year. However, influenza vaccine production is expected to exceed the estimated 79 million doses that were actually sold to providers in 2002.

Influenza causes approximately 36,000 deaths and 114,000 hospitalizations each year. More than 90 percent of those deaths occur among people age 65 and older. Although anyone who wishes to avoid influenza should be vaccinated, CDC strongly recommends influenza vaccination as soon as vaccine is available for any person who is 6-months old or older and is at increased risk for complications from influenza. Those at highest risk for complications from influenza include people 65-years old and older, those with chronic, long-term health problems such as heart or lung disease, kidney problems, diabetes, asthma, anemia, HIV/AIDS or any other illness that suppress the immune system. CDC also recommends vaccination for people age 50 to 64 years because this group has an increased prevalence among those with high risk conditions. In addition, healthcare workers and others in close contact with those at high risk should be vaccinated in order to reduce the possibility of transmitting influenza to those at high risk.

Because young children also are at increased risk of influenza-related complications, vaccination of children 6 to 23 months old, their household contacts and out-of-home caregivers are encouraged to be vaccinated against influenza.

Winter is the prime time for influenza. Influenza season typically ranges from November through March or beyond. Flu activity peaked in January or later during 22 of the past 26 influenza seasons. Heaviest influenza activity occurred in December in four years, January in six years, February in 11 years, March in three years, April one year and in May one year.

Texas Voters Say "Yes" to Proposition 12

By an extremely close margin, Texas voters approved the passage of Proposition 12 on September 13, marking a huge victory for Texas physicians. With 100 percent of the precincts reporting, the vote was 51.12 percent in favor, and 48.88 percent against the proposition that will uphold the cap on non-economic damages in medical malpractice cases with a Constitutional Amendment.

Thanks to all the physicians, students, families, and friends who worked so hard to achieve this victory! Be sure to thank your legislators who helped in this fight!

TxACOFP Presents Top Honors at 2003 Annual Seminar

Dr. Harold D. Lewis "Family Physician of the Year" for 2003

Harold D. Lewis, D.O., of Austin, has been named "Family Physician of the Year" by the Texas Society of the American College of Osteopathic Family Physicians. Dr. Lewis was honored during the TxACOFP's 46th Annual Clinical Seminar, held July 31-August 3 in Arlington at the Arlington Wyndham Hotel.

The award represents the highest honor that can be bestowed by the TxACOFP. It is awarded for outstanding contributions to the osteopathic profession and community by a recipient whose practice reflects the osteopathic philosophy, and who is a stimulus to his or her peers and to students of all ages.

Board certified in Family Practice and Osteopathic Manipulative Medicine, Dr. Lewis has been active in family practice, occupational and sports medicine in Austin for over 20 years. He serves as a clinical associate professor at the University of North Texas Health Science Center at Fort Worth, and participates in the Texas Statewide Preceptorship program. In addition, Dr. Lewis has participated in over thirty medical studies and research trials while running two medical offices in Austin.

He is a 1976 graduate of the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine.

Dr. Lewis has held several elective offices within the TxACOFP. He served as president from 2001-2002, and is the current treasurer.

Other memberships include the American Osteopathic Association; Texas Osteopathic Medical Association, in which he serves on several committees; and the national American College of Osteopathic Family Physicians.

Dr. Donald M. Peterson Receives "T.R. Sharp Meritorious Service" Award

Donald M. Peterson, D.O., a Mesquite family physician, has received the "T.R. Sharp Meritorious Service Award" from the Texas Society of the American College of Osteopathic Family Physicians. The award was presented during the TxACOFP's 46th Annual Clinical Seminar.

The award honored Dr. Peterson for going "above and beyond the call" to help promote the philosophy and practice of osteopathic medicine as well as forward the mission of the ACOFP, which is to "promote excellence in osteopathic family medicine through quality education, visionary leadership and responsible advocacy.

In nominating Dr. Peterson for the award it was noted that "throughout a lifetime of devotion to the profession and to his patients, he serves as a distinctive example to others. His knowledge and furtherance of the principles of osteopathic medicine are truly an asset to the entire profession."

Dr. Peterson maintains a private practice in Mesquite, and has multiple board certifications and fellowship awards. He has served on numerous committees and boards on the local, state and national levels, and is a past president of both the TxACOFP and the Texas Osteopathic Medical Association.

