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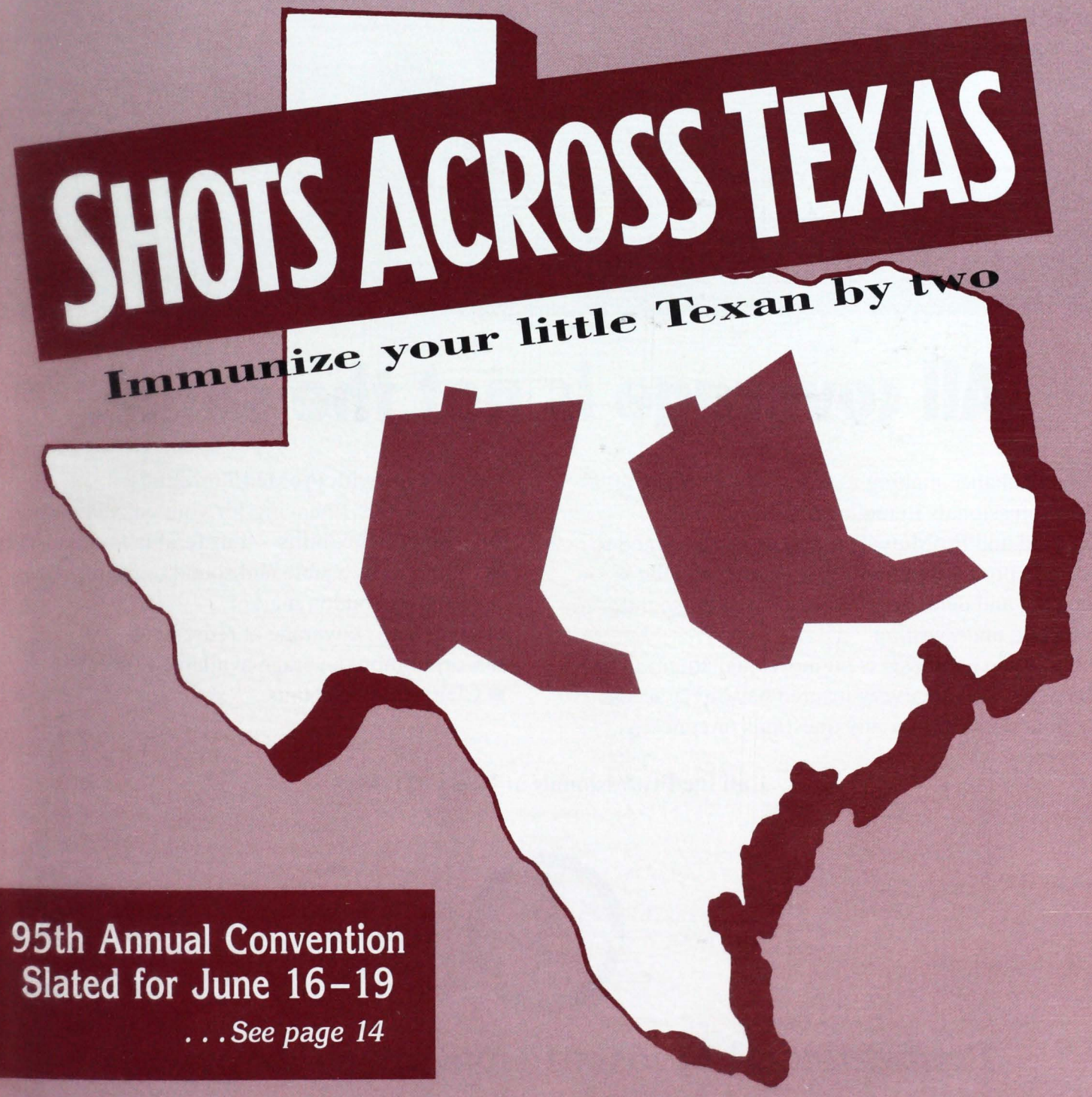
Texas D.O. Volume 51, Number 2

Texas Osteopathic Medical Association

TEXAS DO

XXXXXI, No. 2 TEXAS OSTEOPATHIC MEDICAL ASSOCIATION February, 1994



95th Annual Convention Slated for June 16–19

. . . *See page 14*

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Texas College of Osteopathic Medicine	817/735-2000 Dallas Metro 429-9120
Medicare Office:	
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Part B Telephone Unit	903/463-4495
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
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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

February, 1994

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Calendar of Events

FEBRUARY 13-17

33rd Annual Convention of the Osteopathic Physicians and Surgeons of California, "A Step Ahead"
Location: Las Vegas, Nevada
Hours: 40 Category 1-A credits anticipated
Contact: Osteopathic Physicians and Surgeons of California
455 Capitol Mall, Suite 225
Sacramento, California 95814
916/447-2005
Fax: 916/447-4828

FEBRUARY 27 - MARCH 4

Ski & CME Midwinter Conference
Sponsored by Colorado Society of Osteopathic Medicine
Location: Keystone Lodge and Resort
Keystone, Colorado
Hours: 38 AOA Category 1-A; AAFP prescribed course credits
Contact: Patricia Morales
50 S. Steele Street, Suite 440
Denver, Colorado 80209
303/332-1752
Fax: 303/322-1956

MARCH 2-6

LAMBDA OMICRON GAMMA Medical Society's Annual Convention
(Formerly Log National Fraternity)
Location: Disney's Contemporary Resort
Lake Buena Vista, Florida
Topic: "Sports Medicine"
Hours: 16 AOA Category 1A credits requested
Contact: Lisa Mitchell
LOGMS Executive Secretary
215/649-8086

3-6

Florida Osteopathic Medical Association's 91st Annual Convention
Location: Doral Ocean Beach Resort,
Miami Beach, Florida
Hours: Category 1-A, 30 hours anticipated; five hours of mandatory Risk Management; three hours of mandatory AIDS/HIV required for license renewal
Contact: FOMA Executive Office
2007 Apalachee Parkway
Tallahassee, Florida 32301
(904) 878-7364

4-8

"Fourth Annual Update in Clinical Medicine for Primary Care Physicians
Sponsored by University of North Texas Health Science Center at Fort Worth/ TCOM and Osteopathic Health System of Texas
Location: Harvey's Resort Hotel
Lake Tahoe, Nevada
Hours: 20 Category 1-A, AOA
Contact: Pam McFadden
Program Director
817/735-2581

23-27

Pan American Allergy Society Training Course and Seminar
Location: Doubletree at Post Oak
Houston, Texas
Contact: Ms. Ann Brey
Executive Secretary
Pan American Allergy Society
P.O. Box 947
Fredericksburg, Texas 78624
210/997-9853
Fax: 210/997-8625

APRIL 15-16

"Eighth Annual Spring Update for the Family Practitioner"
Sponsored by University of North Texas Health Science Center at Fort Worth/ TCOM
Location: Dallas Family Hospital
Dallas, Texas
Hours: 10 Category 1-A, AOA
Contact: Pam McFadden, Program Direc
817/735-2581

JUNE 16-19

TOMA's 95th Annual Convention and Scientific Seminar
Location: Wyndham Greenspoint Hotel
Houston, Texas
Hours: 28 AOA Category 1-A anticipat
3 AOA Category 2-B anticipat
Contact: Texas Osteopathic Medical Association
One Financial Center
1717 IH 35, Suite 100
Round Rock, TX 78664-2901
512/388-9400 or 1/800-444-86

Articles in the *"Texas DO"* that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising," according to Tex Govt Code Ann §305.027. Disclosure of the name and address of the person who contracts with the printer to publish the legislative advertising in the *"Texas DO"* is required by that law: Terry R. Boucher, Executive Director, TOMA, One Financial Center, 1717 IH 35, Suite 100, Round Rock, Texas 78664-2901.

SHOTS ACROSS TEXAS

Immunize your little Texan by two

- **Fact:** *In some areas of Texas, the immunization rate is lower than in some third world countries.*
- **Fact:** *Texas leads the nation in the number of reported cases of vaccine-preventable diseases.*
- **Fact:** *70 percent of Texas two-year-old children need one or more vaccines to be completely immunized.*
- **Fact:** *In the past five years, over 4,400 Texas children under five years of age have had measles; 14 of these children have died!*
- **Fact:** *Cost/benefit of vaccines — For every $1.00 spent on vaccines, $10.00 is saved.*

he Texas Universal nmunization Act

This past April, Texas took a giant ep forward in children's health when iovernor Ann Richards signed Senate ill 266, which mandates the age-ppropriate immunization of all Texas iildren up to the age of 18. The law

> *'What we are trying to do is treat kids while they are well to keep them from getting sick."*
>
> — Governor Ann Richards

quires physicians and hospitals to view the immunization history at every ɔportunity; needed immunizations ıould either be given or the child ferred for services. Additionally, ɔspitals are required to refer newborns r immunizations. "What we are trying do is treat kids while they are well to ep them from getting sick," said overnor Richards. As a result of this gislation, giving children their needed ımunizations no longer is common nse, but the law of the land.

The Texas Legislature also appropri-ed $37.7 million for fiscal year 1994 for e Texas Department of Health's DH) immunization initiative to rchase vaccine; increase immunization rsonnel; increase distribution policies; d to add computers, vehicles, ucational materials, immunization pplies and more.

"Shots Across Texas" Coalition Formed

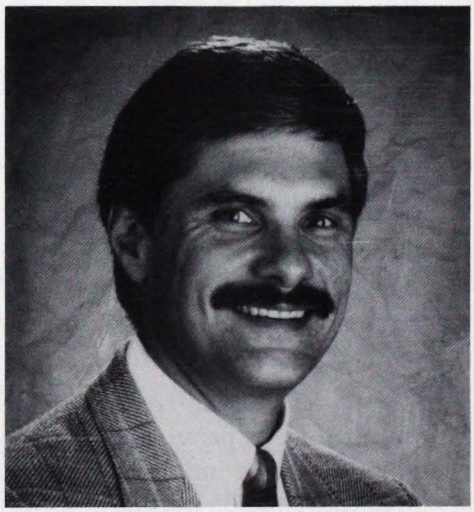
In response to Texas' immunization initiative, the TDH has created "Shots Across Texas," a statewide multi-organizational coalition to boost efforts to immunize Texas children ages 0-2 against such vaccine-preventable diseases as whooping cough, measles, polio, mumps and diphtheria.

A kickoff meeting of the statewide coalition took place October 21 in Austin with an October 20 evening reception at the Governor's Mansion. Governor Richards and Lt. Governor Bob Bullock have joined Dr. David Smith, TDH Commisioner of Health, in making childhood immunizations the state's number one health priority.

Although the coalition will promote the full immunization of all preschool-age children in Texas, the specific goal is to achieve a 90 percent immunization rate for two-year-olds by the year 2000. Currently, there are approximately 303,000 two-year-olds in Texas. Estimates are that while 95 percent of Texas' school-age children are properly immunized, only 30-50 percent of the state's 1.5 million pre-school-age children have received the recommended vaccines.

The TDH is mobilizing the resources of statewide civic, social, political, educational and religious organizations; the media; the military; government agencies; ethnic associations; and child advocacy groups. "This is definitely a non-traditional approach to getting the job done," said Dr. Smith. "It's not something government alone can achieve."

The Texas Osteopathic Medical Association is a member of the First Steps Coalition, a group of professional medical organizations who have pledged their support in working to improve the state's immunization level.



Dr. David Smith, Texas Commissioner of Health

Campaign Will Educate Parents

With the theme, *"Shots Across Texas — Immunize Your Little Texan by Two,"* a promotional campaign is in progress. To include electronic and print public service announcements, billboards and other educational materials, it is aimed at encouraging parents to immunize their children. Dr. Smith noted that some parents dismiss the value of vaccines because they see diseases such as measles and mumps as a normal part of growing up. Others only associate immunizations with school enrollment requirements. ▸

"We want to get the vaccines, the child and the health professional in the same place at the same time," Dr. Smith said. "To do this, we have to bring down as many barriers to immunization as we can. We want to make it as easy as possible for every parent or guardian to see that every child is immunized." Some barriers to immunization include financial restrictions, a lack of familiarity with immunization requirements, inaccessibility and inconvenience.

