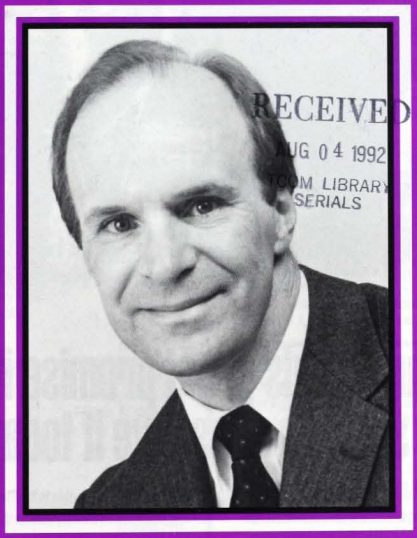
TEXAS DO

XXXXIX, No. 7 TEXAS OSTEOPATHIC MEDICAL ASSOCIATION August, 1992



Robert E. Draba, Ph.D.

Executive Director
American Osteopathic Association

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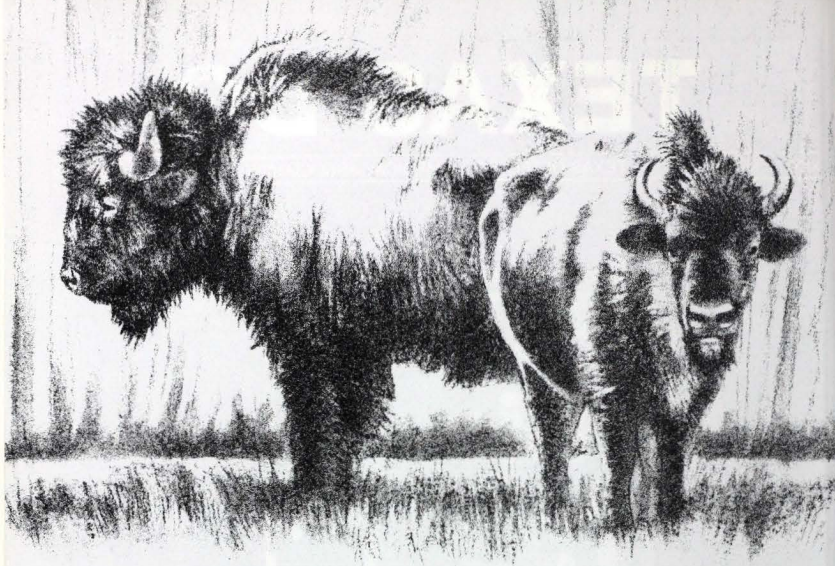

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American Osteopathic Hospital Association	703/684-7700
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Texas College of Osteopathic Medicine	817/735-2000 Dallas Metro 429-9120
Medicare Office:	
Part A Telephone Unit	214/470-0222
Part B Telephone Unit	214/647-2282
Profile Questions	214/669-7408
Provider Numbers:	
Established new physician (solo)	214/669-6162
Established new physician (group)	214/669-6163
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
Texas Osteopathic Medical Association	817/336-0549 in Texas 800/444-TOMA Dallas Metro 429-9755 FAX No. 817/336-8801
TOMA Med-Search	in Texas 800/444-TOMA
TEXAS STATE AGENCIES:	
Department of Human Services	512/450-3011
Department of Public Safety:	
Controlled Substances Division	512/465-2188
Triplicate Prescription Section	512/465-2189
State Board of Health	512/458-7111
State Board of Medical Examiners	512/834-7728
Texas State Board of Medical Examiners (for disciplinary actions only)	800/248-4062
State Board of Pharmacy	512/832-0661
State of Texas Poison Center for Doctors & Hospitals Only	713/765-1420 800/392-8548 Houston Metro 654-1701
Texas Workers' Compensation Commission	512/448-7900
FEDERAL AGENCIES:	
Drug Enforcement Administration:	
For state narcotics number	512/465-2000 ext 3074
For DEA number (form 224)	214/767-7250
CANCER INFORMATION:	
Cancer Information Service	713/792-3245 in Texas 800/392-2040

TEXAS DO

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

FEATURES

DEPARTMENTS

TEXAS DO
TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

August, 1992

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Calendar of Events

SEPTEMBER

11-13

"Midyear Meeting"
Florida Osteopathic Medical Association
Hyatt Regency Westshore
Tampa, Florida
Hours: 20 (1-A)
Contact: FOMA
904/878-7364

12

TOMA Board of Trustees Meeting
10:00 A.M.
TOMA Headquarters Building
Fort Worth, Texas
Contact: TOMA
817/336-0549

ATOMA Board of Trustees Meeting
TOMA Headquarters Building
Contact: Peggy Rodgers
817/429-4140

25-27

"Annual Convention"
South Carolina Osteopathic Medical Association
Hyatt Regency
Hilton Head, SC
Hours: 22 (1-A)
Contact: Harold Nicolette, D.O.
803/766-4100

25-26

TCOM Alumni Association
Homecoming Weekend
Contact: Verlie Edwards
817/735-2559

26-27

Primary Care Update IX
TCOM Continuing Medical Education
Contact: Nancy J. Popejoy
Program Director
817/735-2581

OCTOBER

4-10

"National Osteopathic Medicine" Week

24-25

Osteopathic Manipulative Medicine Seminar
University of Osteopathic Medicine and Health Sciences
Location: 3200 Grand Avenue
Des Moines, Iowa
Contact: Gena Alcorn
Continuing Education Coord.
UOMHS
3200 Grand Avenue
Des Moines, IA 50312-4198
515/271-1480

NOVEMBER

1

"Annual Texas Health Professionals' Peer Assistance Conference"
Texas Pharmaceutical Association
Austin, Texas

1-5

"Annual Convention"
American Osteopathic Association
Marriott
San Diego, CA
Contact: AOA Bureau of Conventions
312/280-5800

3

ELECTION DAY
(Be sure to get your Absentee Ballot before you leave to attend AOA's Annual Convention.)

DECEMBER

12

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

CLIA
Compliance Made Easy

Laboratory testing in physician's offices has been an important part of medicine for years. Now federal regulations to govern the operation of these labs have been developed by the U.S. Health Care Financing Administration under the mandate of the Clinical Laboratory Improvement Act (CLIA-'88).

As of September 1, 1992, all laboratories, physician offices, or other entities performing testing on human specimens for the diagnosis, prevention, or treatment of disease must be CLIA certified by having either a certificte of waiver or a registration certificate. Without one of these, a lab is not in legal compliance nor does it qualify for Medicare and Medicaid reimbursements.

New Manual Cuts The Red Tape

A new manual is available that cuts through the bureaucratic jargon of the CLIA regulations. Developed by the medical and legal staff of Current Concept Seminars, Inc., the nation's largest independent producer of professional education programs, CLIA COMPLIANCE MADE EASY will assist you and your staff to quickly and easily understand the various requirements of the regulations. Topics covered in the manual include:

- Who is covered
- Proficiency testing
- Personnel standards
- Inspections
- Quality control assurance

and much more, including a complete copy of the federal regulations.

CLIA Timeline — The following are the key dates and actions for compliance with the federal government's CLIA '88 regulations.

July 1992	Initial registration fees due HCFA
July-August 1992	HCFA mails inspection bills
September 1992	CLIA standards must be in effect, inspections begin
January 1994	Proficiency testing begins
January 1995	Sanctions for failing proficiency testing implemented
September 1997	Technicians in high complexity labs must have completed associate's degree

— — Also Now Available — —

HAZARD COMMUNICATIONS: A COMPLIANCE KIT

A complete, easy to use package

The Occupational, Safety and Health Administration recently enacted its regulations on bloodborne pathogens. But a separate OSHA regulation also requires that the hazards associated with all chemicals produced or imported into the workplace be evaluated and that information concerning these hazards be transmitted to employees. This is the so-called Right to Know Law, which has been in effect since 1986.

The regulation requires a comprehensive hazard communications program, which should include labeling and other forms of warning, material safety data sheets (MSDS) and employee training. HAZARD COMMUNICATIONS: A COMPLIANCE KIT was developed to "translate" OSHA's requirements into easily understood language. Among the topics covered in this kit:

- How to come into compliance
- An employee training program
- Identifying/listing hazardous chemicals
- A sample hazard communications program

Please send me: Texas-TOMA

_____ copies of CLIA COMPLIANCE MADE EASY at $39.95 each

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AOA Washington Update

Health Reform Proves To Be A Daunting Task

Lawmakers on Capitol Hill are hard at work trying to put together a health care reform package that could muster enough support to pass this session. The biggest roadblock to date is consensus. While it is finally apparent that almost all members recognize the critical need to act on health care reform, the substance of such reform is still very much in doubt. Chairman of the Ways and Means Committee Rostenkowski is loath to provide President Bush with veto bait while other Democratic members of the Ways and Means Committee argue that a plan without substance is worse than no plan at all. Meanwhile, the Republican Committee members believe it is critical to the Republican platform that they appear to be active in the health care reform debate.

At the same time, the Democratic leadership is pushing for action on some health reform plan during the week of July 7. Just exactly what the plan will look like is up for grabs. Some Hill cronies report that the House may be presented with the five plans currently vying for the support of the 435 members in a "king of the hill" legislative scramble where the last plan to survive is the bill which wins.