A 1959 graduate of the University of Health Sciences, College of Osteopathic Medicine in Kansas City, Missouri, Dr. Peterson served an internship at Dallas Osteopathic Hospital.

Specials honors include the TOMA Distinguished Service Award, the AOA Distinguished Service Certificate, and the TxACOFP Family Physician of the Year.

Contingency Plan and Compliance with the HIPAA Transaction and Code Sets

September 11 Statement by Leslie V. Norwalk, Acting Deputy Administrator Centers for Medicare & Medicaid Services

October 16 is just around the corner, and all covered entities should be actively working with their trading partners on outreach, testing and contingency planning. This deadline is the law and we all have to deal with it. It's not something that can be ignored or brushed aside.

Our real challenge now is to help all the entities covered by HIPAA to become compliant as quickly as possible and to plan for the problems that may arise after October 16.

As we face the challenge of HIPAA, we should all keep in mind that in the long run HIPAA is going to make things a lot better for everybody. For one thing, it is expected to result in significant savings for the health care industry – and the taxpayer – over the first ten years, above and beyond whatever start-up costs folks are facing now.

Once the electronic simplification provisions of HIPAA are implemented, processing and paying claims, and exchanging all sorts of medical information will be far easier than it is now. Doctors, hospitals, insurance plans and others will be able to communicate with each other with the same ease of someone from New York traveling in California doing business with his bank back home by going to an ATM that speaks the same language as all the other ATMs. That's a goal worth all our efforts now.

As the largest HIPAA covered entity, we at Medicare do understand the difficulties in becoming compliant first hand. That's why we've been working hard to help our HIPAA partners become compliant. We have held conferences, town hall meetings, and roundtables, provided a variety of outreach materials, conducted a national ad campaign, provided e-mail technical assistance and a toll-free telephone helpline, among many other efforts.

Now we are working on the possibility of Medicare implementing a contingency plan. And I urge other health plans to announce their contingency plans as soon as possible to allow their trading partners enough time to make any needed changes to their business operations to make sure any disruptions in their health care operations are minimal.

On July 24, 2003, the Department of Health and Human Services (HHS) issued guidance regarding the enforcement of the HIPAA transactions and code set standards after October 16, 2003. Industry support remains strong for the HIPAA transaction and code set standards. However, we are not confident that providers are ready or that they have enough time for adequate testing.

HHS recognizes that transactions often require the participation of two covered entities and that noncompliance by one covered entity may put the second covered entity in a difficult position. The Departmental guidance clarified that covered entities, which made a good faith effort to comply with HIPAA transaction and code set standards, may implement contingencies to maintain operations and cash flow.

While Medicare will be able to accept and process HIPAA compliant transactions, the Centers for Medicare & Medicaid Services (CMS) is actively assessing the readiness of its trading partners to make sure that cash flow to Medicare fee-for-service providers will not be disrupted. In September, CMS shared Medicare's fee-for-service contingency plan with the provider community so that they could be prepared to work with the Agency should CMS deploy it. Medicare's contingency plan is to continue to accept and process transactions that are submitted in legacy formats while their trading partners work through issues related to implementing the HIPAA standards.

In reviewing its trading partner readiness and whether to deploy its contingency, Medicare will assess the number of Medicare submitters who are testing and in production with our contractors. If Medicare deploys this contingency, it will be for all Medicare fee-for-service contractors. Medicare will continue its active outreach and testing efforts to bring its trading partner community into compliance in the days before and, if necessary, after October 16th.

Texas Health & Human Services Commission Utilization Review Department

Recommendations To Enhance Compliance with Texas Medicaid Fee-For-Service Hospital Billing

The purpose of this article is to highlight an area for physician and hospital providers where collaboration in patient care delivery exists, but can improve. The Texas Medicaid program, through its hospital utilization review activities, has identified this area for both compliance with provider responsibilities and the reduction of the submission of inappropriate inpatient hospital claims.