TDH Implements Initiatives

- TDH data systems staff are working to develop a statewide immunization tracking system. Phase I of the system was put in place this past July for automation of Medicaid and Women, Infants, and Children's Nutrition Program immunization initiatives. The full tracking system will be in place by late this year.
- TDH is using federal funds from the Centers for Disease Control and Prevention for special immunization projects such as the Border Measles Initiative and the Perinatal Hepatitis B Program.
- On July 1, 1993, TDH began funding immunizations to preschool children who receive services in WIC offices throughout the state. This project has the long-term potential of immunizing half of the children in the state.
- TDH has begun reimbursing Medicaid providers for immunizations administered to Medicaid children outside of Early Periodic Screening Diagnosis Treatment.
- TDH disbursed $3.5 million to regional/local health departments in Texas for special summer immunization activities in 1993. Fees for immunizations in regional clinics were waived for the summer.

In addition, local and regional health departments are extending their days and hours of operation, implementing walk-in immunization services, and hiring new staff. TDH immunization teams are going directly to housing projects, shopping malls, day-care centers, food distribution centers, county fairs, zoos, grocery stores and other locations with immunization services. Teams also travel to rural areas, such as South Texas colonias, to provide immunizations.

April is "Shots Across Texas" Immunization Month

The entire month of April will be designated as "Shots Across Texas" Month at which time the initiative will be given a major push.

> ***"Immunization is about as preventive as it gets, not only in terms of lives saved and suffering avoided, but also in terms of dollars saved."***
>
> **— Dr. David Smith**
> **Texas Commissioner of Health**

In addition, the week of April 24-30 has been chosen by the Centers for Disease Control and Prevention, the Children's Action Network, and the Immunization Education and Action Committee of the Healthy Mothers, Healthy Babies Coalition as "National Preschool Immunization Week." Thus, the CDC and other national partners in the public and private sectors will stimulate activities at national, state and local levels leading to permanent improvements in the delivery of vaccines to infants and toddlers. The CDC notes that although they have designated one week to focus national attention on preschool immunizations, they are aware that only year-round attention to improving policies, practices and programs will result in the desired outcome.

Your Help is Needed

TOMA members are urged to become involved at the local level to ensure that children of the community have access to these vital immunizations. We encourage you to contact Lynn Denton, TDH immunization coalition coordinator, at 512/458-7455 for additional information regarding how you can help.

Number of Doses of Vaccine By Recommended Age

AGE	DTP	DTaP[1]	POLIO	Hib[2]	MMR[3]	HEPT B[4]	TOTAL
BIRTH						X	1
2 MONTHS	X		X	X		X	4
4 MONTHS	X		X	X			3
6 MONTHS	X			X		X	3
12-18 MOS.					X		1
15 MONTHS		X	X	X			3
4 YRS-6 YRS		X	X		X		3
TOTAL	3	2	4	4	2	3	18

*The above is an optimum schedule. Some vaccines can be given at earlier ages. For all products used, consult manufacturer's package inserts for instructions for storage, handling, dosage and administration. Biologics prepared by different manufacturers may vary, and package inserts of the same manufacturer may change from time to time. Therefore, the provider should be aware of the contents of the current package insert.

DTP: Diphtheria, Tetanus, Pertussis Vaccine
DTaP: Diphtheria, Tetanus, Acellular Pertussis Vaccine
Hib: *Haemophilus influenzae* type b Vaccine
MMR: Measles-Mumps-Rubella Vaccine
HEPT B: Hepatitis B Vaccine

NOTES: [1] If DTaP is unavailable, use DTP.
[2] Hib vaccine manufactured by Lederle/Praxis.
[3] MMR vaccine may be administered at 12 months of age. Two doses of MMR are recommended. The 2nd dose may be administered at adolescence.
[4] The 3rd dose of Hept B vaccine may be administered at 6 months through 18 months of age.

Immunization Facts

Half of the nation's 2200 measles cases in 1992 were reported in Texas (1097 cases).

Measles has disproportionately affected minority children in Texas. In 1992, the incidence of disease among Hispanics was 16 times higher than that reported among whites in Texas.

One case of congenital rubella syndrome was reported in Texas in 1992.

Over $878,000 was spent to provide hospital care to 10 tetanus cases reported in Texas in 1991; vaccine cost to immunize these cases = about $25.00

MEASLES OUTBREAKS:

- Houston, 1988-1989, 550 measles cases hospitalized costing $5 million; MMR vaccine costs to immunize 550 children = $8,400.
- Dallas, 1989-1990, 238 measles cases hospitalized costing $3.5 million; MMR vaccine costs to immunize people = $3,600.
- South Texas, 1991-1992, 592 measles cases hospitalized costing $2.4 million; MMR vaccine costs to immunize 592 children = $9,100.

TDI Issues Small Business Health Plan Brochure

The Texas Department of Insurance has announced the publication of *The Small Employer Health Insurance Availability Act: Questions and Answers on the New Law.* The booklet is a user-friendly guide to Texas' new law making health insurance more accessible to small employers.

"With the national spotlight on health insurance availability and affordability, the Small Employer Health Insurance Availability Act has generated a lot of interest in Texas," said Robert Schneider, Associate Commissioner for Consumer Services. "Our objective with the brochure is to provide employers and employees with answers to their basic questions about the new law."

Employers can order free copies of the booklet by calling the TDI toll-free at 1-800-252-3439, or writing to: Texas Department of Insurance, Publications (108-5A), P.O. Box 149104, Austin, Texas 78714-9104.

The 1993 Legislature passed the act, which grew out of a Texas Health Policy Task Force study, to make employee health insurance more widely available. The new law, which includes three prescribed benefit plans and some limits on premium increases, took effect January 1, 1994.

Standards for Pediatric Immunization Practices

The following standards, developed by consensus of the Nation Vaccine Advisory Committee and a broad group of medical and public health experts, are recommended for use by all health professionals in the public and private sector who administer vaccines to or manage immunization services for infants and children.

Standard 1. Immuniza services are **readily available.**

Standard 2. There are **no barriers** or **unnecessary prerequisites** to the receipt of vaccines.

Standard 3. Immunization services are available **free** or for a minimal fee.

Standard 4. Providers utilize all clinical encounters to **screen** and, when indicated, **immunize** children.

Standard 5. Providers **educate** parents and guardians about immunization in general terms.

Standard 6. Providers **question** parents or guardians about **contraindications** and, before immunizing a child, **inform** them in specific terms about the risks and benefits of the immunizations their child is to receive.

Standard 7. Providers follow only true **contraindications.**

Standard 8. Providers administer **simultaneously** all vaccine doses for which a child is eligible at the time of each visit.

Standard 9. Providers use accurate and complete **recording procedures.**

Standard 10. Providers **co-schedule** immunization appointments in conjunction with appointments for other child health services.

Standard 11. Providers **report adverse events** following immunization promptly, accurately and completely.

Standard 12. Providers operate a **tracking system.**

Standard 13. Providers adhere to appropriate procedures for **vaccine management.**

Standard 14. Providers conduct semi-annual **audits** to assess immunization coverage levels and to review immunization records in the patient populations they serve.

Standard 15. Providers maintain up-to-date, easily retrievable **medical protocols** at all locations where vaccines are administered.

Standard 16. Providers operate with **patient-oriented** and **community-based** approaches.

Standard 17. Vaccines are administered by **properly trained** individuals.

Standard 18. Providers receive **ongoing education** and **training** on current immunization recommendations.

(Continued on page 9)

Some Call It A Major Advancement In Connective Tissue Repair

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A myriad of joint and spinal conditions, including osteoarthritis, are associated with articular cartilage and disc deterioration. Several factors can lead to the deterioration, such as direct injury to the joint, mechanical stress due to overuse of the joints, aging and/or hereditary conditions.

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While the treatment for these conditions may vary, the regimen often includes the use of steroids, or NSAID's which, with repeated usage can damage chondrocytes and inhibit the body's natural healing processes.

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Model of Problem of Low Early Childhood Immunization Rate

SUPPLY SIDE BARRIERS

Private Sector

The number of immunizations given by private physicians in their practices has declined dramatically because of:

- Liability concerns
- High vaccine costs
- Fear of adverse effects
- Health insurance policies that don't cover immunizations
- Low number of Medicaid providers (too much paperwork, low reimbursement, clientele, and difficulty satisfying QC/QA staff)

Private physicians and nurses who do give immunizations miss opportunities to do so by:

- Failing to constantly monitor immunization status of patients
- Failing to give simultaneous immunizations
- Following invalid contraindications

Lack of access to an accurate centralized immunization record for each child

Public Sector

Inadequate infrastructure to meet all needs:

- Cuts in federal funds for public health in 80s coincided with recession, shrinking state budgets, increasing unemployment and inability of families to pay for immunizations
- Low clinic staffing rates for number of clientele served
- Inadequate clinic facilities
- Uninviting, uncomfortable, and cramped clinic space
- Long lines and waits
- Inconvenient clinic locations
- Too few trained health professionals to give immunizations

Prohibitive clinic policies and staff behaviors:

- Wrong hours of operation (no evening, lunch hour, weekend clinics)
- Fees for immunizations
- No walk-in immunizations (advance appointments required)
- Only well-baby physicals done (no immunization-only policy)
- No standing orders
- Lack of bilingual and culturally competent staff
- Staff that sometimes appears unfriendly and disinterested

Clinic practices that are counterproductive to immunizations:

- Failure to give simultaneous immunizations
- Failure to assess immunization status at every clinic encounter
- Following invalid contraindications

Lack of appropriate health education material:

- Out-of-date and unattractive
- Not culturally relevant

Inadequate assessment of actual current immunization levels (prevents identification of real barriers and evaluation of remediation)

Lack of accurate centralized tracking system for childrens' immunization records

SYSTEM BARRIERS

Complexity of immunization schedule and techniques for proper administration of vaccine.

Inappropriate portrayals of risk disseminated by special interest groups

Lack of reimbursement for immunizations by insurance providers

Lack of systematic evaluation and administration of immunization by public system providers to at-risk populations—AFDC, WIC, public schools, day-care facilities, Head Start, hospitals

Extreme difficulty in getting proper consent from legal guardians

Complexity or misunderstanding of Texas' liability issues for medical providers and volunteers

High vaccine prices and increased number of required vaccines put pressure on public and private provider systems

Increased poverty leading to increased dependence on the public sector for care

Increasing numbers of children living in poverty who are at higher risk for vaccine-preventable diseases

Complexity of federal and state paperwork requirements

Multiplicity of agencies which provide services and complexity of inter- and intra-agency communications

DEMAND SIDE BARRIERS

Access Issues

Parents or caregivers:

- Lack transportation to nearest clinic
- Don't know where to go for services
- Distrust/dislike of the public health clinics where services are available

Parents or caregivers are required to make appointments for immunizations

resulting in

Lack of utilization of available services

Awareness Issues

Parents or caregivers:

- Don't recognize the seriousness of vaccine-preventable diseases
- Are unaware of the spectrum of vaccine-preventable diseases, the need for age-appropriate immunizations, and the complex immunization schedule
- Believe immunizations are only needed for school enrollment

resulting in

- Lack of demand for immunization services when children are seen for well-baby checkups or other services
- Lack of parental pressure on medical providers to do immunizations
- Lack of willingness to have children receive simultaneous immunizations
- Lack of effort to make appointments for age-appropriate immunizations
- Lack of ability/willingness to keep records of their childrens' immunizations

Lifestyle or Situational Issues

- Teenage parents
- Transient parents leading chaotic lives or just working on basic survival for family
- Parental drug or alcohol abuse
- Family financial difficulties
- Parents who are neglectful or abusive to their children

resulting in

- Lack of regular well-baby care
- Lack of consistent medical provider relationships
- Lack of basic preventive care such as immunizations
- Lack of ability to keep up with immunization records

resulting in *resulting in* *resulting in* *resulting in* *resulting in* *resulting in*

40% immunization rate in Texas for children two years of age and younger. This rate is lower than in some third world countries, such as Mexico, Thailand, India, and Uganda — 10% in Houston, 30% in Dallas, 40% in El Paso.

resulting in

Thousands of cases of vaccine-preventable diseases across the state; dozens of deaths caused by vaccine-preventable diseases.

resulting in

- Emotional and financial costs to patient and families
- Costs to communities in providing expensive medical treatment of diseases and long-term care of preventable disabilities
- Costs to society in terms of lost contributions of children who die or are premanently disabled.