While the plan is touted s the Ways and Means Health Subcommittee Plan, Chairman Stark is having a difficult time garnering support for his measure. Of the full Ways and Means Committee only seven members said they would support such a bill. Others noted that there is no good news in a plan which makes few reforms but imposes strict cost controls. Thus Republican Ways and Means Committee Members lead by Willis Gradison (R-Ohio) introduced their own health reform legislation which includes many provisions in President Bush's plan and Senator Lloyd Bentsen's (D-Tx) proposal. In fact, some Hill insiders believe the House Republican plan stands a better chance at passing both houses by the close of the legislative session because it combines specific health reforms with minimal disruption to the current health care system. As an "incremental" reform package, it is also likely to garner the greatest support among conservatives unwilling to go too far with reform and liberals hoping to make small changes this session in anticipation of greater changes next Congress.

A summary of the two major proposals follows:

The Ways and Means Health Subcommittee Reform Plan

Health Insurance Reforms: Imposes a series of coverage and affordability requirements on private insurance plans including employer groups and self-insured groups.

Self-Employment Deduction Expansion: Expands the self-employed deduction for health insurance expenses to 100 percent (currently the self-employed are allowed a 25 percent deduction). Establishes "administrative simplification" measures designed to reduce overall system costs, including: a uniform electronic billing system for all providers and payors; a single uniform coding system for all diagnoses and procedures; and, a national electronic claims network.

Expansion of Medicare Preventive Benefits: Expands the preventive health coverage under Medicare including: annual mammograms for women over 65; colorectal cancer screening; influenza vaccinations; and, tetnus vaccinations. Establishes a prescription drug benefit under Medicare.

Strict Cost Controls: Imposes strict cost controls including national limits on health spending; payment for all providers under Medicare rules; and, limits on payments for medical equipment, laboratory tests and prescription drugs.

Depends heavily on the recommendations of the Prospective Payment Assessment Commission (ProPAC) and the Physician Payment Review Commission (PPRC) on the allocation of national expenditures among hospitals, physicians and other sectors of the health care system.

National Health Care Fraud Control Program: Establishes a national health care fraud control program. Under the fraud control banner, all-payor fraud and abuse policies would be requires to follow Medicare policies. Extends the physician ownership/referral law to services reimbursed by all payors.

The House Republican Health Reform Plan (H.R. 5325)

Small Employer Insurance: Sets federal requirements for health insurers to make plans more affordable for employees of small companies. Limits coverage exclusions for pre-existing conditions and for small groups with a history of high medical bills. Limits annual premium increases and premium differences among small groups. Requires insurers to offer at least two plans, one providing only "essential medical and preventive benefits" and the other a more generous package.

Self-Employed Health Insurance Deduction: Expands the tax deduction for health insurance premiums from 25 percent to 100 percent.

Community and Rural Health Centers: Authorizes an additional $300 million for the Community and Rural Health Centers. Includes CHC providers under the Federal Tort Claims Act for malpractice covergae. Authorizes a series of grants to train emergency personnel, develop air transport systems, and improve telecommunications links in rural areas. Reauthorizes extra Medicare payments to rural hospitals.

Malpractice Reform: Requires all medical liability claims to be handled first through a dispute resolution process before proceeding to court. Caps attorney fees and damages for pain and suffering, and requires that punitive damages be paid to the state with the funds allocated to programs to reduce the incidence of malpractice. ▸

Administrative Simplification: Establishes administrative reforms such as mandatory standardized claims forms; the use of electronic billing systems; and, uniform provider reporting standards.

Physician Referral Ban: Extends the Stark referral legislation to diagnostic imaging and physical therapy clinics and other facilities owned by referring physicians.

PPRC/HHS Recommend MVPS to Congress

Both the Physician Payment Review Commission (PPRC) and the Department of Health and Human Services have recommended a 0.3 percent increase for non-surgical services and 2.6 percent increase for surgical services for the 1993 volume performance standard (VPS). Unless lawmakers act to change these figures — which is considered unlikely — these updates will go into effect January 1, 1993. The figures are the result of the "default" formula which was included in the OBRA 89 physician payment law.

The two updates will result in two conversion factors, one for surgical services and the other for non-surgical services. Recommendations for the '93 update were delayed due to the reemergence of the old debate about the value and fairness of separate update factors. The arguments illuminate contradictory goals of payment reform. On one hand, the Congress established the VPS to provide a financial incentive to reduce unnecessary services. Thus, the VPS should reward physicians who curtail their spending. Payment reform was also intended, however, to provide more equity in payment by shifting funds to the non-surgical services. Under this VPS, the total Medicare spending in 1993 for non-surgical services 1993 will increase by 0.3 percent and for surgical services will increase by 2.6 percent.

Although the PPRC recommended separate payment updates for this year, the Commission urged that the update apply only to 1993 and not be built into the baseline for future payment. The Commission favors the separate formula for now only because it is part of the law but notes that in the long run it will support a single update and single performance standard.

Congress Proposes Reimbursement for Physicians' Management of Home Health Patients

A bill recently introduced by Senator Christopher (Kit) Bond (R-Mo) would require a study to determine whether physicians should be reimbursed under the Medicare program for the management of home health patients. The Senior Home Care Choice Fairness and Improvement Act (S. 2686) which was introduced May 12, 1992 aims to increase the utilization of home health care as a means to improve the delivery of cost effective health care alternatives. The bill is currently pending in the Senate Finance Committee.

The advent of cost containment programs has shortened hospital stays and increased the use of home care as Medicare patients gradually recover from acute illnesses. The attending physician in these cases, however, remains responsible for the care rendered to the patient and orders the home health visits and treatments provided. The AOA recently investigated the potential for Medicare to expand the home health coverage for reimbursement under Part B. The Health Care Financing Administration (HCFA) responded that Medicare law provided only for home health care reimbursement under Part A — eliminating any possibility for physician payment. The Agency added further that physicians are reimbursed for these services in their billing for evaluation and management services for the patient.

The Bond legislation opens the door to change this policy. S. 2686 would provide for the study of the cost-effectiveness and desirability of reimbursing physicians for providing medical management for complex health care services rendered in the home. It also includes a provision to study the feasibility and propriety of physician reimbursement for select home health cases which require intense physician involvement. The bill also extends "spousal impoverishment" protections included under the Medicaid program to couples wishing to utilize home health care as an alternative to institutional care. Currently, the spousal impoverishment protections apply only to costly institutional care. The protections provide a financial floor for the spouses of patients requiring long-term care services by allowing the healthy spouse to retain a portion of the income and assets of the couple in addition to receiving federal assistance.

Time and fiscal constraints however, make passage of this bill unlikely in this Congress.

Kusserow Resigns

The much maligned Inspector General of the Department of Health and Human Services, Richard Kusserow is resigning to take a position in the private sector. Known for his ambitious strategies for locating health care fraud and abuse, Kusserow served 11 years in the IG post. He will become a consultant with Strategic Management Associates, a Washington, D.C.-based firm.

During his tenure, Kusserow claimed to save the government $50 billion with his tough investigations on health care fraud and abuse. The health care community however, told a different story. Many claimed his tactics were unethical and ruthless causing organized medicine to call for his resignation. Among the laws implemented during his reign include anti-kickback plans and safe harbor rules.

D.O.S. Nominated To Cardiology Panels

The American Osteopathic Association recently submitted four candidates to panels being established by the Agency for Health Care Policy and Research on the Management of Cardiac Dysrhythmia, the Diagnosis and Management of Unstable Angina, and Cardiac Rehabilitation. The panels are charged with the review and consideration of practice guidelines for these clinical conditions. ■

AOA Names New Executive Director

The American Osteopathic Association tapped the ranks of osteopathic colleges to select Robert E. Draba, Ph.D., as its new Executive Director, to help lead the profession into its second century.

A resident of Munster, Indiana, Dr. Draba has held several positions at the Chicago Osteopathic Health Systems (COHS) and Chicago College of Osteopathic Medicine (CCOM), separate divisions of a $200 million corporation that provides health care services and osteopathic physician training in Chicago, Olympic Fields, Illinois, and Downers Grove, Illinois.

He began his stint at CCOM in 1981 as the director of evaluation and measurement before assuming the director of educational resources and administration/basic sciences position in 1983. He became associate director of intern and resident training in 1984 and also worked as associate professor of medical education, where he proposed that COHS-CCOM open a school of pharmacy, a project that the osteopathic college broke ground on last year.

Dr. Draba moved over to COHS in 1986, serving as director of corporate services from 1986 to 1988. He became assistant to the president in 1986 and then served in a dual capacity as executive secretary of the boards and vice president, administration. In this position, Dr. Draba prepared the corporate budget and oversaw expenditures of the Office of the President. He also helped develop a consolidated budget of $200 million for COH's operating divisions.

Dr. Draba came to CCOM from Gary Community School Corporation, a public school system in northwest Indiana where he was educational analyst; coordinator of basic skills; and English, reading and journalism teacher. At Gary Community School Corporation he implemented school-wide tests of basic skills and identified students with deficiencies in writing, reading and math. He also sponsored an award-winning student newspaper.

Dr. Draba completed a double major in English and social studies at Indiana University in 1968. After graduation he entered the Peace Corps, where he created an English language learning laboratory and organized a volunteer program with Filipino university students. In 1970, he designed the first Peace Corps training project held entirely in the host country.

He received a Ph.D. and M.S.T. in administration and psychometrics and a master's in business administration from the University of Chicago.