The Texas Health and Human Services Commission (Commission) is required to operate a utilization review program that controls the utilization of Medicaid inpatient hospital services for hospitals reimbursed under the prospective payment system. An admission review of paid, inpatient hospital claims is conducted retrospectively to evaluate the medical necessity of inpatient admissions. For purposes of utilization review, medical necessity means the patient has a condition requiring treatment that can be safely provided only in the inpatient setting. When medical necessity is not established, the hospital inpatient claim is denied and the inappropriate payment to the hospital is recovered.

In order to enhance compliance with Texas Medicaid fee-for-service hospital billing and decrease the submission of inappropriate inpatient hospital claims, the Commission's Utilization Review Department is offering the following suggestions:

- Physicians and hospital personnel (primarily case managers, utilization review, billing) should become familiar with the Hospital Inpatient Screening Criteria used by the Commission staff in performing reviews of hospital medical records related to paid, inpatient hospital claims. The criteria provide guidelines for review staff to assist with the determination of medical necessity of inpatient stays. The criteria may be found on the Commission web site <www.hhsc.state.tx.us/OIE/index.html>, Medicaid Hospital Inpatient Screening Criteria.
- Consideration should be given to initially admitting patients in observation status if the physician feels that it is reasonable to expect the patient may be able to be discharged within twenty-four hours. In the Texas Medicaid program, if the patient is initially admitted in observation status (per physician order), the stay is greater than twenty-four hours, and the hospital submits an inpatient claim, the hospital will be given the opportunity to rebill the first twenty-four hours of services on an outpatient claim should the inpatient claim be subsequently denied per retrospective utilization review.
- When a patient is admitted to the hospital as an inpatient and is discharged in less than twenty-four hours, the hospital may request that the physician change the admission order from inpatient status to outpatient observation status. This billing practice is acceptable under the Texas Medicaid program when the physician makes the changes to the admitting order from inpatient status to outpatient observation status before the hospital submits the claim for payment.

This correction in admission status avoids errors in billing and the potential need for a more lengthy appeal process. If the physician admitting orders do not accurately reflect the services provided, the hospital inpatient claim may be denied and the inappropriate payment recovered from both the hospital and the admitting physician.

The Commission encourages physician and hospital providers to consider these recommendations and support appropriate utilization of inpatient hospital services.

FYI

Emergency Preparedness Fact Sheet Available from HHS

A new Department of Health and Human Services (HHS) fact sheet on "Public Health Emergency Preparedness: Transforming America's Capacity to Respond" is on the HHS Web site at <www.hhs.gov/news/facts/bioprep.html>.

The fact sheet describes extensive activities of the last two years in expanding preparedness for a possible bioterrorism incident, especially the ongoing efforts to improve emergency medical response capacity at the federal, state and local levels.

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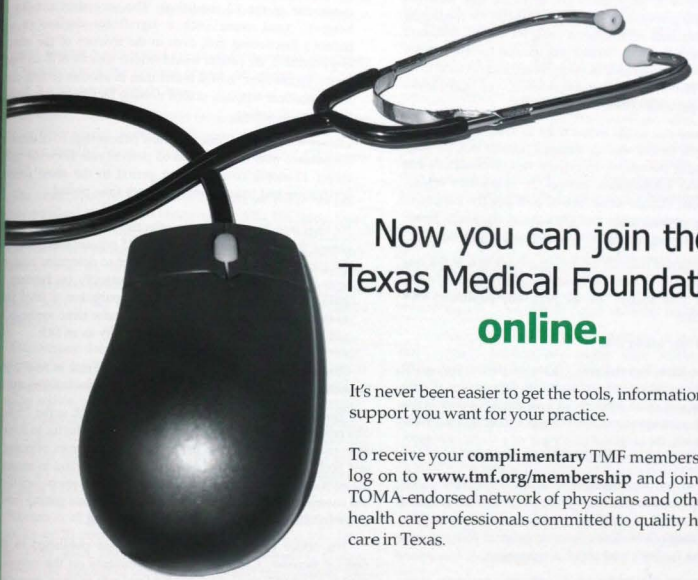

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CMS Proposes Changes in Classifying Inpatient Rehabilitation Facilities

On September 2, the Centers for Medicare and Medicaid Services (CMS) proposed changes in the criteria for classifying hospitals as inpatient rehabilitation facilities (IRFs). Medicare reimburses these hospitals, which provide specialized care for patients recovering from conditions requiring intensive inpatient rehabilitation therapy, such as strokes or spinal cord injury, under a prospective payment system.