Guide to Contraindications and Precautions to Immunizations

Vaccine	True Contraindications and Precautions	Not True (Vaccines may be given)
GENERAL FOR ALL VACCINES [DTP/DTaP, OPV, IPV, MMR, Hib, HBV]	Anaphylactic reaction to a vaccine contraindicates further doses of that vaccine	Mild to moderate local reaction (soreness, redness, swelling) following a dose of an injectable antigen
	Anaphylactic reaction to a vaccine constituent contraindicates the use of vaccines containing that substance	
	Moderate or severe illnesses with or without a fever	Mild acute illness with or without low-grade fever
		Current antimicrobial therapy
		Convalescent phase of illnesses
		Prematurity (same dosage and indications as for normal, full-term infants)
		Recent exposure to an infectious disease
		History of penicillin or other nonspecific allergies or fact that relatives have such allergies

This information is based on the recommendations of the Advisory Committee on Immunization Practices (ACIP) and those of the Committee on Infectious Diseases (Red Book Committee) of the American Academy of Pediatrics (AAP). Sometimes these recommendations vary from those contained in the manufacturers' package inserts. For more detailed information, providers should consult the published recommendations of the ACIP, the AAP, the AAFP, and the manufacturers' package inserts.

Vaccine	True Contraindications and Precautions		Not True (Vaccines may be given)
DTP/DTaP	Encephalopathy within 7 days of administration of previous dose of DTP		Temperature of <40.5°C (105°F) following a previous dose of DTP
	Precautions*	Fever of ≥40.5°C (105°F) within 48 hrs after vaccination with a prior dose of DTP	Family history of convulsions**
		Collapse or shocklike state (hypotonic-hyporesponsive episode) within 48 hrs of receiving a prior dose of DTP	Family history of sudden infant death syndrome
		Seizures within 3 days of receiving a prior dose of DTP (see footnote** regarding management of children with a personal history of seizures at any time)	Family history of an adverse event following DTP administration
		Persistent, inconsolable crying lasting ≥3 hrs, within 48 hrs of receiving a prior dose of DTP	

*The events or conditions listed as precautions, although not contraindications, should be carefully reviewed. The benefits and risks of administering a specific vaccine to an individual under the circumstances should be considered. If the risks are believed to outweigh the benefits, the immunization should be withheld; if the benefits are believed to outweigh the risks (for example, during an outbreak or foreign travel), the immunization should be given. Whether and when to administer DTP to children with proven or suspected underlying neurologic disorders should be decided on an individual basis. It is prudent on theoretical grounds to avoid vaccinating pregnant women. However, if immediate protection against poliomyelitis is needed, OPV, not IPV, is recommended.

**Acetaminophen given prior to administering DTP and thereafter every 4 hours for 24 hours should be considered for children with a personal or with a family history of convulsions in siblings or parents.

Vaccine	True Contraindications and Precautions		Not True (Vaccines may be given)
OPV***	Infection with HIV or a household contact with HIV		Breast feeding
	Known altered immunodeficiency (hematologic and solid tumors; congenital immunodeficiency; and long term immunosuppressive therapy)		Current antimicrobial therapy
	Immunodeficient household contact		Diarrhea
	Precaution*	Pregnancy	
IPV	Anaphylactic reaction to neomycin or streptomycin		
	Precaution*	Pregnancy	

*The events or conditions listed as precautions, although not contraindications, should be carefully reviewed. The benefits and risks of administering a specific vaccine to an individual under the circumstances should be considered. If the risks are believed to outweigh the benefits, the immunization should be withheld; if the benefits are believed to outweigh the risks (for example, during an outbreak or foreign travel), the immunization should be given. Whether and when to administer DTP to children with proven or suspected underlying neurologic disorders should be decided on an individual basis. It is prudent on theoretical grounds to avoid vaccinating pregnant women. However, if immediate protection against poliomyelitis is needed, OPV, not IPV, is recommended.

***There is a theoretical risk that the administration of multiple live virus vaccines (OPV & MMR) within 30 days of one another if not given on the same day will result in a suboptimal immune response. There are no data to substantiate this.

Vaccine	True Contraindications and Precautions		Not True (Vaccines may be given)
MMR***	Anaphylactic reactions to egg ingestion and to neomycin****		Tuberculosis or positive PPD
	Pregnancy		Simultaneous TB skin testing*****
	Known altered immunodeficiency (hematologic and solid tumors; congenital immunodeficiency; and long term immunosuppressive therapy)		Breast feeding
			Pregnancy of mother of recipient
	Precaution*	Recent (within 3 months) IG administration	Immunodeficient family member or household contact
			Infection with HIV
			Nonanaphylatic reactions to eggs or neomycin
Hib			
HBV			Pregnancy

*The events or conditions listed as precautions, although not contraindications, should be carefully reviewed. The benefits and risks of administering a specific vaccine to an individual under the circumstances should be considered. If the risks are believed to outweigh the benefits, the immunization should be withheld; if the benefits are believed to outweigh the risks (for example, during an outbreak or foreign travel), the immunization should be given. Whether and when to administer DTP to children with proven or suspected underlying neurologic disorders should be decided on an individual basis. It is prudent on theoretical grounds to avoid vaccinating pregnant women. However, if immediate protection against poliomyelitis is needed, OPV, not IPV, is recommended.

***There is a theoretical risk that the administration of multiple live virus vaccines (OPV & MMR) within 30 days of one another if not given on the same day will result in a suboptimal immune response. There are no data to substantiate this.

****Persons with a history of anaphylactic reactions following egg ingestion should be vaccinated only with extreme caution. Protocols have been developed for vaccinating such persons and should be consulted (J Pediatr 1983,102:196-9, J Pediatr 1988;113:504-6).

*****Measles vaccination may temporarily suppress tuberculin reactivity. If testing can not be done the day of MMR vaccination, the test should be postponed for 4-6 weeks.

New Insurance Law For Small Texas Employers Began January 1

The Small Employer Health Insurance Availability Act, aimed at helping small businesses purchase affordable health insurance for employees, went into effect January 1, 1994. Basically, those who employ between three and 50 employees will have the option of purchasing one of three benefit packages:

- The Standard Benefit Plan, which covers most necessary health services;
- The Preventive and Primary Care Benefit Plan, which covers office visits, preventive and routine medical care, but only offers five days a year of hospitalization; or
- The In-Hospital Benefit Plan, which offers hospitalization and up to 90 days of follow-up care, but doesn't cover preventive or primary care benefits unless purchased extra in the form of policy riders.

Employers must pay at least 75 percent of the premium for each employee, however, there is no requirement to pay for dependents. The plans can be purchased directly from participating health insurance companies or HMOs, or through licensed agents. The new law also allows purchasing cooperatives to be formed by two or more small employers.

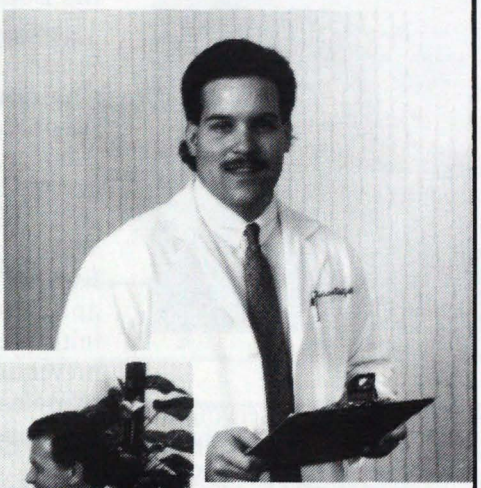
According to the Texas Department of Insurance, most of the largest HMOs and health insurance companies, which includes Aetna, Prudential, Sanus, Kaiser, Blue Cross Blue Shield, and Travelers, have received certification to operate in the small employer market. HMOs may offer the Standard Benefit Plan and the Preventive and Primary Care Benefit Plan in addition to their other benefit packages.

The law limits the amount of premium increases from year to year and all plans purchased by small businesses must be renewable. Additionally, insurers selling these policies cannot cover a portion of the employees, excluding those with pre-existing conditions.

Although small businesses are not required by law to purchase health insurance, the TDI hopes that those who are presently uninsured will take advantage of the small business benefit packages. It is estimated that two million employees of small businesses in Texas are uninsured.

Employers can receive a free question-and-answer booklet by calling the Texas Department of Insurance's consumer services division at 1-800-252-3439. ■

"FOR MY SBA LOAN, ALL I NEEDED WAS ONE GOOD BANK."



▲ *Dr. Richard Chatfield*

When Dr. Richard Chatfield needed a long-term competitive interest rate SBA loan, he came to Bank of North Texas for the bank's SBAdvantage program.

"I wanted a loan to purchase a new building and some land for my practice," said Chatfield. "I knew Bank of North Texas had an excellent reputation, so I decided to apply."

◀ *Dr. Chatfield and Don Waters, President of Bank of North Texas*

Chatfield found the loan application process surprisingly simple.

SBAdvantage

"Don Waters, the president of the bank, sat down with me and explained exactly what I needed to do. And the staff was extremely professional and efficient."

Soon, Chatfield had just what he needed: a new home for his thriving practice.

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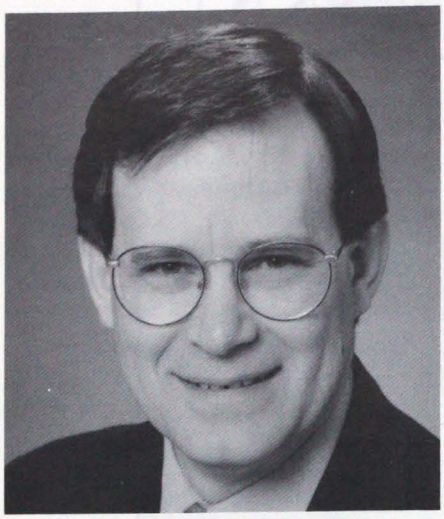
MEMBER FDIC AND NORTH TEXAS BANCSHARES, INC.

Introducing TOMA's 1994 Program Chairman



John R. Bowling, D.O.

John R. Bowling, D.O., is serving as program chairman for the Texas Osteopathic Medical Association's 95th Annual Convention and Scientific Seminar, to be held June 16-19 in Houston. As such, he has provided a brief rundown of what physicians can expect to gain from the topics to be presented.

"*As program chairman for the 1994 TOMA State Convention, I would like to invite you to Houston for a relaxing and informative time.*

With health care reform upon us, and the prospect of managed care a reality, we have planned a program that I believe will be timely to all physicians, whether they are practicing in a primary care field or a sub-specialty; in a metropolitan or a rural community.

The osteopathic profession's heritage is in treating the whole person, and preventing and maintaining health. Prevention is the foundation upon which managed care is building. This year's program will emphasize how we can include prevention in our daily practice patterns, and will help us refocus on our osteopathic heritage of wellness, prevention and the whole person.

There will be several breakout/workshop type learning experiences which will provide a more interactive learning environment, and will enrich your educational experience.

Keep June 16-19 open on your calendar and plan to meet us in Houston to help the profession prepare to "blast off" into the next century of health care."

Dr. Bowling is Associate Professor/Vice Chairman of the Department of Family Medicine at the University of North Texas Health Science Center at Fort Worth. He also serves as director of the Central Family Practice Clinic of the Department of Family Medicine.

Other activities include Advisor to the Student Chapter of the ACOFP, Chairman of the Student Health Advisory Committee, member of the Admissions Committee and the MSRDP Board, all at the University of North Texas Health Science Center at Fort Worth; the Preventive Medicine Task Force of the Texas Medical Association; and the CATCHUM Project, an initiative for development of a cancer prevention curriculum in Texas medical schools.

Dr. Bowling is a 1969 graduate of Kirksville College of Osteopathic Medicine, Kirksville, Missouri, after which he interned at Doctors Hospital, Columbus, Ohio. He is certified by the American Osteopathic Board of Family Physicians.

Professional society memberships include the Texas Osteopathic Medical Association; TOMA District II; American Osteopathic Association; Texas Society of the American College of Osteopathic Family Physicians; Ohio Osteopathic Association; American Academy of Osteopathy; American College of Osteopathic Family Physicians; and the Society of Teachers in Family Medicine.