Dr. Draba has been a frequent contributor to both the *Journal of the American Osteopathic Association* and *The D.O.*, both monthly publications of the AOA. He replaces John P. Perrin, who resigned in November of 1991. ■

NIA Testing Non-Drug Therapies for Hypertension

Scientists supported by the National Institute on Aging (NIA) and the National Heart, Lung and Blood Institute (NHLBI) are studying two non-drug therapies — weight loss and salt restriction — to see if they are safe and effective long-term substitutes for high blood pressure medication in older people.

The Institutes have pumped $2.8 million into the first year of a clinical trial, known as the DIET (Dietary Intervention in the Elderly Trial) study, to determine how many older people with hypertension can be treated safely without drugs. The study will last four years and follow 900 overweight and normal weight older men and women with hypertension.

According to Dr. James Cooper, chief of the NIA's cardiovascular program, previous studies have shown that weight loss and sodium restriction are effective in controlling high blood pressure in many middle-aged volunteers for at least one year. "We hope this study will demonstrate that these dietary interventions are effective in older individuals, and that the effect is long lasting," he said

The NIA and the NHLBI are two of the 13 National Institutes of Health. The NIA is responsible for the conduct and support of research on the aging process and the study of diseases and other special problems and needs of older people. The NHLBI is responsible for the conduct and support of research on cardiovascular, pulmonary, and blood diseases in all age groups. ■

Finding Physicians for Rural Texas

by Troy Alexander

Finding physicians for rural Texas, that is what HealthFind is all about. Created by the Texas Center for Rural Health Initiatives in 1991, HealthFind is a linkage between prospective physicians and Texas rural communities searching for a doctor. The Exchange is geared toward the resident or practicing physician seeking a practice location in rural Texas. HealthFind provides physicians a unique opportunity to visit with business and community leaders from rural Texas communities needing primary care physicians, or more specifically, family physicians.

Many organizations are pooling their resources for the 1992 HealthFind Exchange. The TAFP has contributed staff time, produced HealthFind T-shirts and donated advertising to the project. Other organizations which are assisting in the coordinated effort include the Health Care Options for Rural Communities, Texas Department of Health, Texas Higher Education Coordinating Board, Texas Hospital Association, Texas Medical Association, Texas Osteopathic Medical Association and Texas Organization of Rural and Community Hospitals.

HealthFind is need driven, since Texas currently has 159 health professional shortage areas, an increase of 100 from the 1980s. There are currently 17 Texas counties with no licensed physician and many more with only one physician. Additionally, 47 Texas counties rely solely upon care provided by family physicians. This evidence exemplifies the need to connect those rural practice opportunities with prospective physicians.

The 1992 HealthFind Exchange is a two-day meeting which will be held in Fort Worth at the Worthington Hotel, from 10 a.m. Saturday, Sept. 26 until 3:30 p.m. Sunday, Sept. 27. The Exchange is limited to enrolling 50 rural communities. Participating communities are designated as rural and have a population of less than 30,000. Each community will have a booth displaying items which are representative of their area. A community may decide to cover one section of their booth with photographs featuring their town. At last year's Exchange, Floydada, located in West Texas, focused on their home grown gourds which they used as a decorative focal point. Floydada's representatives also wore pumpkin nametags. Creative booths such as these attract more physicians.

The prospective physicians are able to move from booth to booth, visiting with community representatives and hearing about each town and its environment. The physicians are able to discuss what kind of recruitment package each community is offering to physicians who agree to practice in their community.

The HealthFind program is not just one large event, though. A great deal of preparation goes into the HealthFind Exchange. Many of the participating communities attended workshops geared to teach their representatives how to recruit a physician and how to market their community. These workshops were held in April, May and June in five different locations around the state: Amarillo, Odessa, Nacogdoches, Corpus Christi and Austin. The workshops are vital to helping communities have a successful recruitment at the HealthFind Exchange.

This year the Texas Center for Rural Health Initiatives is encouraging attending physicians to visit each booth. Those physicians who visit each booth qualify for a 1992 HealthFind T-shirt, compliments of the TAFP. Once the physician visits each booth, his/her name is entered into a drawing for door prizes. The intended result is that each physician will have an opportunity to see all of the available incentive packages and practice opportunities.

Approximately 50 physicians, mostly first, second and third year residents, attended the Fall 1991 HealthFind Exchange. The 1991 Exchange matched five physicians with recruiting communities, and an additional three physicians are in the contract stages of the negotiating process.

Registration costs for prospective physicians attending the 1992 HealthFind Exchange are $30 for Resident Physicians and $125 for Practicing Physicians. Registration includes:

- Hotel room Saturday night for the physician, spouse and children
- Two luncheons, a reception and breakfast for the physician and spouse
- Child care and meals for children
- A continuing medical education seminar

The registration deadline for physicians is September 4, 1992. For more information contact: Carol Peters, Texas Center for Rural Health Initiatives by phone at (512) 479-8891 or by mail at P.O. Drawer 1708, Austin, Texas 78767.

Excerpt from "Texas Family Physician"

In Memoriam

Thomas P. Galbraith

Thomas P. "Tommy" Galbraith, of Gordonville passed away on June 16 in a Grand Prairie hospital after a short illness. He was 72 years of age. He was the father of immediate past ATOMA president, Rita Baker, of Fort Worth.

A rosary service was held at Bean-Massey-Burge Funeral Chapel and a mass was held at Holy Cross Catholic Church in Madill, Oklahoma. Burial was in Dixie Cemetery in Whitesboro.

Mr. Galbraith was a native of Arlington and had been a resident of Gordonville for the past six years. He was also a former resident of Duncanville and Wichita Falls. He retired in 1982 from National Cash Register after 32 years of service as a service manager.

He was a former member of the Lions Club and Kiwanis Club. He also served in the U.S. Air Corps during World War II as a crew chief in Bomber Squadron. He was a member of the Holy Cross Catholic Church in Madill, Oklahoma.

Mr. Galbraith is survived by his wife, Rita Galbraith of Gordonville; sons, Barry Galbraith of Bedford and Jimmy Galbraith of Arlington; sons and daughters-in-law, Tommy and Sherry Galbraith Jr. of Carrollton, Stan and Camille Galbraith of Wichita Falls, and John and Susan Galbraith of Plano; daughter, Montie Smith of Dallas; daughters and sons-in-law, Peggy and Edward Gahagan of Wichita Falls and Rita and Mark Baker of Fort Worth; and 11 grandchildren and one great-grandchild.

Dale W. McCormack, D.O.

Dr. Dale W. McCormack passed away on July 5, 1992, in Park County, Colorado. He was 32 years of age.

Funeral services were held July 10 at the First United Methodist Church in Hurst, where he was a member. Burial was in Bluebonnet Hills Memorial Park in Colleyville.

Dr. McCormack was a 1972 graduate of L.D. Bell High School in Bedford, and attended the University of North Texas at Denton and Tarrant County Junior College. He graduated from Texas College of Osteopathic Medicine in 1988. He served an internship at Osteopathic Medical Center of Texas in Fort Worth.

He was a lifelong Fort Worth resident, and served as the director of the Granbury Hospital emergency room in Granbury, Texas.

Survivors include his wife, Ada Dean Strickland of Fort Worth; father, James McCormack of Hurst; brother, Mike McCormack of Euless; two sisters, Elaine Harris of Grand Prairie and Audrey Belue of Bedford; and grandmother, Mary Fox of Gober.

In lieu of flowers, the family has suggested that memorials be made to the Dr. Dale McCormack Scholarship Fund at the Texas College of Osteopathic Medicine, 3500 Camp Bowie Boulevard, Fort Worth, Texas 76107.

John C. Conte, D.O.

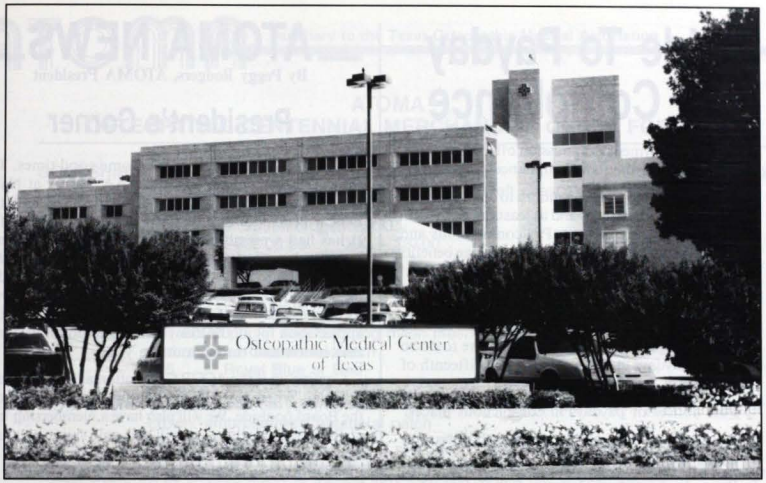
Dr. John C. Conte passed away on July 10 in Dallas. He was 39 years of age.

Funeral services were held July 12 at Shannon Rose Hill Funeral Chapel.

Dr. Conte was born in Margate, England, and lived in Fort Worth off and on for 12 years. He graduated from John Jay High School in San Antonio in 1971, and attended St. Mary's in San Antonio and the University of Texas at San Antonio. He received his D.O. degree in 1983 from Texas College of Osteopathic Medicine. Dr. Conte served an internship at Doctors Hospital in Groves and an occupational medicine residency at the University of Texas School of Public Health in Houston.