The proposed rule would reduce from 75 to 65 the percentage of patients in the facility who are admitted because they are diagnosed with one of the specific qualifying medical conditions and require intensive rehabilitation services in an inpatient setting. These conditions include stroke, spinal cord injuries, congenital deformity, amputations, major multiple traumas, fracture of femur, brain injuries, polyarthritis, neurological disorders, and burns.

"In this proposed rule, we are taking a fresh look at the current 75 percent rule to see if it should be changed," said CMS Administrator Tom Scully. "We are proposing significant revisions to the rule."

The proposed rule would also:

- Delete the term "polyarthritis" from the current list of 10 qualifying conditions and replace it with three groups of conditions that will more precisely identify the types of arthritis-related ailments appropriate for care in a rehabilitation facility. As a result, the proposed 65 percent rule would now apply to a total of 12 medical conditions.
- Continue to use the inpatient rehabilitation facility's total patient population to determine compliance with the proposed 65 percent rule, but establish an administrative presumption that if the facility's Medicare patient population complies with the rule, the facility's total population complies.
- Count toward the proposed 65 percent, not only those patients whose principal diagnoses match the 12 conditions, but also those who have a secondary medical condition that meets one of the 12 conditions. The secondary condition, however, must cause such a significant decline in the patient's functioning that, even in the absence of the admitting condition, the patient would require treatment in an inpatient rehabilitation facility, rather than in another setting such as an inpatient hospital, skilled nursing facility, home health or outpatient setting.
- Change the period of time to review patient data to determine compliance with the proposed 65 percent rule from the most recent 12-month cost reporting period to the most recent, appropriate and consecutive 12-month time period.
- No later than 3 years from the effective date of the final rule, change the compliance percentage to 75 percent and phase out the use of a secondary medical condition to determine compliance. These changes will occur automatically on January 1, 2007, unless prior to that date CMS publishes a final rule adopting another method or readopting these same methods as part of the criteria used to classify a facility as an IRF.

CMS suspended enforcement of the current rule in June 2002 because of concerns that it was being enforced inconsistently.

"Because we have decided to take another look at the 75 percent rule, we will be instructing our fiscal intermediaries to refrain from enforcing the rule until the revised rule becomes effective," said Scully. "But the rule remains extremely important in separating inpatient rehab hospitals from other types of inpatient facilities, and ensuring the Medicare pays for patients who are getting intensive rehabilitation in the most appropriate setting."

The notice of proposed rulemaking was published in the *Federal Register*. CMS will accept comments on the proposal until November 3, and will publish a final rule as soon thereafter as possible.

Asthma Drugs Serevent and Advair to Carry New Warning

The FDA is adding new safety information and warnings to the labeling of drug products that contain salmeterol, a bronchodilator used to treat asthma and chronic obstructive pulmonary disease. The new labeling will warn about a small increased risk of life-threatening asthma episodes or asthma-related deaths seen in a recent study. Affected products are Serevent Inhalation Aerosol, Serevent Diskus, and Advair Diskus. <www.fda.gov/bbs/topics/ANSWERS/2003/ANS01248.html>

NHLBI Study Finds Moderate Physical Activity Promotes Weight Loss as Much as Intense Exercise

Women trying to lose weight can benefit as much from a moderate physical activity as from an intense workout, according to a new study supported by the National Heart, Lung, and Blood Institute (NHLBI), part of the National Institutes of Health in Bethesda, Maryland.

Prior studies had focused on short-term weight loss. Data were lacking about the optimal degree and amount of physical activity for long-term weight loss.

The study, "Effect of Exercise Dose and Intensity on Weight Loss in Overweight, Sedentary Women: A Randomized Trial" appears in the *The Journal of the American Medical Association* (JAMA).

The same issue of JAMA also includes an article on recreational physical activity and breast cancer risk. The study, based on data from the Women's Health Initiative's Observational Study, found that increased physical activity was associated with a reduced risk for breast cancer in postmenopausal women. Longer duration physical activity gave the most benefit but the physical activity did not need to be strenuous to reduce breast cancer risk.