Dr. Bowling is on the active staff of Osteopathic Medical Center of Texas in Fort Worth, where he also serves on the Medical Records Committee. ■

95th Annual Convention and Scientific Seminar

June 16-19, 1994

Wyndham Greenspoint Hotel Houston, Texas

Educational Grantors and Exhibitors

A C Medical
Allermed Corporation
Central Pharmaceutical, Inc.
Doctors Hospital
Don Self & Associates
Environmental Health Center-Dallas
ION Laboratories
Lederle Laboratories
MAST Immunosystems
McNeil Consumer Products Company
Mead Johnson Pediatrics
Muro Pharmaceutical, Inc.
Ortho Pharmaceutical Corporation
PD/Aparat Medical
Physician Manpower Training
Physician Oncology Education
Physician Resource Network, Inc.
Schering Laboratories
Syntex Laboratories, Inc.
TEI Computers
Tex. State Board of Med. Examiners
Wyeth - Ayerst Laboratories
X-Ray Sales & Service Company

Educational Grants

Marion Merrill Dow
Upjohn

More to come. . .

TOMA 95th Annual Convention and Scientific Seminar

Osteopathic Medicine: The Launching Pad for Prevention, A Journey Toward Managed Care... T-6 and Counting.

June 16-19, 1994
Wyndham Greenspoint Hotel
Houston, Texas

28 AOA Category 1 - A CME Hours anticipated
3 AOA Category 2 - B CME Hours anticipated

Pre-Registration Deadline May 31, 1994

Name _____ **First Name for badge** _____
(please print or type)

Address _____ **City** _____ **St.** _____ **Zip** _____

D.O. College _____ **Year Graduated** _____ **AOA#** _____

Spouse\Guest _____ **will accompany me.**
(first and last name)

CONVENTION PRE-REGISTRATION FEES:

____ TOMA MEMBERS	$300
____ 1st & 2nd Year in Practice	$200
____ Spouses, Military, Retired, Interns, Residents and Associates	$150
____ TOMA NON-MEMBERS	$400

REGISTRATION AFTER MAY 31, 1994 OR AT THE DOOR:

_____ TOMA MEMBERS	$400
_____ 1st & 2nd Year in Practice	$300
_____ Spouses, Military, Retired, Interns, Residents and Associates	$200
_____ TOMA NON-MEMBERS	$500

Amount Enclosed _____

Family Day Options, Friday, June 17, 1994

Please choose a family event below. No clinical program will be held Friday afternoon.

OPTION #1

TOMA "WELLNESS BY GOLF" TOURNAMENT

*Handicap*_____

*At the prestigious **TOUR 18** golf course, 15 minutes from the Wyndham Greenspoint . This beautiful course provides 18 holes of America's most famous courses at one club. $85 Registration fee includes Charter Bus Transportation, Green fees, 1/2 Cart, Range balls, buffet dinner and team awards.*

Golf is limited to 100 so respond now!

Amount Enclosed _____

OPTION #2

SPACE CENTER TOUR AND ASTRONAUT LECTURE

*At the phenomenal **Space Center Houston** NASA complex. $10 per person or $25 per family, includes Charter Bus transportation, admission to the space center, a buffet dinner and a presentation by an astronaut the whole family can enjoy.*

*Number of Adults ages 12 and up attending*_____
*Number of children under age of 12 attending*_____

Please sign-up early to confirm your participation!

Amount Enclosed _____

TOTAL AMOUNT ENCLOSED _____

REFUND POLICY:

All cancellations must be received in writing. A $25.00 processing fee will be charged to all registrants who cancel. If cancellation is necessary the following policy will apply: 45 days prior to program, full refund (less processing fee). 30-45 days prior to program, 50 % of fees paid will be refunded. 15-30 days prior to program, 25% of fees paid will be refunded. Less than 15 days prior to program, NO REFUND.

Laurie B. Jones To Speak At Keynote Luncheon

Laurie Jones

Laurie Jones, president and founder of The Jones Group, a San Diego, California-based health care advertising, marketing and public relations firm, will be the featured speaker during the Keynote Luncheon on Thursday, June 16, during TOMA's annual convention in Houston. She has chosen *The Osteopathic Advantage* as her topic for discussion, which will deal with trends in health care marketing and her ideas, passion and vision for the osteopathic profession. Additionally, Ms. Jones will be conducting a workshop later in the afternoon, entitled *Marketing You and Your Profession.*

For over five years, Ms. Jones has spoken on such diverse topics as leadership and management skills, personal growth, patient/physician communication and winning marketing strategies. She has been consulting with The American Academy of Osteopathy on marketing, strategic planning, long range goals, editor of their journal and promoting the osteopathic principles to the public. In addition, she is presently working with Parkview Hospital in Toledo, Ohio, as the osteopathic identity coordinator.

Ms. Jones became so passionate about osteopathic principles that she has devoted a great deal of time researching and writing articles. A few popular ones are *I Had A Dream* and *Why The Osteopathic Profession Needs a Triple By-Pass in Order to Survive.* She has presented this seminar to over 50 osteopathic hospitals, associations and D.O.s across the country.

She is the author of a cassette tape series called, *How to Love 'Em and Lead 'Em: The Omega Management Style*, and has recently authored a book entitled, *Jesus, CEO*, to be published this September.

After graduating as an Outstanding West Texas Scholar and number one in her class, Ms. Jones attended the University of Texas at Austin on Scholarship, majoring in speech and communications. She entered the work force as Administrative Assistant in the School of Business Administration at Georgia State University. She honed her business administrative skills at Georgia State University and then moved to El Paso, where she was hired as PR Director of the Metropolitan YMCA. After one year, she was recruited to be Women's Information Service Director for the YMCA, a job which required the marketing and promotion of 80 programs annually with a zero budget.

Her innovative approaches to marketing did not go unnoticed in the profit sector, and she was soon approached by so many companies to help market their products or services that in 1980 she launched her ow advertising, marketing and publi relations firm.

Within 18 months she had over employees working for her, was elect President of Women in Radio an Television, and won major awards f copywriting, creative design an marketing. She won the Hospit Corporation of America's account f their regional hospital in a competiti with six other agencies.

Ms. Jones then branched out to Sa Diego and within two years had wo prestigious accounts by large private an health oriented companies, the mo publicly recognized being Chart Medical Corporation. She has sinc acted as a consultant to numero professionals in the health care field.

She was selected to be among the fir Most Notable Women of Texas, is liste in *Who's Who of American Busine women*, the International Edition *Who's Who* and has continued to w awards for creative excellence.

TOMA members are encouraged attend TOMA's Keynote Luncheon order to hear this dynamic speaker presentation of *The Osteopath Advantage.*

TOMA Members Interviewed In Boston For Local Radio Stations

Barry Beaty, D.O., John G. Mills, D.O., and John L. Sessions, D.O., were each interviewed at the American Osteopathic Association's annual convention in Boston for local radio stations.

The program, sponsored by the AOA, invited physicians to be interviewed in Boston. The interviews were then sent via overnight mail or phone to radio stations in the physician's local market(s). The interviews, or "sound bites," were then incorporated into the radio stations' news broadcasts.

The interview by Dr. Beaty, who practices in Fort Worth, was carried on KFRO-AM/FM (Longview), KESS-AM (Fort Worth) and KLTY-FM (Fort Worth). This represented 406,500 audience impressions.

Dr. Mills, also from Fort Worth, h his interview carried on KSTV-AM/F (Stephenville), KESS-AM (Fort Worth and KLTY-AM (Fort Worth), represen ing 667,400 audience impressions.

Dr. Sessions, who practices Kirbyville, had his interview carried KAYC-AM (Beaumont), KAYD-F (Beaumont), KQHN-AM (Nederlan and KQXY-FM (Nederland). Th represented 121,600 audien impressions.

A total of 150 interviews we accepted, and radio stations report that each interview was aired an averag of 3.4 times. The total estimate audience for the interviews wa 40,803,230.

TOMA's 1994 Convention Speakers

Speakers and topics for TOMA's 95th Annual Convention and Scientific Seminar, to be held June 16-19, 1994, in Houston, are being finalized as of this writing.

A few of those who have confirmed include the following:

David Ostransky, D.O., of Hurst, will present *Environmentally Induced Asthma: How Can We Prevent Lost-Time Illness?* as his topic of discussion.

Dr. Ostransky has a private pulmonology practice in Fort Worth and Bedford; serves as a Clinical Associate Professor at the University of North Texas Health Science Center at Fort Worth; and as a consultant and reviewer for the Texas Workers' Compensation Commission for Tarrant County.

He is certified in both Internal Medicine and Medical Diseases of the Chest by the American College of Osteopathic Internists/American Osteopathic Association, and is a diplomate of the National Board of Osteopathic Examiners.

A 1979 graduate of Kirksville College of Osteopathic Medicine, Kirksville, Missouri, Dr. Ostransky served an internship and an internal medicine residency at Grandview Hospital/Medical Center, Dayton, Ohio. He served a pulmonology fellowship at Grandview and at the University of Texas Health Sciences Center, San Antonio; a lung pathology fellowship at Washington University School of Medicine, St. Louis, Missouri; and an occupational lung diseases fellowship at the University of Cincinnati, Ohio.

Dr. Ostransky is a staff physician at Osteopathic Medical Center of Texas, Fort Worth, where he is also a member of the Department of Internal Medicine: and at Northeast Community Hospital in Bedford, where he is a member of the Department of Internal Medicine and member of the Pharmacy and Therapeutics Committee.

Professional memberships include Texas Osteopathic Medical Association; American Osteopathic Association; Texas Medical Association; American College of Osteopathic Internists; American Thoracic Society; Tarrant County Medical Society; American Lung Association of Texas; KOPPA Society; and the American College of Occupational and Environmental Medicine.

TB is Back: Can We Prevent a New Epidemic? will be presented by Stephen E. Weis, D.O., of Fort Worth.

Dr. Weis serves as an Associate Professor of Medicine/Endocrinology in the Department of Internal Medicine at Texas College of Osteopathic Medicine; as Associate Graduate Faculty of the Department of Health Sciences at North Texas State University, Denton; Director of Tuberculosis Services and Medical Director of the Hansen's Disease Clinic at the Tarrant County Health Department, Fort Worth; and as Medical Director of the Tarrant County Parkinson's Association.

Dr. Weis is certified in internal medicine and endocrinology and serves as TOMA's representative on the Texas Tuberculosis Control Board.

A 1978 graduate of the University of Osteopathic Medicine and Health Sciences, Des Moines, Iowa, Dr. Weis interned at Baptist Hospital, Brooklyn, New York, where he also served a medical residency. He served endocrinology and nuclear medicine/nuclear cardiology fellowships at S.U.N.Y., Stony Brook, New York.

Dr. Weise is affiliated with Osteopathic Medical Center of Texas, HealthSouth Rehabilitation Hospital, Harris Methodist Hospital and HCA Medical Plaza Hospital, all of Fort Worth.

Professional memberships include Texas Osteopathic Medical Association; Iowa State University Alumni Association; American Osteopathic Association, in which he is the AOA representative to the National Cholesterol Education Program; American College of Osteopathic Internists; American College of Osteopathic Internists, Endocrinology Subsection; American Diabetes Association; board member of the American Heart Association; Texas Medical Foundation; and the Fort Worth Endocrine Society. ■

Provisions for Liability Premium Discounts In Effect Through 1997

House Bill 18, passed by the Texas Legislature in 1989, contained provisions allowing physicians, who meet certain eligibility requirements, discounts on professional liability premiums. Physicians should be aware that after the Sunset Commission reviewed the Texas Medical Practice Act in 1993, the program was retained, and physicians have until September 1, 1997, to take advantage of the discounts.

The eligibility requirements mandate that: physicians must deliver charity care in at least 10 percent of their patient encounters during the policy term; physicians must complete 15 hours of CME in risk reduction and patient safety within the calendar year that the policy is in effect; and physicians must have a valid professional liability insurance policy for medical malpractice with specified limits.

Charity care is defined as: Medicaid; Texas Department of Human Services County Indigent Health Care Program; TDH Primary Health Care Services Program; TDH Chronically Ill and Disabled Children's Services Program; a contract with a federally funded migrant or community health center; and treatment for emergency patients provided the physician is not compensated.

In addition, the 1993 review approved the following patient encounters which can also be used toward the charity care requirement: inmates of a county correctional institution; patients encountered through an indigent health care program of a hospital district; and patients treated in an approved family practice residency training program, provided there is no compensation for services.