He was an assistant professor in the Department of Public Health and Preventive Medicine at Texas College of Osteopathic Medicine. Memberships included TOMA, American Osteopathic Academy of Sports Medicine and Temple Bethel Church. Dr. Conte was a retired Navy lieutenant.

Survivors include two brothers, Michael Conte of Kyle and Daniel Conte of Austin; and a sister, Concetta Johnson of San Antonio.



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For more information or to refer a patient, contact our Physician Support Services at 1-800-725-OMCT. (6628).

Osteopathic Medical Center of Texas

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Guide To Payday Law Compliance

The Texas Employment Commission offers the following easy steps to payday law compliance.

1. Pay wages at least twice a month to employees not exempt from overtime, and at least once a month to those who are exempt. Pay commissions and bonuses on time as agreed, and pay fringe benefits as agreed in writing.
2. Make semi-monthly pay periods as equal as possible.
3. Designate paydays. The law says failure to do so means paydays must be the first and fifteenth of the month.
4. Post notices of paydays in conspicuous places.
5. Pay an absent employee on a regular business day at the employee's request.
6. Pay a discharged employee in full no later than the sixth day after discharge, and an employee who quits no later than the next regularly scheduled payday.
7. Pay wages by electronic funds transfer, check negotiable on demand or cash, unless the employee agrees in writing to payment in another form.
8. Send wages by registered mail to arrive by payday, or deliver wages to employees at work, unless the employees agree in writing to payment by other means.
9. Do not deduct from an employee's wages unless ordered by a court, authorized by law or authorized in writing by the employee for a lawful purpose.
10. Comply on time with all TEC and court orders on payment of wages, penalties and bonds.
11. Give paychecks to the employee only, unless the worker authorizes in writing that the check can be given to someone else.
12. Call 1-800-342-3836 for advice anytime there is a question about the Texas Payday Law.
13. Post a required payday poster notifying employees where complaints can be filed if there is ever a dispute over a paycheck.

TexasBusiness Today

ATOMA NEWS

By Peggy Rodgers, ATOMA President

President's Corner

Summertime certainly brings some good times. This summer began for me with the SAA Dinner at Nancy Zachary's house on May 29 prior to the Installation Luncheon on Saturday. We had a wonderful time. District II has had a membership drive at Tulisha Buchanan's house in June in the form of a Luau. What a great idea! Rita Baker also had a Girls Night Out at her house during June. Good times. On July 7, Rita, B.J., and myself took the TOMA office out to Tours Restaurant in appreciation for all the many things they do for us during convention and throughout the year.

Coming up is the ACGP Convention at the Doubletree in Irving, where we will have a brainstorming session of the Board poolside. We will also have a membership table at Registration where we will sell golf shirts, ties, and hats. Ranger games seem to be a great place to get together for district meetings also. Summer can be a fun time for getting together and increasing membership.

During June I went to a marketing session representing AAOA. They have authored a cookbook, "Still Gathering. . .Centennial Celebration." This can be a moneymaking project on the District level. It has photos and stories of osteopathy and 700 tested recipes. This could be a good promotion during NOM Week. If you are interested in ordering some for you or your district, please contact me for an order form or refer to your "Accent" for more info. There is a price break if ordered by the end of September.

This year we are changing our fiscal year to January - December. We will be billing in October instead of January. When you pay your dues you will get a membership card to carry in your wallet. We would love to hear your ideas on your membership drives in your districts. Even if you plan a semi-annual get together in unorganized districts, we would love to hear what your district is doing. The perfect way to let us know of your activities is to write them up for the *"Texas DO."* Send your articles into the TOMA office by the 10th of the month to go in the next month. There will be more next month in the *"Texas DO"* about our membership drive.

There will be an ad for ordering golf shirts in the *"Texas DO"* each month. Some districts are considering buying some for door prizes at their district meetings and getting some financial help from different donors. Contact me for orders and information. We appreciate all of you for financially supporting ATOMA in your purchases. THANKS.

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
$15 Royal Blue or Red

VISOR: 100% polyester, soft terrycloth sweatband, adjustable headband, 2-3/4″ high crown, embroidered Centennial patch
$12 Royal Blue or Red

**Most orders will be shipped within 10 working days from the 1st and 15th of each month.
**Freight and handling charges — Add $3.00 for the 1st item and $1 for each additional item — $10.00 max.

NAME:_____ DAYTIME PHONE_____

MAILING ADDRESS:_____

QTY.	ITEM	SIZE	COLOR	PRICE	TOTAL

**This merchandise is a fundraiser for ATOMA as well as a way to promote and celebrate 100 years of Osteopathic Medicine. Thank you for your support!

SUBTOTAL_____
FREIGHT_____
TOTAL_____

**Mail your order form and check to:
Peggy Rodgers
ATOMA Fundraiser
3711 Melstone
Arlington, Texas 76016

(Make your check out to ATOMA.)

Texas ACGP Update

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

The Texas Medicaid Reimbursement Methodology (TMRM), which went into effect on April 1, 1992, is still not well understood by some Texas physicians. For many years, primary care physicians were on the short end of the stick when it came to Medicaid reimbursement. The TMRM was designed to improve reimbursement for primary care physicians; however, if physicians do not familiarize themselves with how the system works, they probably will not see any improvement in Medicaid reimbursement. For example, physicians should have a single fee structure for all patients. Third party payers usually do not pay the billed amount unless that charge is equal to or lower than the approved amount set by the insurance company. If physicians have set their fees for medical services lower than the approved amount set by the third party payers, they will continue to be reimbursed at a rate less than the fair market value for those services.

Evaluation and management code 99213 for an established patient, office or outpatient visit, is $26.87 under the TMRM. A Texas physician who submits a charge of $13 to Medicaid for code 99213 will not receive the approved amount of $26.87.

The Texas Medicaid program will pay your fee, $13, or the TMRM fee, $26.87, whichever is the lowest.

If this physician adjusts his or her fee schedule so that code 99213 is equal to or greater than $26.87, then and only then would that physician receive 100 percent of the allowable fee set by Texas Medicaid.

Physicians must decide for themselves what to charge for their medical services. In some cases, it may simply be based on what they charge private pay patients. However, the patient mix (private pay, Medicare, Medicaid, etc.) should influence the final calculation of medical fees. Remember, the Texas Department of Human Services has done its part. It has substantially increased reimbursement for primary care services under Texas Medicaid. Now it's up to Texas primary care physicians to correctly utilize the new system of reimbursement.

In case some of the Texas ACGP membership did not receive a flyer from TOMA regarding how osteopathic manipulative treatment (OMT) would be treated under the TMRM, it is reprinted here for your information. The information comes from the *Texas Medicaid Bulletin, No. 88, March 1992.*

"Effective for dates of service on or after April 1, 1992, the following procedure codes must be used by all providers when billing for OMT.

Code 1-97260
Code 1-97261

Procedure code 1-97261 (manipulation, each additional area) is limited to three areas per day. NHIC will allow payment for physical therapy in addition to OMT on the same day.

All claims filing procedures as outlined on pages 316 and 317 of the 1991 Medicaid Provider Procedures Manual, must be followed to ensure accurate claims processing. The modifier "AT" must be used when identifying an acute condition.

OMT continues to be a noncovered service to independently practicing physical therapists."

The allowable fee for Code 1-97260 is $11.55 and for Code 1-97261 is $6.45.

On Friday, July 10, 1992, I attended the Texas Department of Human Services' Medical Care Advisory Committee meeting in Austin, Texas. A Governor's Health Policy Task Force update was presented by Austin Kessler. His update of tentative recommendations made by the Health Policy Force was informative and chilling. A draft of the final recommendations should be out on August 17, 1992.

I would like to share just a few of his comments with you. A recommendation of equal pay for equal work: the same pay for a midwife as that of a physician for delivering a baby. A recommendation that the Texas State Board of Medical Examiners have a nonphysician executive director and that a majority of its members be lay people. There were many more equally disturbing comments. I have often wondered what it was going to take to wake up many of my fellow physicians to the real world. Think the Governor's Health Policy Task Force will be the cure for Texas physician lethargy.

For years, physicians have had the luxury of sitting on the sidelines and watching various groups do battle over health care issues, without taking sides or getting personally involved. Those days have come and gone forever. In battle, how many bullets do you have to dodge, or casualties do you have to take, before you realize that the other side is serious about wanting to inflict serious harm upon you?

First, visualize a high winding mountain road with wide shoulders, and no guard rail. Over the years, erosion has taken its toll and those wide shoulders have disappeared. The only thing left is the road. Traffic will not allow one to simply stop in the middle of this road; it is going to push you over the side.

The journey down this road will be physically much easier and much quicker than going up the road. It is simpler to give up and let nonphysicians and politicians run us in the health care system. It is to medically default and let nonphysicians and politicians become the sole advocate for our patients while we simply draw our paycheck and look the other way. On the other hand, the journey up this road will be physically hard and slow. ▶

Nonphysicians and politicians will contest your progress every foot of the way. Victories will be shortlived and setbacks will be numerous. Your patients will be your greatest source of strength if you travel the high road. They will remain physician advocates as long as you do not abandon them.

The time has now come when we, as physicians, must decide whether to go up or down this road or get pushed off of it.

Today, more than ever, the justification for political action committees and personal political involvement is very clear. It is called survival.