The exercise dose and intensity trial involved 201 overweight but otherwise healthy women ages 21-45. All received reduced calorie meals in addition to being randomly assigned to one of four physical activity regimens, which varied by intensity and duration. The regimens consisted of either a moderate or vigorous intensity physical activity performed for either a shorter (21/2 to 31/2 hours per week) or longer (31/2 to 5 hours per week) duration. The physical activity consisted primarily of brisk walking, and the regimens used about 1,000 or 2,000 kcal per week.

Women in all four groups lost a significant amount of weight, about 13 to 20 pounds, and maintained their weight loss for a year. They also improved their cardiorespiratory fitness. However, the amount of weight lost or fitness improvement was not different among the four groups.

FDA Explains Proposed Changes to Safety Reporting Requirements

The FDA has posted an updated list of 10 questions and answers to help explain a rule the agency has proposed that would revise current safety reporting regulations for drug and biological products. The proposal is aimed at strengthening FDA's role in managing the risks of medical product use, both during clinical trials and when products are on the market.

The updated list also is intended to help clarify the FDA's current thinking about standardized medical terminology for postmarketing safety reporting. The list can be viewed at <www.fda.gov/oc/initiatives/barcode-sadr/qa-sadr.html>.

FDA Launches Collaborative Campaign to Inform Women About Menopausal Hormone Therapy

The FDA has launched a campaign aimed at raising awareness about recent findings on risks and benefits of menopausal hormone therapy. Working in collaboration with NIH and other Department of Health and Human Services agencies, FDA has developed science-based informational materials on its latest guidance on menopausal hormone therapies (estrogens and estrogens with progestins), and is working closely with women's health organizations, community-based organizations and other experts to get this information out to women and health-care providers.

The main tools of the campaign are a menopause and hormone therapy fact sheet, and a purse guide that provides questions for discussion with a health professional. These materials are available in both English and in Spanish at <www.fda.gov/womens/menopause>.

The campaign, led by FDA and HHS agencies, is also being sponsored by a wide variety of participating organizations. It is designed to clarify the recent information from studies including the landmark Women's Health Initiative Study (WHI), one arm of which was halted in July 2002 due to concerns about increased risks of heart disease, stroke, breast cancer and other health concerns.

In January 2003, based on the findings of the WHI study, FDA advised women and health care professionals that menopausal hormone therapy, estrogen and estrogen with progestin, is associated with an increased risk of heart disease, heart attacks, strokes, and breast cancer. The warning emphasized that these products are not approved for heart disease prevention.

The FDA has also modified the approved indications of these menopausal hormone therapies (estrogen and progestin hormone products) to clarify that these drugs should be used only when the benefits clearly outweigh risks. As new information becomes available that affects women's health, FDA will be carefully evaluating that information to ensure that FDA-approved products remain safe and effective.

TDH Website Lists Pregnancy, Parenting and Depression Resource List

House Bill 341, which became effective September 1, requires physicians who provide prenatal care to a pregnant woman during gestation or at delivery to provide the woman with a list of professional organizations that provide postpartum counseling and assistance to parents. The resource list developed by the Texas Department of Health (TDH) can now be found on its website at <www.tdh.state.tx.us>. TDH recommends that the information be given twice, once at the first prenatal visit and again after delivery.

For more information on HB341 or postpartum depression, please contact Chan McDermott, Perinatal Health Program, at 512-458-7796 or <chan.mcdermott@tdh.state.tx.us>.

Bay Area Corpus Christi Medical Center Welcomes Eight New Interns

Eight new interns began their training at Bay Area Corpus Christi Medical Center on July 1, 2003.


Adibeh Awaida, D.O.


Norman Crabb, D.O.


Clinton Damron, D.O.


Rajpaul Ganesh, D.O.


Nicole Marietta, D.O.


Carolyn Smith, D.O.


Kirk Smith, D.O.


Connie Speece, D.O.

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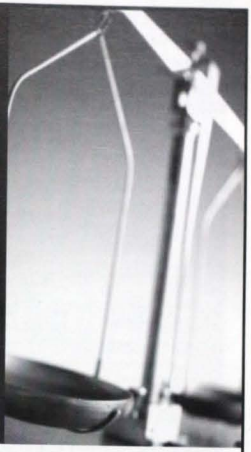

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