In the event of a malpractice claim against a physician arising from the charity care portion of the program, the state will be the first party to pay for actual damages.

Physicians who wish to take advantage of the premium discounts offered by House Bill 18 are required to contact their liability insurance carrier at the time of application or renewal, to inform them that they plan to meet the required 15 hours of CME and the charity care requirements. ■

HOUSTON: Another Advantage of Being A TEXAN and a TOMA MEMBER

The fourth largest city in America will host the 95th Annual TOMA Convention and Scientific Seminar, June 16-19, 1994. From the Space Center Houston and NASA to the historic appeal of Old Town Spring, it's easy to see why Houston ranks among the top in catering to the lifestyles of millions of visitors each year.

Houston offers the perfect combination of sophistication and western hospitality, while boasting a classic appeal found only near the Gulf Coast Country. This year's convention site is home to three major sports teams, 7000 restaurants, more than 50 golf courses, miles of sun-drenched beaches, national golf and tennis tournaments, polo, rodeos and so much more.

Your kids will enjoy "The Houston Experience" as much or more than you. Between the Space Center Houston — designed by Walt Disney Imagineering, AstroWorld — a Six Flags theme park, the Houston Museum of Natural Science and IMAX theater, kids of all ages can indulge in what will possibly be the greatest experience of the summer.

The Wyndham Greenspoint Hotel will be the center of our meeting activities and its proximity to the Greenspoint Mall (across the parking lot) will bring a smile to those who have the urge to shop. The avid shopper is well aware of The Westin Galleria Complex with over 300 restaurants and shops.

John R. Bowling, D.O. of Fort Worth is the program chairman for the TOMA meeting in Houston. He is developing a clinical seminar that will cross many segments of medicine and is guaranteed to generate a high level of interest. A few highlights of the annual meeting are Ethical Decisions in Managed Care, Family Violence, Prostate Cancer, A Symposium on Female Health, and Manipulating the Frail Elderly. The seminar is currently shaping up to offer 28 hours of AOA approved category 1-A CME and 3 hours of AOA approved category 2-B CME.

Join us for the 95th Annual Meeting and "The Houston Experience." It's far more than just another CME. . . the 1994 Convention is: ***The Launching Pad for Prevention — A Journey Toward Managed Care. . .T-6 and Counting.***

Former Texas House Speaker Gib Lewis Honored By UNT Health Science Center

Gibson D. "Gib" Lewis

The health science library at the University of North Texas Health Science Center at Fort Worth was renamed in honor of Gibson D. "Gib" Lewis, former speaker of the Texas House of Representatives in a ceremony on Friday, December 3, 1993.

Lewis was honored for his contributions to the creation and growth of the Texas College of Osteopathic Medicine and its recent redesignation as a health science center.

Among the state and national lawmakers attending the ceremony were U.S. Congressman Pete Geren and state senators Mike Moncrief and Chris Harris.

Geren said that the impressive turnout of civic and business leaders for the event was the best indicator of the admiration for Lewis. "When someone is in office, especially as speaker of the House, it's easy for them to draw a crowd. You often wonder what kind of crowd you'll draw after you lay down the reins of power. You wonder, 'are they only here because of what I can do for them?' Well, I think this is one more example of the loyalty and devotion of friends to Gib Lewis the person."

UNT Health Science Center President David M. Richards, D.O., said it is entirely appropriate for Lewis to be recognized by renaming the library in his honor. "No one has done more over the years in the Texas Legislature to help TCOM obtain its needed programs, personnel and buildings," said Richards. "He eloquently and convincingly advocated our mission and set the stage for the redesignation of TCOM as a health science center."

Jerry Farrington, chairman of the Board of Regents for the University of North Texas and the health science center, noted that a vision for the state of Texas is what led Lewis to champion the cause of the health science center in its beginnings over 20 years ago. "Gib brought a vision of medical care for Texas, a vision of family practice to serve the people in even the smallest towns of the state," he said.

Farrington, the center's Chancellor Alfred Hurley, Ph.D., and Richards joined Lewis in unveiling the commemorative plaque that will be permanently displayed in the library lobby.

Lewis described his support of TCOM and the health science center as a "labor of love for myself and my colleagues." "I assure you, this did not come about by the efforts of Gib Lewis alone. It took the whole effort of my colleagues in the Tarrant County delegation. I share this honor with them," he said. Lewis also praised the medical school for being true to its mission. "When we created the state support for this institution," he said, "the debate and the commitment we made to the House and the Senate at that time was that we would supply the best medical practitioners, general practitioners, this state has ever seen. We never lost the vision of that commitment and you, the people who are in charge of the curriculum and agenda of this university and this medical school, have never lost sight of that commitment we made. You have allowed us to keep our word. You have made me very, very proud."

Lewis was first elected to the Texas Legislature in 1971. He quickly became a strong advocate of making TCOM, then a private institution, a state-supported medical school. In January 1975, he introduced legislation proposing the union of TCOM and what was then North Texas State University. He also guided through the House of Representatives the Senate bill introduced by Betty Andujar that placed TCOM under the governance of the North Texas Board of Regents.

Lewis was instrumental in obtaining state funds for construction of the health science library which opened in 1986. The building, with 110,000 square feet of space and room for 200,000 volumes, also houses biomedical communications, computing services and computer classrooms. ■

(L-R) Jerry Farrington, Chairman, Board of Regents, University of North Texas Health Science Center; Alfred Hurley, Ph.D., Chancellor; David M. Richards, D.O., President; Gibson D. Lewis.

What's Happening In Washington D.C.

- ***A 17% Miscue.*** Recent studies now indicate that the Clinton Administration's cost estimate for its health care package is off by at least 17%. Cost estimates and funding options will be a primary focus of the Congressional debates that will draw much attention over the next few months.
- ***Rostenkowski Speaks Out.*** The Chairman of the House Ways and Means Committee is questioning two key funding tools in the Administration's health care package — the proposed tobacco tax and the requirement that small employers provide health benefits to all employees. The fear is that the first will have a severe impact on the tobacco industry and the second will lead to more unemployment.
- ***'94 Numbers Are In.*** The IRS has released inflation adjustments for 1994. Here are a few examples. Personal exemptions for 1994 will be increased to $2,450. The standard deduction for married couples will go to $6,350. The 15% tax bracket for married couples will be extended to $38,000, and the 28% tax bracket will be extended to $91,850. The new rates of 36% and 39.6% will not be adjusted for inflation until 1995. The threshold price for the automobile excise tax will be increased from $30,000 to $32,000.
- ***Fewer But Bigger.*** That describes the United States Tax Court docket today. The number of docketed cases has decreased nearly 50% since 1986, from 84,000 cases to approximately 40,000 cases today. But the deficiencies at stake in the pending cases have more than doubled, going from $16 billion to nearly $34 billion. The stakes have gone up because of numerous jumbo cases, each of which involves more than $100 million.
- ***Cash Can Hurt.*** The IRS once again is stepping up its efforts to attack money laundering. Anyone who engages in a trade or business and receives more than $10,000 cash in a transaction (or any two or more related transactions) is required to report the transaction on IRS Form 8300. The Service now has announced that it will begin assessing intentional disregard penalties for those who fail to file the form. The amount of the penalty will be the greater of $25,000 or the amount of cash received in the transaction, not to exceed $100,000.

S Corp Relief

New legislation to help privately-held businesses is being proposed by Senators Pryor and Danford. It would eliminate many of the restrictions and disadvantages that now apply to S corporations. Here are some of the highlights:

1. The number of shareholders that S corporations would be permitted to have would be increased from 35 to 50.
2. Members of a single family would be treated as only one shareholder.
3. Certain charities and nonresident aliens would be permitted to own S corporation stock.
4. Most trusts would qualify as S corporation shareholders.
5. S corporations would be allowed to issue preferred debt and convertible stock.
6. An employee who owns more than 2% of the stock of an S corporation could receive the same fringe benefits as a shareholder/employee of a C corporation.
7. S corporation shareholders would be permitted to borrow from their accounts in qualified retirement plans.

If You Are Thinking Of Buying A Business...

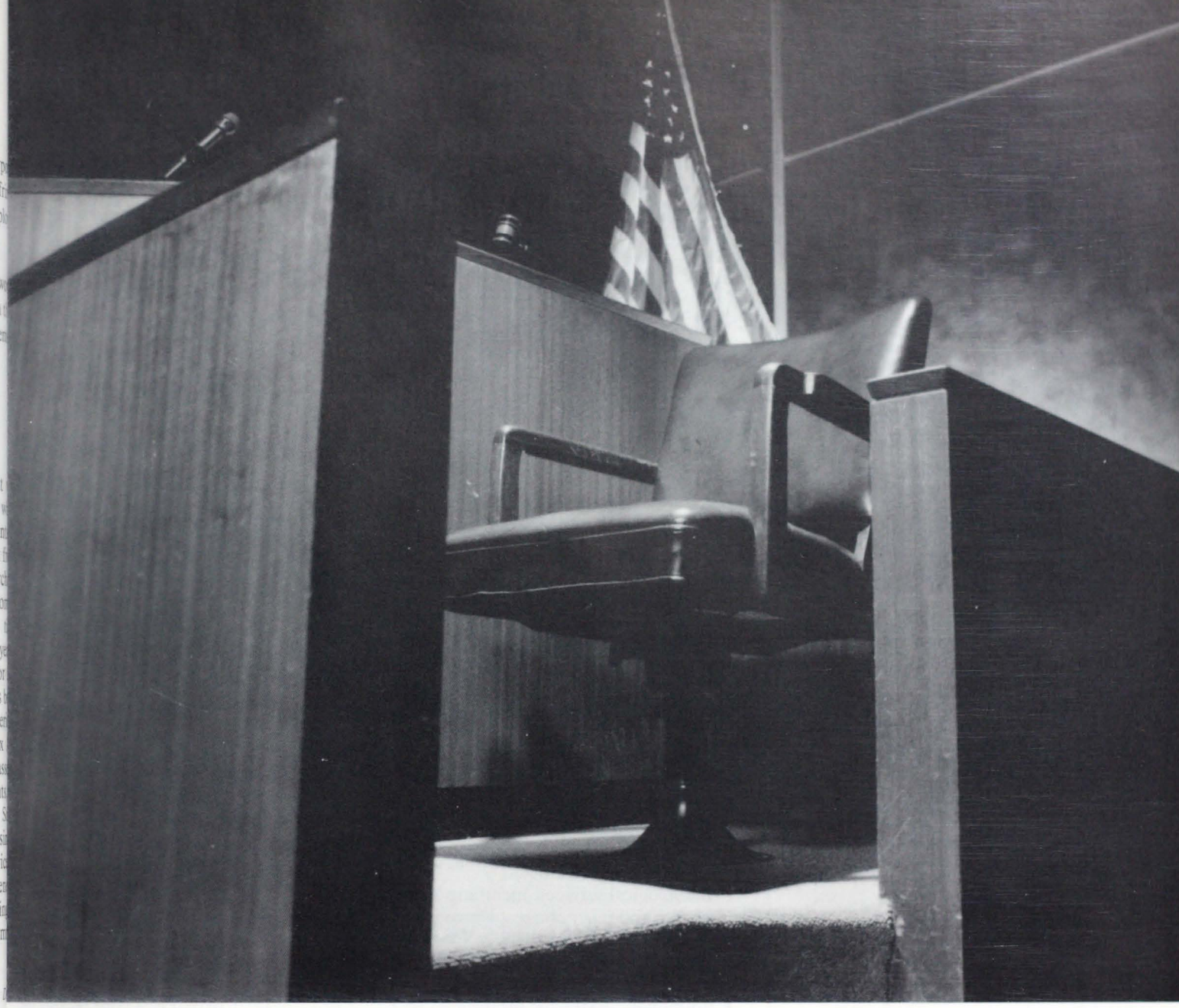
Watch out for a new rule that was added by the 1993 Tax Act. Often when a business is bought, the buyer wants to secure a noncompetition covenant from the seller. A portion of the purchase price is allocated to the seller's promise to not compete for a defined time period, typically three to five years. Historically, the tax treatment for the price allocated to the covenant has been to amortize it over the designated period. A new provision in the 1993 Tax Act requires that certain intangible assets, including noncompetition covenants, be amortized over a 15 year period. So if you are thinking of buying a business and allocating a portion of the price to such a covenant, the tax benefit associated with the payment is going to be diluted and stretched over a much longer period of time.