Most physicians do not have the time or the personal resources to lobby on a daily basis on behalf of their patients and for quality health care. The Texas Osteopathic Medical Association Political Action Committee was established to protect and promote the interests of osteopathic medicine in Texas. If you are not a member of TOMA-PAC, please consider joining it. Join with us on the journey up the high road. There is strength in numbers. Whatever you decide to do, keep tuned in to what is occuring in Austin regarding health care issues. Don't let nonphysicians and politicians tune you out of the health care debate.

In closing, hope you all like the recent newsletter sent to Texas ACGP members. The Texas ACGP board is working hard to promote the interests of Texas D.O.-G.P.s and to provide more services to its membership. ■

TOMA HAS DISCOVERED AN IMMUNIZATION FOR THE HEALTH INSURANCE "EPIDEMIC"

The high cost, no guarantee system of health insurance coverage is a "disease" that is affecting ALL small employers. Instead of providing long-term, affordable protection from financial losses due to accidents and illness, today's health insurance industry has created tremendous short-term burdens with no certainties of continued coverage in an environment that is as volatile as ever.

A recent item from *Medical Economics* magazine (March 5, 1990) indicates further the troubles that surround small employers, and even more specifically physicians. It reads:

> "While state and federal legislators debate the merits of requiring employers to provide health-care coverage for their workers, health insurers are refusing to issue policies to more and more small businesses and professions. Some carriers are even blacklisting physicians and nurses, chiropractors, dentists, and others in the health-care field. One reason that medical workers may be excluded, carriers say, is they tend to have a high rate of utilization."

Although a total cure for these problems may still be far away, TOMA has discovered an "immunization" for its members that can help shield the frustrations that managing health insurance (or the lack of) can cause.

TOMA has appointed DEAN, JACOBSON Financial Services to handle the complexities of health insurance environment for you. They have just negotiated with CNA Insurance Company (an A+, Excellent rated company with a long, successful record in the accident and health business) to offer Major Medical coverage to TOMA members at very competitive rates. Best of all, with CNA's strength in the health insurance market and DEAN, JACOBSON's management of insurance services, TOMA will have a superior Health Insurance Program that has long been needed.

DEAN, JACOBSON Financial Services is recognized statewide for their expertise in insurance and related areas. So regardless of your current situation with health coverage, call DEAN, JACOBSON Financial Services to help you immunize against the health insurance "epidemic."

For information on coverages, costs, and enrollment forms contact:

DEAN, JACOBSON FINANCIAL SERVICES

(Formerly William H. Dean & Associates)

(817) 335-3214
P.O. Box 470185
Fort Worth, TX 76147

(800) 321-0246
(817) 429-0460
Dallas/Fort Worth Metro

FYI

TERMINOLOGY CHANGE: FROM IVDU TO IDU

Since the AIDS epidemic began, the term "intravenous drug user" (IVDU) was used for individuals who were at risk of HIV infection or had been infected through sharing equipment used for intravenous injection of drugs. However, the Centers for Disease Control (CDC) interviewed people with HIV infection and AIDS who were infected through nonintravenous injection of drugs, for example, injection of heroin under the skin (skin popping). As a result, the CDC adopted the terms "injecting drug user" (IDU) and "drug injector" to describe the risk of those who inject nonintravenously as well as intravenously.

DR. PATRICIA PETERSON RECEIVES AWARD

Patricia Peterson, D.O., daughter of Dr. and Mrs. Donald Peterson of Dallas, graduated from the New England College of Osteopathic Medicine June 7, 1992. Dr Peterson was awarded the Medical Humanities and the Clinical Clerkship Awards at the Awards and Senior Banquet. She will be doing her internship at Brighton Medical Center in Portland, Maine.

ASSISTANCE FOR HEALTH INSURANCE SHOPPERS

Employers needing assistance and/or timely tips choosing health insurance should obtain the Texas Department of Insurance (TDI) booklet "Shopping for Health Insurance." It offers advice on selecting a company; provides telephone numbers to call and confirm license status, financial stability and customer service history; and gives suggestions for companies unable to afford commercial insurance. To receive a booklet, call TDI's Publications Division at (512) 322-4283.

TB RANKINGS

According to the Texas Department of Health, Texas is ranked third in the nation in the total number of TB cases reported in 1991. Texas reported 2,525 cases, which was behind New York with 4,430 cases and California with 5,273 cases.

Among the cities with populations in excess of 250,000, Houston ranked seventh with a rate of 34.5 per 100,000 and El Paso ranked 14th with a rate of 25.9. Austin had a rate of 24.6 per 100,000; Dallas, 21.3; Fort Worth, 18.3; San Antonio, 15.7; and Corpus Christi, 13.9. The big city with the highest rate was Atlanta, Georgia, with a rate of 76.4 per 100,000 population.

LOAN DEFAULTERS MAY HAVE THEIR WAGES GARNISHED

The Texas Guaranteed Student Loan Corp. now has the authority to collect up to 10 percent of a defaulted borrower's paycheck, due to a federal law passed in November. Loan officials plan to begin pursuing this course in mid-August unless repayment arrangements have been made.

Defaulters are defined as borrowers who have made no payments on their loans for at least six months. Additionally, a loan is considered in default when the lending bank files a claim and is reimbursed by the federal government.

According to the Texas Guaranteed Student Loan Corp., the current amount of defaulted loans in Texas is nearly $870 million. Since the program began in 1981, 978,569 students in Texas have used the loans.

To arrange to repay a federally backed student loan that is considered defaulted, call the Texas Guaranteed Student Loan Corp. at 800-222-6297.

ALMOST ONE-FOURTH OF TEXAS CHILDREN LIVE BELOW POVERTY LINE

Nearly 18 percent of all children in the United States live in poverty, according to the Children's Defense Fund, in an analysis of 1990 Census data. Texas tied for seventh place with Alabama in the list of states with the highest child-poverty rates. Mississippi was the leader, with 33.5 percent of the state's children stuck below the poverty line.

New Hampshire led the nation with the lowest poverty rate for children, seven percent, followed by Connecticut, Alaska, Maryland and new Jersey.

Joining Mississippi, Texas and Alabama as the 10 states with the highest poverty rates were Louisiana, New Mexico, West Virginia, Arkansas, Kentucky, Arizona, Oklahoma and South Carolina.

Texas has 1.1 million children, or 24 percent, living below the poverty line.

DR. VASENIUS NAMED "SPECIALIST OF THE YEAR"

On Saturday, June 13, 1992 at Northeast Community Hospital's Annual Intern and Resident Dinner, Keith A. Vasenius, D.O., Assistant Professor of Internal Medicine at TCOM, was named by the interns and residents, Specialist of the Year for 1991-92. Ten years earlier, Chester Godell, D.O., Dr. Vasenius' partner, was also named Specialist of the Year. ■

Public Health Notes

Violence In Our Homes

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

Being the director of public health for our community and a member of the board of directors of our medical society has provided me with a number of unique opportunities which I greatly appreciate. One of those opportunities is that of being able to meet many of you, the members of our society. Another opportunity has been to serve the Texas Medical Association as a representative to the Council on Public Health of the TMA. During our recent meeting which was held in conjunction with the Leadership Conference, we had an unusually large number of items to consider on our agenda. In fact, we met from 6 to almost 11 p.m. on Friday, Feb. 28. The Council on Public Health has the responsibility of recommending policy positions which cover a wide variety of subjects. These recommendations are ultimately taken up by the House of Delegates. Our Council may be asked to consider issues as far ranging as immunization policy, control of youth access to tobacco products, HIV infected physicians, immigration policy, adolescent sex education, and radiation therapy, as examples.

The item which really caught my attention during our most recent meeting was a new one. As a part of its 1992 objectives, the Council on Public Health will take up the issue of family violence. This is something I know very little about. I expect that is true for most physicians. But, as noted in a very fine statement by the Pennsylvania Academy of Family Physicians, "If you have female patients, you treat victims of domestic abuse. Domestic violence is the single largest cause of injury to women in the United States." The first response of many people, I suspect, will be that this is not their concern; that it is a personal matter between family members. That same statement from the Pennsylvania Academy of Family Physicians goes on to point out that 20 percent of medical visits by women are the result of domestic violence and battered children often show up in our emergency rooms.

What is domestic violence? My definition of domestic violence is violent behavior among people who are married, living together or otherwise in an ongoing relationship, and their offspring. According to the National Women Abuse Prevention Project, 95 percent of the victims of this violence are women.

Why don't these women just leave their violent partners? Cultural, social and religious background play some part. Some women will accept the physical and emotional abuse in the hope of keeping the family together, especially if there are children involved. An abusive partner is not abusive 100 percent of the time. In fact, after outbursts of violence, the partner may show great remorse and be very solicitous. This, unfortunately, does not last. Another important reason that women do not leave these relationships is that many are financially dependent on the partner. Statistics tell us that a woman with children who leaves her partner has approximately a 50 percent chance that her standard of living will drop to below the poverty level. Interestingly a battered woman frequently has to deal with the greatest danger when she attempts to leave. There may be threats of violence which may extend to threats on her life. She therefore fears for the safety of her children and her own safety. In fact, 70 percent of all women who are victims of family violence have already left their batterer. They are often stalked, beaten, even killed. Of the women murdered in this country, 30 percent are killed by exhusbands, husbands, or boyfriends.

There are some misconceptions about family violence that must be corrected. Perhaps the greatest misconception is that this is a problem only with lower-income groups of people. This is not correct. Family violence extends across all socioeconomic, ethnic, and racial groups. My first and only experience with domestic violence occurred when I was a medical student. One of my best friends in school was a white, well educated, upper-middle class young man from a "good family." His father was a prominent attorney; his mother a clinical psychologist; the perfect family. Yet, this young man from the perfect family introduced me to domestic violence. He regularly beat his fiancee, at times causing significant injury. I, not knowing the complexities of such relationships, continued to ask her, "Why don't you just leave?" She eventually did so and he did not follow her. It was an experience I will never forget.

Another common misconception is that family violence is caused by alcohol and drug abuse. Alcohol and drug abuse do not cause family violence. Use of such substances may remove inhibitions, but they are not root causes of the violence. Controlling the abuse of alcohol ▸

and other drugs does not necessarily stop the violence within the family.

The Council on Public Health will doubtless address this issue in greater depth in the future. However, because of its prevalence and destructive nature, I've decided to put it before you at this time. What can we as physicians do in combating family violence? Here are some suggestions. (1) Keep an open mind. Family violence is pervasive. It occurs with all ages, races, religions, socioeconomic groups and professional groups. (2) If you suspect abuse, ask the patient. Don't ignore it. She may be hesitant to discuss the issue, but attempt to reassure her and get her to discuss it with you. (3) Give her the phone number of the local domestic violence shelter or program. If she is uncomfortable or afraid, offer to make the call for her.

There are a number of sources of information about domestic violence and shelters available to the citizens of our community.

Texas Department of Human Services
Civil Rights Division
Texas Council on Family Violence
3415 Graystone Drive
Suite 220
Austin, Texas 78731
(512) 794-1133

SHELTERS

Arlington, The Women's Shelter (817) 460-5566

Dallas, The Family Place (214) 941-1991

Denton, Denton County Friends of the Family (817) 382-7273

Fort Worth, Women's Haven of Tarrant County (817) 535-6464

Plano, Collin County Women's Shelter (214) 422-7233

Physicians can play an important role in arresting the cycle of domestic violence. We have a special opportunity to stand up for the weak and defenseless. Let's take that opportunity and help these women and children achieve a chance for a happy, healthy life.

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Osteopathic Medical Center of Texas Receives JCAHO Accreditation

Osteopathic Medical Center of Texas has achieved accreditation from the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) as a result of its demonstrated compliance with the Joint Commission's nationally recognized health care standards. The Joint Commission on-site survey was conducted in April.

The JCAHO is a voluntary, international accrediting agency which has credentialed more than 8,000 institutions.

This was the medical center's first accreditation review by the JCAHO. Joint Commission standards represent a national consensus on quality patient care that reflects changing health care practices and health care delivery trends. Accreditation engages the organization's governing board, professional staff and administration in a cooperative effort to continuously improve patient care quality.

Osteopathic Medical Center of Texas has maintained accreditation through the American Osteopathic Association since 1971 and has been approved by the College of American Pathologists.

Phillip E. Sowa, chief executive officer, said, "I feel tremendous pride in the entire staff, who responded professionally and enthusiastically to the challenge of preparing for the Joint Commission survey." In addition, Sowa called the accreditation proof of an organizational-wide commitment to provide quality health care service on an ongoing basis. ■

AOA Efforts to Include OMT Codes in CPT

The AOA appeared before the Current Procedural Terminology (CPT) Editorial Panel in early May to request that codes for distinctive osteopathic procedures (MO700 series) be included in the 1993 edition of CPT. Panelists responded to the request with questions which reflected their lack of knowledge about OMT and their overall unfamiliarity with how the non-osteopathic manipulative medicine codes currently included in CPT are utilized.

Largely because of this confusion, CPT ruled against the inclusion of the MO codes in the 1993 CPT edition. Instead, a task force will be established to review and revise the manual medicine section of CPT. The task force will be made up of osteopathic physicians, neurologists, rheumatologists and physical therapists and will convene sometime this summer. It is expected that recommendations made by this task force, if approved by the CPT panel, will be incorporated in the 1994 edition of CPT.

The AOA is seeking inclusion of OMT codes with CPT to ensure full recognition of OMT by third party payors. Because of the delay until 1994 to be reconsidered by CPT, the AOA is planning to meet with HCFA officials in the interim to enlist their assistance in communicating to carriers nationwide that the MO codes are included in HCPCS. As such, these codes are recognized by Medicare as representing a covered service and should be reimbursed accordingly.

On an OMT-related note, the AOA has retained the services of a Washington-based "Medicare expert" law firm to assist in negotiations with HCFA to allow payment for both an office visit and OMT regardless of initial or subsequent visit status.

Liaison Committee On Health Professionals Peer Assistance Programs To Sponsor Annual Conference

Several health care profession's peer assistance programs were represented at a unique meeting held last December at the Texas Pharmaceutical Association when representatives of the professions' peer assistance programs met. As a direct outgrowth of that first meeting, final arrangements for a conference have now been completed.

The following topics will be addressed at the November conference: Types of Interventions, Intervention Role Playing, Intervention Experiences and the Nuts and Bolts of Peer Assistance Programs for Professionals. The program will be opened with a presentation by a physician sharing his story of addiction and recovery. Experts from around the state will serve as faculty members.

The program will be of interest not only to recovering health care professionals and other individuals working with the program, but also other members of the professions as well.

The conference will be held at the Texas Pharmaceutical Association Building, 1624 East Anderson Lane (east U.S. Hwy. 183), Austin, TX 78752 from 8 a.m. until 5 p.m., Sunday, November 1, 1992. Pre-registration is $40; on-site registration is $50. A continental breakfast and lunch will be included in the cost. Continuing education credit will be available. If you have any question about the conference, call Jean W. Sheffield at 512/836-8350 or 1-800-727-5152, or Linda Kuhn at 512/370-1300.

Peer assistance programs of the following professionals are represented on the liaison committee: dentists, dieticians, licensed professional counselors, nurses, optometrists, osteopaths, pharmacists, physicians, physicians assistants, podiatrists and veterinarians. ■

Dangers of ACE Inhibitors During Second and Third Trimesters of Pregnancy

FDA recently approved important labeling changes for angiotensin-converting-enzyme (ACE) inhibitors, emphasizing the existing warnings about possible fetal injury and death when these drugs are used during the second and third trimesters of pregnancy.

Women of childbearing age who are prescribed ACE inhibitors, used to treat hypertension and congestive heart failure, should be informed of the fetal risks and advised to return promptly to their physicians if they become pregnant.

Specific risks to the fetus associated with the use of ACE inhibitors in the second and third trimesters of pregnancy include potentially fatal hypotension, anuria, and renal failure (sometimes irreversible). This decreased renal function can lead to oligohydramnios (lower than normal amounts of amniotic fluid), which in turn may result in fetal limb contractures, craniofacial deformities, and hypoplastic lung development.

These adverse effects to the fetus have been recognized in the drugs' labeling for several years, but new cases continue to be reported. More than 50 cases of fetal and neonatal injury due to ACE inhibitors have been reported in the world literature or to FDA. Very limited epidemiological evidence from Tennessee and Michigan Medicaid data bases indicate that morbidity from exposure to ACE inhibitors in the second and third trimesters may be as high as 10 percent to 20 percent.

In an effort to prevent exposure during the second and third trimesters of pregnancy, a new boxed warning has been added before the description section in the labeling. Nearly all women can successfully be transferred to other antihypertensives for the remainder of their pregnancies.

At FDA's request, the U.S. manufacturers of all approved ACE inhibitors recently sent a joint "Dear Health Care Professional" letter to a wide group of physicians describing the labeling changes and emphasizing the need for patients to see their physicians promptly about switching to a different drug if they become pregnant. Pharmacists have also been sent stickers to put on all ACE inhibitor prescriptions with the same patient message. Other educational efforts are also planned.

Physicians and other health profesionals are urged to report any suspected serious fetal injuries to FDA. ■

TWCC Changes Policy Regarding Submission of Medical Bills

It has been the policy of the Texas Workers' Compensation Commission (TWCC) that in accordance with Rule 134.801 "health care practitioners shall submit to the carrier a properly completed bill within 15 days after the initial service or treatment date." However, according to TWCC, there has been no method of enforcement established to ensure "properly completed bills" are submitted to the carriers, and the number of improperly completed bills being submitted, not only to the carriers but to the Commission, has developed into an unmanageable quality assurance issue.

According to TWCC, the submission of improperly completed bills causes the system to slow down due to increased audits, administrative processing, and the return and resubmission of corrected bills. The quality of billing also impacts the establishment of the statewide medical billing database, which is the first of its type nationally. The information contained in the database is essential and strumental in the development and revision of all treatment and reimbursement guidelines.

Therefore, the following changes will be implemented to enforce quality control in provider billing:

- Effective September 1, 1992, carriers are instructed to begin enforcing the return of all improperly completed bills submitted for reimbursement to the provider in accordance with Rule 133.300(c).

- The time periods described in Article 8308-4.68 for reimbursement do not begin until a properly completed bill is received by the carrier.

- The carrier will be held accountable for any improperly completed bills submitted to the Commission. A carrier who submits improperly completed bills to the Commission will be in violation of Rule 134.802 and may be subject to an administration violation. Should electronically submitted bills require to be returned to the carrier, the entire tape will be returned. The 15 days start upon "final payment" according to Rule 134.802(a).

Anyone requiring further assistance or having questions should contact the Medical Review Division at (512) 440-3513. ■

Dr. Joseph Namey Named President of New Osteopathic College

Joseph J. Namey, D.O., Vice President for Medical Affairs for Southeastern University of the Health Sciences, North Miami Beach, Florida, has announced his plans to resign to assume the position of President of the newly formed Lake Erie College of Osteopathic Medicine in Erie, Pennsylvania.