The above information was provided by Dean Jacobson Financial Services, Fort Worth.

Pass the Pizza, Please

Domino's Pizza, which conducts an informal study relating to pizza sales during political events, says that pizza orders are on the rise since President Clinton took office. Domino's gets an average of 72 calls daily from the White House and Old Executive Office Building — and sales leap another 18 percent when Hillary is absent from home.

During the Bush years, deliveries averaged 50 per day; however, for three days prior to the attack on Iraq, deliveries to the White House zoomed to 500 a day.



THIS IS NOT WHERE YOU WANT TO PRACTICE MEDICINE.

Your most important partner is a flexible, cost-effective professional liability insurance program. That's why you need DEAN, JACOBSON FINANCIAL SERVICES.

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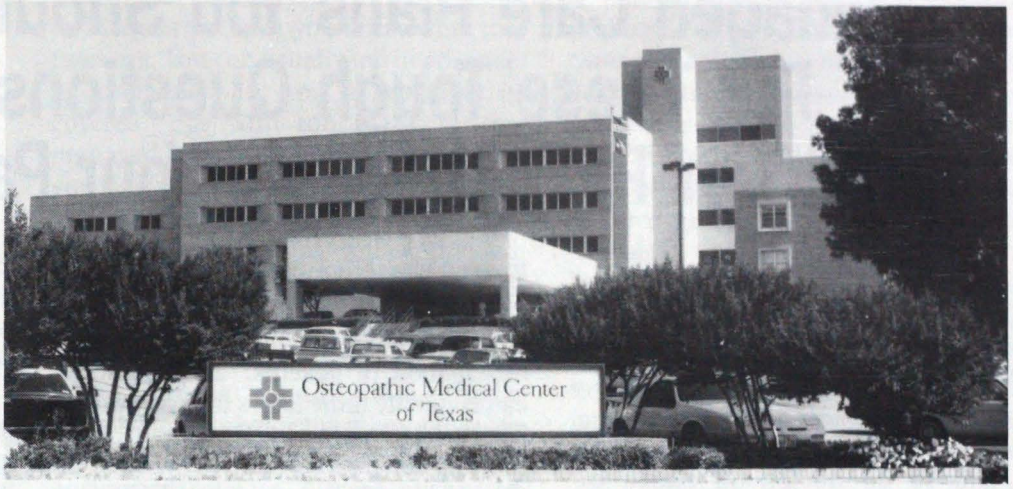

About Our System...

Osteopathic Health System of Texas provides this network of hospital and allied services to osteopathic physicians across Texas for a very good reason: to help provide quality health care in the fast-changing medical environment of the '90s.

All these services are built on a philosophy pioneered more than 100 years ago by Andrew Taylor Still, founder of osteopathic medicine.

And that philosophy, which is coming more and more into focus as the rest of the world catches up to it, is simple. It views patients as individuals, each with unique needs that are best met when they work in partnership with their physicians.

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For more information or to schedule a patient for services, contact CareLink 24 hours a day at 1(800) 299-CARE (2273).

Osteopathic Health System of Texas

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Managed Care Plans You Should Not Join: Put These Tough Questions To Any HMO or PPO Soliciting Your Participation

By Karen A. Zupko

As local employers go more and more into managed care, so do local patients — and so do doctors in search of patients. In many parts of the country, managed care plans are springing up like mushrooms. Contractors are cobbling together panels to market under the managed care banner. In your haste to keep and attract patients, you could easily get burned by an inferior plan.

An HMO or PPO operated by a traditional insurance company with experience in managed care can protect your patient base and keep your bottom line reasonably healthy. But increasingly, doctors are being approached by administrators of plans that don't have the experience, capital, or resources to meet their obligations. Don't let a shiny brochure fool you into thinking a contractor knows what it's doing. A plan needs to be run well and offer you adequate support, or it can become a nightmare.

Contracts you're seriously considering will ultimately need your lawyer's scrutiny. But you can perform an initial screening yourself, to weed out those that don't warrant the expense of an attorney's review. Just use the questions below as a list to ask each plan. The comments following each one explain why that question is important.

Which employers are offering the plan? Most doctors participate in managed care plans to add or keep patients. You also want a plan with enough enrollees and resources to meet its financial obligations. For both these reasons, you need to know which major local employers have contracted with your plan. In a small town, the most important employers may include the school system, town or county government, or the community hospital, as well as businesses. Call their employee benefits directors and ask what plans they provide.

In a big city, it's harder to tell which plan sponsors are key, but you still need to keep a weather eye out for what the large local employers are doing.

May I have a sample of the plan's explanation of benefits? This question can eliminate more losers than any other. That's because the EOB can cause you more problems than any other item in the whole arrangement. A bad EOB may include nothing more than the patient's name, the date of service, and the amount the plan is paying. This makes it impossible for you to track your receivables.

Say you've sent the plan an itemized bill with CPT codes and charges for a $95 office visit, a $30 lab test, and a $25 injection, totaling $150. The plan sends you back one of these detail-free EOBs along with a payment of $80. Your bookkeeper can't post it: What's the $80 for? The visit? The test? The injection? All three, each at a discounted rate?

At the very least, someone has to telephone for the particulars. At the worst, the plan won't be able to tell you why it paid what it did even when you reach it. Some of the least explanatory EOBs come from small-time third-party administrators — companies that process claims, form provider networks, and do utilization review — hired by self-insured businesses. These organizations may be too thinly staffed even to answer your call promptly.

If the EOB doesn't look like those you get from the Blues and Medicare, don't sign up.

On what basis does the plan pay — discounted fee-for-service? UCR? RBRVS? Capitation? Discounted fee-for-service may be based on your actual charges or on the plan's idea of usual, customary, and reasonable. Many plans set their own UCR levels and then apply the discount, resulting in a payment drastically lower than your fee. One Chicago area primary care practice discovered that its managed care plan, using this system, paid less than Medicare! Needless to say, the doctors dropped the plan.

If the plan uses RBRVS, you need to know which one (1992? 1993? Some other variation?) and what conversion rate it uses. Will it be used for all services? If not, what other payment system applies?

If the plan is capitated, you need to know the services you're expected to provide for the flat rate. If the plan pays you a small amount for an unrealistically long list of services, stay away. Also watch out for plans that require services you don't normally perform. Some plans expect all participating primary care doctors to do women's pelvic exams. If you're an internist who doesn't provide that service, think twice about joining a plan that asks you to.

Does the plan have a withhold or incentive system? If part of your payment is to be withheld against referral or hospitalization costs, you need to know how it's administered. Will the amount withheld be broken out on the explanation of benefits, so your bookkeeper can track it? If you charge $130 for a visit, and the plan allows you $100, you will write off the $30 as the plan discount.

If the plan then goes on to pay you $85 and withhold $15, however, you should track that differently — because you will want to compare what was withheld against what is returned to you at the end of the year. If you have just been writing off that 15 percent all year, when the plan sends you a lump $5,000 as an adjustment, you won't know whether you have recovered all or only part of the money withheld. If you think you are owed more, you won't be able to argue effectively for it.

You should maintain a withhold account for each plan, listing the date of service, patient's name, and the amount withheld. A well-run plan should give you a year-to-date total for withholds on each statement — but many plans don't. And don't sign with a plan that withholds part of your capitation or reimbursement if your staff or computer system can't track the money. Some of the larger medical office software manufacturers are now developing managed care modules to add on to their billing and bookkeeping

programs. The new packages can track withholds and capitation payments — older software may have no place to keep these records.

You may also want to know whether your withholds are pooled with those of all participating doctors, or only within your own specialty, and whether withholds are returned at different rates depending on specialty, utilization, or other criteria, such as quality.

What's the plan's record for paying back withholds? Small, poorly capitized plans sometimes don't pay back withholds in their early years because they just don't have the money. A primary care physician in Dayton, Ohio, got nothing back after the first two years she participated in one plan. "In year three it improved and in years four and five it was acceptable," she told me. But she was lucky — an awful lot of IPA HMOs have gone under.

What if a new plan has signed a good portion of the patients in your area? You may want to take the risk, betting that returns will improve as the plan finds its legs. But if a plan has a history of not making its incentive payments, participate only if you can afford to lose the money withheld.

When does the plan pay capitation and fees? Slow payment terms can wreak havoc on your cash flow and make it hard to reconcile receipts. If the plan is prepaid, do you receive the capitation at the beginning or the end of the month?

Many fee-for-service plans pay in 60 days — giving themselves a two month, interest free loan at your expense. And the clock may not start running until after the claim is approved. If you've got the computer capacity to submit claims electronically, ask whether the plan has the software to receive them, and whether electronic claims will be turned around faster.

Is there a training program for physicians' office staffs? Support varies dramatically from plan to plan. Some have very complete manuals; others will mail you four pages of instructions with no follow-up.

Best of all is help from a training team. One physician in Fort Worth asked several of his PPOs for help and the best ones sent representatives to his office for sessions with his staff. "All I had to do was ask," he says.

What are the rules? With Blue Shield or Medicare at least you know what the rules are. You can usually tell in advance whether a service you're providing is covered. But with too many of the managed care plans now being written, you don't have access to the rule book. You will find out a service isn't covered after the fact — when you are denied payment.

The best advice is to sign only with a plan that will let you know the rules in advance. If that's not possible, at least quiz the medical director about the rules that apply to your most frequently performed services. Get an answer to this question, too: When coverage is denied after the fact, can you bill the patient at the plan's rates?

Also ask about coverage of lab tests. If your own lab meets CLIA requirements, will the plan pay for tests you do yourself, or do you have to refer them out?

Most important, who decides which services are medically necessary? Is there a manual of treatment protocols you must follow to be sure the services are covered? Whose approval do you need if the patient's condition requires you to step outside those protocols? Must you get approval in advance? Use examples from your own practice.

Is there a phone number for provider questions? A good plan has a number — preferably toll-free — that you can call to find out whether a patient is eligible for coverage, whether a particular service is covered, and what approvals you'll need. Without such access, it can be impossible to follow the plan's rules.

Try calling the number a few times before you sign. If it's impossible to get through, it's of no use to you.

How can patient eligibility be verified? Some of the biggest PPO contractors don't provide eligibility updates, so you can hardly expect smaller ones to. But you can insist that the plan's provider information line allows you to confirm that a patient who's carrying the card is still a member. Some plans even have an 800 number for eligibility questions. If you're going to do any procedure for which the bill will be significant, your best bet is to check coverage in advance — it takes more time to chase receivables when your charges are rejected than it does to make that phone call.

What is the claims review and appeal process? Who will review claims: computer software, a nurse, a physician, a physician in my specialty? Ask the contractor for the specific steps you must follow to appeal a decision, and who is involved. If there is a rigid reliance on a computer program or a list of rules, what does it take to get a human involved in the process?

What kinds of quality evaluation will I be subject to? Will treatment patterns be reviewed? Will your office be inspected? Will patients be surveyed about their satisfaction with your care?

A well run practice may actually benefit from these quality assessments. A plan that cares about these details is likelier to satisfy its customers — and stay afloat — as well. And some plans reward high quality practitioners by reducing their withholds.

What is the plan's liability insurance requirement? Some plans are asking doctors to carry more insurance than their hospitals require for granting privileges. For example, one insurer in Illinois is requiring up to $500,000 more coverage for obstetricians than the best hospitals ask them to have. For an FP who delivers babies only occasionally, that can be a big bite for the privilege of accepting a plan's discounted payment. If you have to add insurance to join the plan, assess the extra expense and make it a factor in your decision.

While you're checking liability requirements, be on the lookout for clauses that saddle you with all the responsibility if a plan members sues either you or the HMO for malpractice. Under some HMO contracts, "hold-harmless" clauses require you to pay the HMO's share of the damages and costs as well as your own. You're also barred from suing the HMO if you lose in a malpractice case brought by an enrollee against you alone.

Will the plan send a sample member's benefit card? You're checking for two things: The card should clearly state the patient's copayment, and it should have a phone number you can call to verify the patient's eligibility. These two items alone can save a thousand headaches. If it's a toll-free 800 number, so much the better.

Will the plan pay for my 20 most frequent services, identified by CPT code? ▸

This the the best way to figure out whether you can afford to join a PPO. If the plan can't — or won't — answer, it isn't managed well enough to be worth your time. And if the payments listed are lower than your overhead for each service, you'll know it's not worth the trouble of participating.