Dr. Namey joined Southeastern in 1983 as Assistant Dean for Clinical Affairs. He served as Dean of the College of Osteopathic Medicine from 1988 until 1990, when he assumed the vice presidency.

The decision to leave Southeastern, he said, came after a period of anguished soul-searching. "I have very mixed feelings about leaving Southeastern," said Dr. Namey. "I was very happy working here, but I have been given an opportunity to advance the profession of osteopathic medicine and I accepted it. Also, the new school is close to my hometown of Farrell, Pennsylvania, where I can spend some time with my family."

Dr. Namey was a recipient of the 1983 American Osteopathic Association's Distinguished Service Award and the 1977 American College of General Practitioners' General Practitioner of the Year Award. A Fellow of the ACGP, he has held numerous leadership positions and assumed committee chairmanships in national and state professional associations for many years. He delivered the prestigious Andrew Taylor Still Memorial Address, established in honor of the founder of osteopathic medicine, in 1991 for the AOA.

Arnold Melnick, D.O., Southeastern University's Executive Vice President and Provost and Dr. Namey's predecessor as Dean of the College of Osteopathic Medicine, said "I've known Dr. Namey for many years and his commitment to serving the profession has been widely recognized. He has been instrumental in the establishment of no less than nine osteopathic medical schools, and we expect every success of him with his newest college." ■

UNT and TCOM to Ask Legislature for Health Science Center Designation

The UNT/TCOM Board of Regents endorsed a proposal at its June 19 meeting to request approval of the next session of the Texas Legislature to develop a University of North Texas Health Science Center at Fort Worth. TCOM would become the medical school component of the health science center, which also could include schools of graduate biomedical sciences and allied health, and a college of public health and public health policy.

UNT/TCOM Chancellor Alfred Hurley, Ph.D., told the regents that the request to the legislature would be a joint proposal of the two institutions and would not involve new funding. "We're asking the Legislature to let us begin planning," said Hurley.

A rationale report to the regents stated that development of a health science center is needed in order to remain competitive for highly qualified faculty and students, and key administrative staff. The report stated that TCOM must "broaden itself into a Health Science Center (HSC) in order to ensure its long-term viability as an educational institution and to position itself to effectively meet the health care needs of individuals and communities in north Texas."

The report noted that five of the six other public medical schools in Texas are part of health science centers and the sixth, Texas A&M College of Medicine, has applied for HSC status. "When compared with its stand-alone (medical school) counterpart," the report asserts, "the Health Science Center propels the medical school and each HSC component to new levels of quality in carrying out their missions."

Regent Chairman Jerry Farrington said that the action by the regents was a "very small step to begin dealing with creation of a framework" for a possible health science center. ■

Reprinted from July 3, 1992 "Dateline"

Drug-Free Workplace Policies Help Cut Accident Rates, Absenteeism, Study Shows

Employers who put into practice a comprehensive plan to battle drug and alcohol abuse and their effects in the workplace can cut accident rates and absenteeism, a Texas Workers' Compensation Commission study shows.

The study, conducted by the Commission's Division of Workers' Health and Safety, found that employees of businesses with substance abuse policies have nine percent fewer accidents and miss 11 percent fewer days of work than employees of businesses without the plans. In addition, the study found a 10 percent drop in theft and property damage rates for employers with substance abuse policies.

The new Texas Workers' Compensation Act, which became effective in January 1991, requires Texas employers with workers' compensation insurance and 15 or more employees to develop and put into practice a plan to eliminate drug and alcohol abuse and their effects in the workplace. The law requires employers to distribute copies of the policy to each of their employees. The policy must describe any penalties that workers may suffer for using drugs or alcohol at work and must describe any drug and alcohol abuse treatment programs available to employees.

Testing employees for drug or alcohol use is not required by the law or Commission rules, but if an employer conducts drug testing, the employer must describe the testing program in its drug policy.

In another study, conducted by the National Institute on Drug Abuse, Arizona State University and the AFL-CIO, about 10 percent of all workers in the United States were found to have drug or alcohol problems that affected their work.

For more information on drug and alcohol abuse and the effects they have in the workplace, or for information on how to develop a substance abuse policy, call the Commission's Drug-Free Workplace Program at (512) 440-3878. ■

Change In Texas Controlled Substances Schedule

As of April 29, 1992, propylhexedrine was removed from the Texas Controlled Substances Schedules and is now a legend drug only.

Rural Communities Prevention Resource Guide

The *Rural Communities Prevention Resource Guide* contains a wealth of information for health professionals concerned with drug and alcohol abuse by rural young people. Issued by the federal Office for Substance Abuse Prevention of the Alcohol, Drug Abuse and Mental Health Administration, the resource guide lists books, scripts, brochures, posters and research studies examining drug and alcohol use among the rural young.

Among some of the informational facts in the book:

- One-third of rural children have had their first drink on their own by the age of 10, according to results of a survey conducted in one small middle-Atlantic town.
- Arrests for drug abuse violations in rural counties increased 54 percent from 1984-88.
- Arrests for cocaine and heroin use rose 20 percent in rural areas from 1984-88.
- Rural children as young as 11 and 12 are drinking as many as 14 to 18 beers as part of their Friday and Saturday nights out.

A copy of the resource guide can be obtained by writing to: National Clearinghouse for Alcohol and Drug Information (NCADI), Box 2345, Rockville, Maryland 20852. ■

CHAMPUS HOTLINE TELEPHONE NUMBERS

The Texas Medical Foundation maintains three toll-free telephone lines for CHAMPUS callers. The lines are answered from 8 a.m. to 5 p.m. central time, Monday through Friday, except on nationally recognized holidays. Other than these hours, callers may leave a recorded message, which will be answered the next business day.

General Inquiry
1-800-299-8963

Beneficiary
1-800-299-2363

Preadmission/Preprocedure Authorization
1-800-299-3627

Newsbriefs

NIA FUNDS RESEARCH ON SLEEP, MELATONIN AND CIRCADIAN CLOCK

The National Institute on Aging (NIA) has awarded researchers at Oregon Health Sciences University nearly $1 million to begin studying the role of the natural hormone melatonin in controlling sleep and wakefulness.

The NIA estimates that more than half of the nation's 29 million people over the age of 65 experience disrupted sleep. Additionally, millions of other Americans don't get enough sleep because of work schedules.

The Oregon sleep study has two goals: to understand the influence of melatonin on the parts of the brain that generate the circadian or sleep/alertness rhythms, and to understand the importance of aging on this system.

Basic scientists will conduct studies in animals to find out how melatonin works on the brain structures that control sleep and wakefulness. At the same time, clinical scientists will study humans to see if administering melatonin at certain times can correct the sleep deficits and the changes in the circadian clock that are associated with aging. The studies are expected to take five years.

CHECKMATES

Joseph L. LaManna, D.O., (center) chairman of Dallas Southwest Osteopathic Physicians, Inc., gives Janice Knebl, D.O., chief of TCOM's division of geriatrics, and Thomas J. Fairchild, director of UNT's Center for Studies in Aging, a check for $24,000. The TCOM/UNT Gerontology Assessment and Planning Program will use the money to provide a geriatric/gerontology training program during 1992 and 1993 at Dallas Family Hospital. Participants will include physicians, nurses, social workers, other staff members and residents of the Oak Cliff area.

Denial of Hospital Privileges Due to Training Is Not Reportable to Data Bank

The denial of hospital privileges because of osteopathic training is not a reportable action to the National Practitioner Data Bank. This information was confirmed by the Data Bank for the American College of Osteopathic Surgeons (ACOS) after an ACOS member was told that the denial of his application for hospital privileges would be reported to the Data Bank.

In the July 1992 ACOS newsletter, a spokesperson for the Data Bank states, "Requirements for ACGME training or ABMS board certification are hospital criteria to be met and not compentency issues." This subject will be clarified in a future supplement to the Data Bank's guide book.

In the same newsletter, David Kushner, president of the American Osteopathic Hospital Association, said "Physicians should not be discriminated against because of osteopathic training and credentials. Further, reports to the Bank should not be used as thinly veiled threats to discourage expansion of osteopathic medicine by those who are either uninformed or are biased against osteopathic medicine."

If a report is filed in the Data Bank on a physician's denial of hospital privileges because of osteopathic training, he or she should contest the report. ■

TCOM SmokeFree Program First In Area To Combine Counseling, Nicotine Patches

Smokers who are unable to maintain their New Year's resolution to "kick the habit" on their own now have an alternative: Texas College of Osteopathic Medicine's SmokeFree Program.

The new individualized treatment program offered by TCOM's Department of Public Health and Preventive Medicine combines use of the recently introduced nicotine patch and other medications with education and behavioral counseling.

Program director John Licciardone, D.O., says he is unaware of any other smoking cessation program in the area that combines medical treatment with counseling. "Physicians can now prescribe nicotine patches, and other treatment programs offer behavioral counseling, but we're the only program that I know of in Tarrant County that combines the two," he says. "The nicotine patch delivers nicotine through the skin to the bloodstream, which allows the smoker to gradually wean off of it while we try to help them deal with their psychological dependence on cigarettes."