How can doctors get out? of practices where the doctors don't know how long their contracts with managed care networks run — or even where they've filed the contracts. But you need to know how long you're obligated to the plan, and under what terms you can get out if things go sour. Some plans obligate you to participate until the end of the year, no matter what; others let you out on 90 day's notice.

Terms vary on how long you're responsible for patients who are plan members after your participation in the contract ends. Under some plans, you stay responsible for the patients even if the plan goes belly-up! Before signing, make sure you see the terms under which you can end your association with the plan. You'll also want to know the terms under which the HMO can drop you.

You'll save yourself time by putting these questions in a standard memo you give to managed care recruiters before you agree to see them. That way, you'll get information in a form that lets you compare plans easily. If a plan doesn't answer these questions to your satisfaction, it's not the plan for you. Don't roll over and play dead. A plan that scores poorly on some points but seems worthwhile on others may be amenable to change. Talk to your colleagues and your local medical society. While you can't legally confer on fees — that violates antitrust laws — you can get together to discuss common administrative requirements, such as the need for adequate EOBs, a clear appeal mechanism, and an understanding of the criteria for reimbursement.

Then, as a united front, present your demands to the plan, either directly or through your hospital administrator, if the hospital also is affiliated. If half the doctors in town petition the HMO, saying "We can't run our books off this system," the HMO may be willing to change. ■

In Memoriam

RICHARD M. MAYER, SR., D.O.

Dr. Richard M. Mayer of Lubbock passed away on December 30, 1993, at his home. He was 71 years of age.

Funeral services were held January 3, 1994 at St. Paul of the Plains Episcopal Church, with entombment in Resthaven Mausoleum.

Dr. Mayer was born in 1922 in Amarillo and had been a Lubbock resident since 1948. He was a 1946 graduate of the Kansas City College of Osteopathy and Surgery (now known as the University of Health Sciences College of Osteopathic Medicine). Dr. Mayer interned at Coats-Gafney Hospital in Tyler. He practiced in Silverton prior to moving to Lubbock, and was certified in geriatrics.

He was a member of the Texas Osteopathic Medical Association; TOMA District X; a life member of the American Academy of Osteopathic Surgeons; life member of the Texas Medical Association; Lubbock-Crosby-Garza Medical Association; American Medical Directors Association; Texas Medical Directors Association; and the Texas Geriatric Society. Dr. Mayer was a Certified Medical Director of Long-Term Care Facilities.

Dr. Mayer married Bobbie Smith in Lubbock in 1983 and was a member of St. Paul of the Plains Episcopal Church.

Survivors include his wife; a son, Richard II of Lubbock; a daughter, Marsha Beaudoin of Paris, France; three stepsons, David Smith of Los Angeles, California, Mark Smith of Austin and Eric Smith of Lubbock; two stepdaughters, Debbie Pate of Burbank, California, and Kathy Hoffman of Tyler; and three grandchildren.

The family suggests memorials to St. Paul of the Plains Episcopal Church or to a favorite charity.

JOE P. ALEXANDER, D.O.

Dr. Joe Alexander of Abilene passed away on December 31, 1993. He was 72 years of age.

Funeral services were held January 3, 1994, at St. Paul United Methodist Church, with burial in Elmwood Memorial Park.

Dr. Alexander was born in 1921 in Jayton. He attended Wayland Baptist College in Plainview and Baylor University before graduating from Kirksville College of Osteopathic Medicine in 1944.

He practiced in Spur with his father and brother until 1957, when he moved his practice to Abilene. He was joined by a son four years ago and had just announced his retirement.

Dr. Alexander was a life member of the Texas Osteopathic Medical Association and the American Osteopathic Association, as well as a member of TOMA District IV.

He was a past president of the Abilene Founder Lions Club and was named the club's Lion of the Year in 1992. He was a 32nd Degree Mason, affiliated with both Abilene Lodge 559 and Spur Lodge. Dr. Alexander was also a member of the Scottish Rite Bodies in Lubbock and York Rite Bodies in Abilene. He was a past-Potentate of Suez Shrine Temple of San Angelo. He also had memberships in the Royal Order of Jesters, Court 160, Order of Eastern Star, and the Royal Order of Scotland. He was a member of the Profiteer Sunday school class, a member of St. Paul United Methodist Church and a past member of its administrative board.

Survivors include his wife, Janie; a son, Joe Bob Alexander, M.D., of Abilene; two daughters, Eunice Hamrick of Denver City and Betsy Byrum of Gainesville; a brother Jack of Big Spring; and four grandchildren.

Memorials to St. Paul United Methodist Church, Chisholm Trail Council of Boy Scouts of America or Shrine Burn Institute are suggested.

TOMA Member Receives COMP's "Distinguished Alumnus Award"

Jeffrey Alan Stone, D.O. of Dallas, Texas, received the "Distinguished Alumnus Award for 1993" from the College of Osteopathic Medicine of the Pacific (COMP) in Pomona, California.

Dr. Stone was honored at the college's 13th annual founders dinner dance held at the Century Plaza Hotel in Los Angeles on November 6.

"Dr. Jeffrey Stone has distinguished himself in the field of medicine and in the profession of osteopathic medicine," said Rod Wineberg, chairman of the COMP Founders Committee. "We are proud to present him with this prestigious award that is given each year to a COMP alumnus that has achieved success and whose accomplishments have benefited the profession of osteopathic medicine and the community."

Dr. Stone is currently the associate director of hyperbaric medicine and director of aerospace medicine at the Institute for Exercise and Environmental Medicine at Presbyterian Hospital of Dallas, Texas. He is also clinical associate professor of public health at the Texas College of Osteopathic Medicine in Fort Worth and clinical assistant professor of family medicine at COMP.

Dr. Stone received his bachelor of science degree from Arizona State University in Tempe and his doctor of osteopathy degree from COMP in 1983. He began a career in the military and served an internship in pediatrics at the William Beaumont Army Medical Center in El Paso, Texas. He received flight surgeon training at Beaumont and was named "Health Service Flight Surgeon of the Year" in 1985 by the Society of U.S. Army Flight Surgeons.

In 1986, Dr. Stone was assigned to Fort Rucker, Alabama to serve as assistant chief of aviation medicine. A year later he became chief of professional education of the Army's school of aviation medicine.

Dr. Stone began a residency program in aerospace medicine in 1987, spending the first year at the Harvard School of Public Health, where he earned a master of public health degree, and the second year at the U.S. Air Force School of Aerospace Medicine at Brooks Air Force Base in San Antonio, Texas.

It was in June of 1989 that Dr. Stone became involved in hyperbaric medicine and entered a fellowship program in hyperbaric medicine at Brooks. He was the third Army physician and the first osteopathic physician to be selected for this program.

Upon completion of the fellowship, he was named chief of the Department of Aviation and Hyperbaric Medicine at the U.S. Army Aeromedical Center at Fort Rucker, Alabama, where he is credited with developing the Army's hyperbaric medicine program which included treatment of war injuries from Desert Storm.

Board-certified in hyperbaric medicine and aerospace medicine, Dr. Stone also serves as a senior medical examiner for the Federal Aviation Administration and as a hyperbaric medical consultant to the U.S. Army Aeromedical Center, Medicare of Texas, Veterans Hospital and the Dallas Poison Control Center.

Dr. Stone is the author of published articles on hyperbaric oxygenation and decompression sickness.

He and his wife Anne live in Dallas with their two sons.

The College of Osteopathic Medicine of the Pacific (COMP) is a non-profit, accredited, independent academic health center, located on over ten acres in downtown Pomona, California. Founded in 1977 as a four-year medical school to educate osteopathic physicians, the college has expanded its mission by offering educational programs in the allied health professions. Over 800 students are enrolled in programs leading to the Doctor of Osteopathy (D.O.) degree, Master of Science in Health Professions Education (M.S.H.P.E.) degree, Master of Physical Therapy (M.P.T.) degree and Physician Assistant certificate (PA) program. COMP also provides continuing medical and professional education for physicians and other health care professionals.

Congratulations to Dr. Stone from TOMA! ■

Whooping Cough Rising Due to Missed Vaccinations

The Centers for Disease Control and Prevention has warned that scores of American children are catching whooping cough, also called pertussis, because too many are failing to receive vaccinations on time. In 1993, 5,457 cases were reported through December 4, the highest total since 1967. The 1993 figure represents an 82 percent jump over 1992 figures, and 19 percent over 1990 totals. Thirty-seven states reported an increase in whooping cough cases in 1993. The CDC found that approximately half of preschool-age children who developed whooping cough in 1993 had not received the proper vaccination.

The DPT shot (diphtheria, tetanus and pertussis) should be administered at ages two months, four months, six months and 15 months. Additionally, children should receive a booster shot before they enter school. Dr. D.A. Henderson, deputy assistant secretary for health and science at the Public Health Service in Washington, noted that parents and physicians are becoming complacent about vaccination schedules. "What we're trying to get across (to doctors) is that every time you see a young child, the vaccination status should be checked out," he said. He added that parents need to understand that their child needs four doses of the vaccination. ■

FYI

COLLEGE ENROLLMENTS DROPPING

A poll by the American Council of Education found that college and university enrollments fell in the fall of 1993 in three out of four states. Of 16 states responding, only Texas, Georgia, New Jersey and Tennessee reported increases. The enrollment decline is attributed to tuition increases, smaller course offerings and enrollment caps.

DOCTORS RETURNING TO RURAL PRACTICES

The number of physicians in rural areas of Texas is increasing, according to the Texas Department of Health. The number of rural doctors peaked in 1987 at 2,293; fell to 2,169 in 1991; and bounced up to 2,374 in 1993.

ATTENTION: TOMA MEMBERS

This serves as a reminder that any member or district planning to present resolutions to the TOMA House of Delegates' meeting on Wednesday, June 15, 1994, during the Annual Convention must submit such resolution(s) to the TOMA State Office prior to May 15, 1994.

No resolutions will be voted on in the House of Delegates' meeting unless they have been received in the State Office prior to the above date.

If you have any questions regarding resolutions, please call TOMA at 1-800-444-8662.

THE FUTURE OF AIDS

Future AIDS victims will be primarily young and black, according to a compilation of new studies presented in late December at the First National Conference on Human Retroviruses. The overall U.S. prevalence of HIV in white men is 0.27 percent; in black men, it is 1.9 percent. In black men between 18 and 39, the HIV rate is 2.5 percent. The study found that overall, the HIV rate in young black men is 10 times higher than the rate in the general U.S. population.

A major study presented by the National Cancer Institute during the conference indicates that the average age of infection has fallen three to five years over the course of the epidemic. The age of the average HIV-positive person in the mid-1980s was 30; between 1987 and 1991, the average age had fallen to between 25 and 27. Researchers found that one in four new HIV infections occur in Americans younger than 23.

Another study found that for the first time, more women tested positive for HIV than men among people who received care in 1991 at hospitals treating poor and inner-city patients in the Northeast.

An estimated 550,000 Americans are currently infected with HIV, however, the National Center for Health Statistics feels the real number may be as high as 1.02 million.

METROPOLITAN LIFE's ADVERTISING UNDER INVESTIGATION

Responding to consumer complaints, the Texas Department of Insurance is investigating the advertising practices of New York-based Metropolitan Life Insurance Company. The complaints specifically target direct-mail advertising allegedly used to sell life insurance as "retirement plans" to nurses and other professionals. The investigation is focusing on direct-mail ads by the company's agents in Texas. For more information, contact the customer service department of the Texas Department of Insurance at 800/252-3439.

FUTURE TEXAS MEDICAID PROJECTIONS ARE ALARMING

Texas Comptroller John Sharp has predicted that up to 3.5 million Texans will be eligible for Medicaid by the year 1995. This figure represents a leap from the two million now on Medicaid (out of a total population of 17 million). Sharp further projects that the tab would come to $21 billion — $7 billion of which would have to be paid by state funds. Texas currently has more Medicaid-eligible children than 19 other states combined, and about 40 percent of all births in Texas are paid for by Medicaid.