According to Licciardone, the average smoker will spend about three months in the program and will visit the SmokeFree Clinic about six times. On the first visit, which is scheduled a week to 10 days before the "quit" date, patients receive a medical examination, an assessment of pulmonary function, and counseling to prepare them for cessation. They also are asked to keep a five-day smoking diary and to fill out questionnaires detailing their smoking motives and medical and smoking history.

Licciardone uses the information gathered in the first visit to design an individualized treatment plan. One to 14 days after the "quit" date, the patient returns for a medical follow-up and relapse prevention counseling. Subsequent visits are scheduled on an "as needed" basis.

Licciardone says the nicotine patches, which are changed every 24 hours and come in different strengths, cost about $100 per month. "Which is less than the average two-pack-a-day smoker spends on cigarettes each month," he says.

For more information or to make an appointment, call Licciardone at (817) 735-2252.

TCOM is a four-year, state-supported medical school under the direction of the University of North Texas Board of Regents.

Smoking facts and figures*

- Two six-week group trials reported on in the Dec. 11, 1991, issue of the *Journal of the American Medical Association* found that transdermal nicotine doses significantly decreased the severity of nicotine withdrawal symptoms and reduced cigarette use by patients who did not stop smoking. No serious adverse effects were suffered by patients using the patches.
- Smokers who are urged by their doctors to quit are two to 10 times more likely to succeed than smokers receiving no advice to quit.
- Smoking is the leading preventable cause of death in our country, killing 434,000 people a year, more than 1,000 every day.
- Smoking accounts for about 85 percent of all lung cancer deaths, about 80 percent of all chronic obstructive pulmonary disease deaths.
- Smoking costs America $52 billion annually in health care and other costs.

Sources: Journal of the American Medical Association, National Cancer Institute. ■

Blood Bank Briefs for Physicians

Hemostatic Abnormalities in Massive Transfusion

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

Massive transfusion is defined as the replacement of one or more blood volumes within 24 hours. A blood volume is estimated as 75 ml/kg or about 5,000 ml (10 or more units of whole blood) in a 70 kg adult.

Studies on patients massively transfused with predominantly whole blood show that pathologic hemorrhage is caused more frequently by thrombocytopenia than by depletion of coagulation factors. However, whole blood is not widely available and most bleeding patients are given crystalloid and packed red blood cells. In addition, intraoperative blood salvage is often used during which washed, relatively free plasma free cell saver red blood cells are reinfused into the patient.

Previous studies attest to the safety of administering packed red blood cells and crystalloid in patients who bleed less than one blood volume during aortic and cardiac surgery. In addition the study of Murray and coworkers included seven elective surgery patients transfused with 1.3 to 2 blood volumes of red blood cells and crystalloid and the presumed causes of the abnormal bleeding in their patients massively transfused were either thrombocytopenia and/or hypofibrinogenimia. A recent report by Leslie and Toy reported their findings on replacing more than one blood volume loss in patients at an urban trauma hospital. Their studies show that significant prolongations in PT and PTT consistently occurred with cell saver red blood cells, packed red blood cells and crystalloids used to replace more than one blood volume loss. The patients in their study were more likely than elective surgery patients to develop coagulopathy because of preexisting coagulopathy due to liver disease, dilution due to large amounts of crystalloid resuscitation or disseminated intravascular coagulation due to prolonged hypotension or brain injury.

This is a retrospective study with the possible pitfalls of a retrospective study but I feel it is important to share this data with you because of the sparse literature in this area.

The data suggest that coagulation factor replacement is necessary in patients who receive 12 or more units of packed red blood cells or cell-saver blood and platelet replacement is necessary in patients who receive 20 or more units of any red blood cell product. A prospective study is needed to determine whether the expected abnormal clinical bleeding indeed occurs in patients with such laboratory coagulation abnormalities and to determine when plasma transfusion is indicated in patients massively transfused with red blood cells.

References:

Leslie S, Toy P. Laboratory hemostatic Abnormalities in Massively Transfused Patients Given Red Blood Cells and Crystalloid. AJCP 1991;96:770-773.

Murray D, et al. Coagulation changes during packed red cell replacement of major blood loss. Anesthesiology 1988;89:839-845.

Why Do They Go Down?

Top four reasons why their rural hospital closed, according to small-town mayors:

1. Government reimbursement policies.
2. General financial problems.
3. Physician shortage.
4. Poor management.

Least-cited reasons for closure:

1. Lack of community support.
2. Poor quality physician care.
3. Poor hospital reputation and services.

(Source: L. Gary Hart, Michael J. Pirani, and Roger A. Rosenblatt, "Causes and Consequences of Rural Small Hospital Closures from the Perspectives of Mayors." The Journal of Rural Health, summer 1991.) ■

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., 100 N. University, Suite 212, Fort Worth, 76107. 817/332-2313. FAX 817/335-3837. (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)

DALLAS, TEXAS — Primary care physicians for private practice opportunities in and around the service area of Dallas Family Hospital. For details, contact Eloise Gusman, Physician Recruiter, 817-924-1699 or 800-535-7698 or Mike Mastej, Managing Director, 214-330-4611 or send CV to P.O. Box 101656, Ft. Worth, TX 76185. (22)

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)

FAMILY PRACTICE, CRANE — Enjoy city amenities without having to live there. Crane Memorial Hospital is looking for two family practitioners. Beautiful modern 28-bed hospital and office building. Small town, medically underserved area. Healthcare professional shortage area. Only 45 minutes from international airport. Only 30 minutes from interstate highway. Excellent schools. Warm dry climate. Great recruitment package. Contact: Steve Goode, Administrator, Crane Memorial Hospital, 1310 S. Alford Street, Crane, 79731. Phone 915/558-3555. (29)

GENERAL PRACTICE RESIDENCIES AVAILABLE, Oklahoma City — Accepting applications for 1992 residencies in general practice under the direction of Hillcrest Health Center. AOA approved, two-year program, relocation allowance available. Send inquiries to Donn Turner, D.O., Residency Program Director, Hillcrest Health Center, 2129 SW 59th Street, Oklahoma City, OK 73119 or call 405/680-2105. (30)

HOUSTON AREA — The town of Anahuac needs a family practice physician. A new office and a reasonable guarantee awaits. We are on the bay in Chambers County. Contact: John Luff, Bayside Community Hospital, Anahuac, 77514 or call 409/267-3143. (38)

ESTABLISHED PRACTICE FOR SALE — Available June 5, 1992. Good growth potential. Send inquiries to TOMA, Box 39, 226 Bailey Avenue, Fort Worth, TX, 76107. (39)

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)

LOOKING FOR PART TIME/FULL TIME DOCTORS for walk-in clinics in D/FW area. Also need doctors for hospital based practice near Austin. For further information call Jerry Lewis, The Lewis Group, 1-800-666-1377. (02)

PHYSICIAN WITH TEXAS LICENSE — needed to practice general medicine at Student Health Center September through May. Forty-hour week, Monday-Friday. Minimal call duty. Fringe benefits. Contact Sheila Meyer, Director, University of North Texas Health Center, P.O. Box 5158, Denton, 76203, 817/565-2786. Equal Opportunity/Affirmative Action Employer. (35)

PRACTICE FOR SALE — Solo GP's estate offering 25-year-old medical practice with fully equipped clinic in small college town, 60 miles NE of Dallas. Call 214/969-5028. (25)

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)

OFFICE SPACE AVAILABLE

FOR LEASE — Medical office; established medical-dental building on Hulen between Vickery and W. Fwy.; approx. 1,400 sq. ft. which includes 3-4 exam rooms, lab, business office, private office, and extras. Recently remodeled and ready to move in. 817/338-4444 (12)

FOR RENT — Medical Office in Arlington. Three to six months free rent with proper lease. Ideal for general practitioner. Call 817/265-1551. (15)

FOR LEASE OR PURCHASE — Medical practice, 1000 sq. ft. building, newly remodeled, fully equipped. IBM System 36/AS 400 Medical Billing System. Office located in central Richardson. Contact Judith Pruzzo, 214/231-7482 or 214/931-8760. (26)

GRANBURY — Quality office space for lease adjacent to Hood General Hospital. Call Linda Powell, 817/573-1595. (18)

FOR SALE — Profitable Osteopathic General Practice — in the Fort Worth/Watauga area. Office fully equipped including office manager and LVN. OB optional. Please call Debbie Stanley at 817/284-7380. (08)

FULLY EQUIPPED OFFICE SPACE—near thriving Roanoke, in Alliance Airport area. Available immediately for $1,200 monthly, including equipment. Short term lease available. Contact: Dr. Brad Griffin, 817/491-2564. (10)

MISCELLANEOUS

RECONDITIONED EQUIPMENT FOR SALE — Examination tables, electrocardiographs, sterilizers, centrifuges, whirlpools, medical laboratory equipment, view boxes, weight scales, IV stands and much more. 40-70 percent savings. All guaranteed. Mediquip-Scientific, Dallas, 214/630-1660. (14)

FOR SALE — OB/GYN Table. Call Carolyn Delaney, 817/923-6111. (31)

EXPERIENCED CLINIC PHARMACY GROUP — interested in leasing a small area in physician's office or clinic. Heavy Medicaid and insurance okay. We need to talk. Respond to Pharmacist, P.O. Box 563, Grapevine, 76099. (17)

ASSUME PAYMENTS — Lightly used QBC 11 with Printer. Good Condition. Call Cindy Sullivan, 214/254-6129. (36) ■

TEXAS OSTEOPATHIC MEDICAL ASSOCIATION
226 Bailey Avenue
Fort Worth, Texas 76107

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