RU-486 MAY LEAD TO BIRTH CONTROL PILL FOR MEN

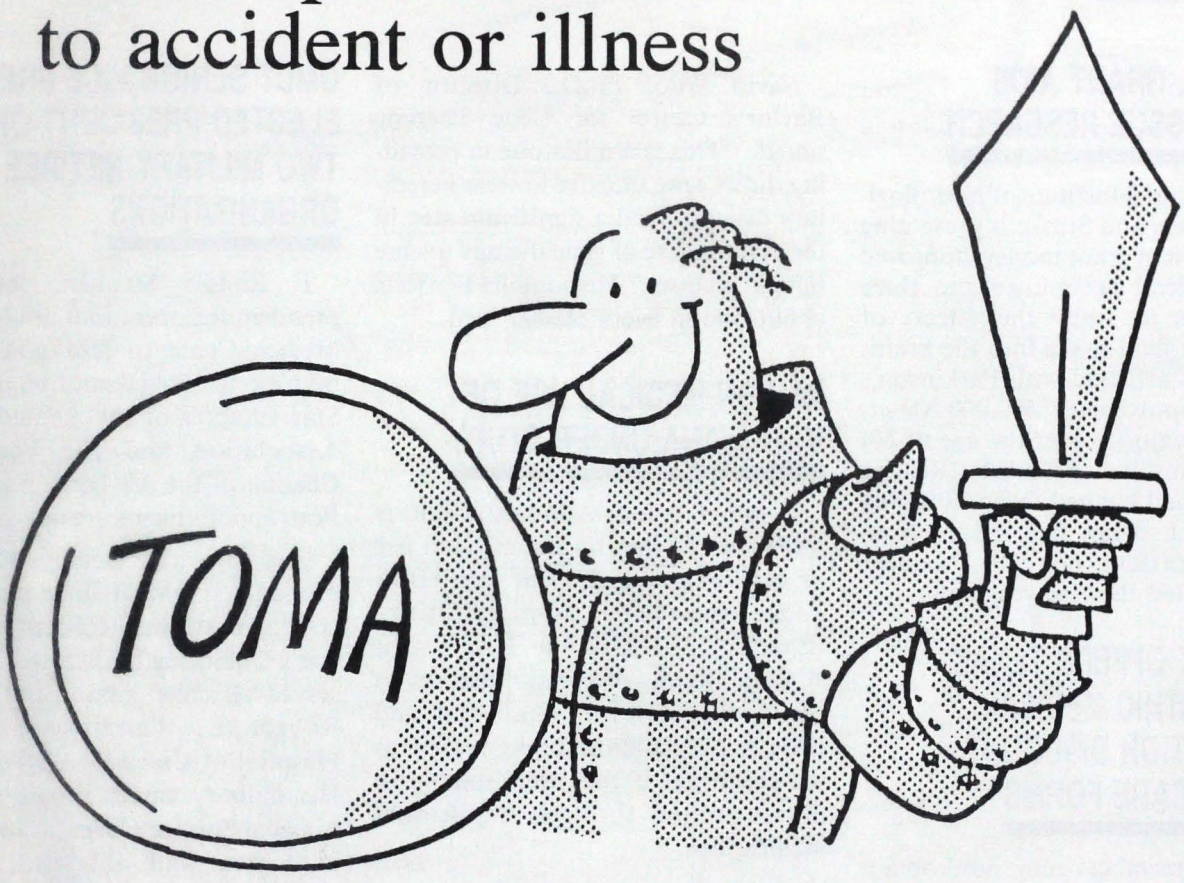
RU-486, the so-called "French abortion pill," may lead to a breakthrough birth control pill for men that could become active in a few seconds. Recent testing with human sperm indicates that the pill may function as a kind of "hormonal condom," according to Dr. Etienne-Emile Beaulieu, the developer of RU-486. He also noted that effects of the pill would wear off quickly. Research has shown that the drug in the pill prevents calcium from penetrating the sperm. In the absence of calcium, sperm lose their mobility and cannot fertilize the female egg. Preliminary testing has begun on monkeys and rats, with human testing expected to begin in two or three years.

NEW PAIN DRUG HITS THE MARKET

A nonprescription pain reliever containing a new analgesic ingredient has just been approved by the Food and Drug Administration. Naproxen sodium (known as Naprosyn) will be sold over-the-counter as a pain reliever.

(Continued on page 30)

How to protect your future from catastrophic loss due to accident or illness



HEALTH INSURANCE - A Strategy For The `90s

The high cost, no guarantee system of health insurance coverage is an enemy that is battling ALL small employers, especially physicians.

Although a total victory over these problems may still be far away, TOMA has discovered a "knight in shining armor" for its members who can help shield the frustrations that managing health insurance (or the lack of) can cause.

TOMA has appointed DEAN, JACOBSON FINANCIAL SERVICES to battle the complexities of the health insurance environment for you. Insured through CNA Insurance Company (an A++ Excellent rated company with a long, successful record in the accident and health business) the TOMA plan offers superior Major Medical coverage to its members at very competitive rates.

So, regardless of your current situation with health coverage, call DEAN, JACOBSON FINANCIAL SERVICES to help you protect your future!

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

DEAN, JACOBSON FINANCIAL SERVICES

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

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

FEDERAL GRANT AIDS FETAL TISSUE RESEARCH

The National Institute of Neurological Disorders and Stroke is presenting $4.5 million in grant money, approved by the federal government, to three institutions to study the effects of implanting fetal tissue into the brains of patients afflicted with Parkinson's disease. Approximately 500,000 Americans, the majority over the age of 60, have Parkinson's. Presidents Reagan and Bush had banned federal funding for research using fetal tissue from elective abortions, however, President Clinton lifted the five-year ban.

GRAFTEK OFFERS TEXAS OSTEOPATHIC MEDICAL ASSOCIATION DISCOUNT ON MEDICARE FORMS

TOMA members may now obtain HCFA 1500 forms at a 10 percent discount off the published list prices, provided you are carried on our roster as a member in good standing, and indentify yourself as a TOMA member when ordering. Graftek will also provide an additional five percent discount on all personalized or blank non-continuous forms.

Discounts will be extended on ALL reorders as long as you remain a TOMA member. Graftek has marketed 1500 forms for years and maintains, on a regular basis, the most competitive prices in the nation. Their toll free number is 800/848-2992. (9 a.m. to 6 p.m.), Monday through Friday. No deposit is required and satisfaction is guaranteed.

HOPE FOR HEMOPHILIACS

A team of United States scientists, including researchers at Baylor College of Medicine, have successfully used gene therapy to provide long-term treatment of hemophilia B in laboratory animals, according to the Texas Society for Biomedical Research.

Savio Woo, Ph.D., Director of Baylor's Center for Gene Therapy noted, "This is a milestone in providing direct gene transfer to treat hereditary diseases, and a significant step in the eventual use of gene therapy to cure human illnesses." Hemophilia B affects about one in every 30,000 men.

BAN ON MEDICAL USE OF MARIJUANA UNDER STUDY

The Clinton Administration is reviewing the ban on the medical use of marijuana which went into effect under the Bush administration. Beginning in 1976, the government allowed victims of certain diseases to file application with the Food and Drug Administration for permission to use the drug, if they were unable to obtain relief through traditional medications.

Medical use of marijuana was approved by the FDA on a case-by-case basis for conditions such as glaucoma, to alleviate eye pressure; cancer and AIDS, to ease the nausea and loss of appetite accompanying treatment for these diseases; and multiple sclerosis and spinal cord injuries, to ease muscle spasms.

FOR MEMBERS ONLY — TOMA ANNOUNCES NEW MEMBERSHIP BENEFIT

The Texas Osteopathic Medical Association has negotiated special rates for TOMA members who utilize the services of Alamo Rent A Car. The special rates, which reflect a discount from Alamo's standard retail rates, allow for $2 off daily and five percent off weekly rates.

For additional information regarding this new benefit, contact Brenda Gross, TOMA Membership Secretary, at 1-800-444-8662.

OMCT SENIOR VICE PRESIDENT ELECTED PRESIDENT OF TWO MILITARY RETIREE ORGANIZATIONS

F. Ronald Stephen, senior vice president for operations at Osteopathic Medical Center of Texas (OMCT), has been elected president of both the Lone Star Chapter of the Retired Officers Association and the Fort Worth Chapter of the Air Force Association. Both appointments are one-year terms.

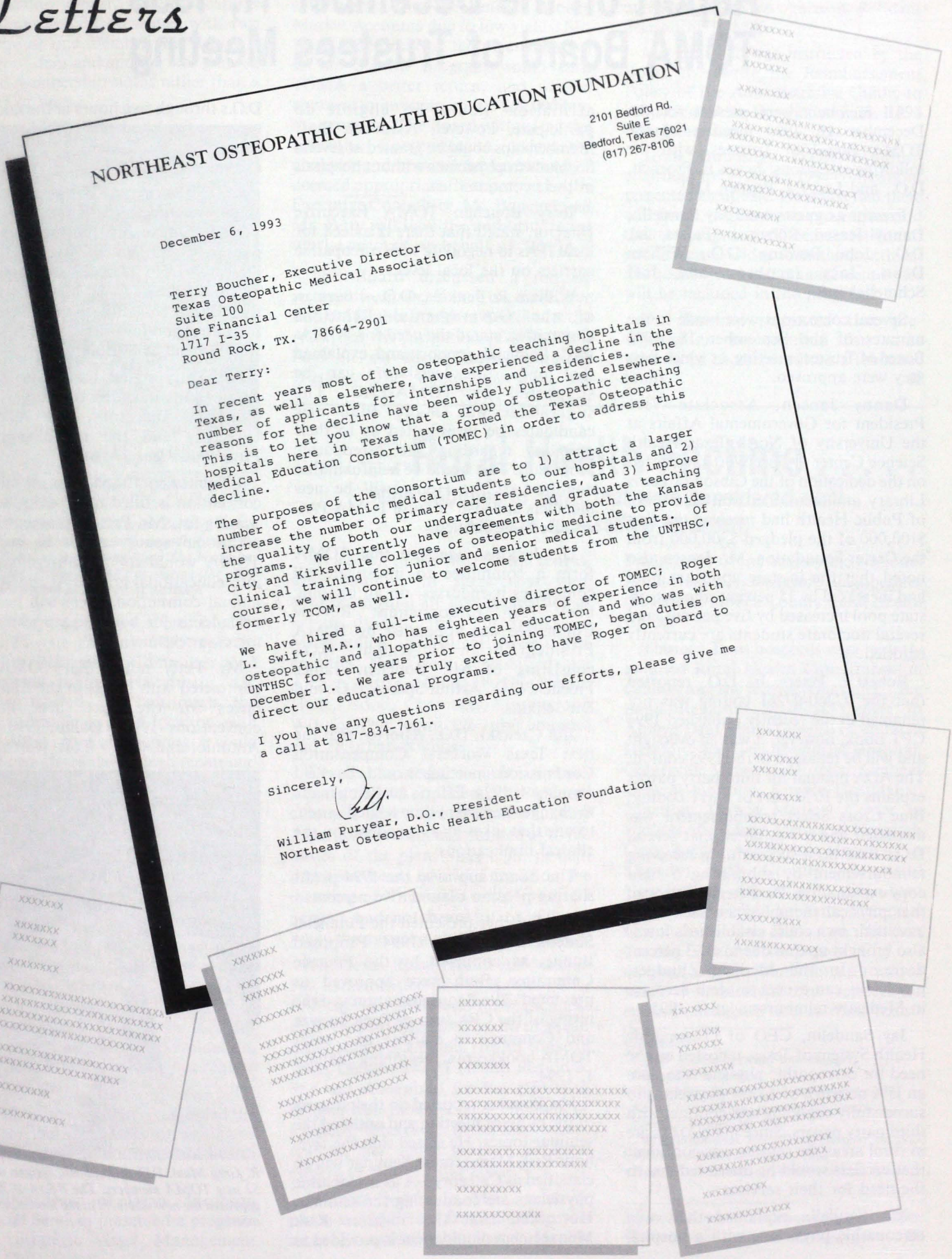
Stephen has been senior vice president at OMCT since 1989. Before coming to the medical center, Stephen was a Colonel in the U.S. Air Force and served as chief administrator at the Robert L. Thompson Strategic Hospital at Carswell Air Force Base. His military career in the Air Force Medical Service Corps included tours in Korea and England, and he completed assignments as chief administrator of four military hospitals.

During his tenure at OMCT, Stephen developed and implemented the highly successful Carswell Osteopathic Medical Plan. The multi-faceted program helps military retirees and their families access health care and other services once provided by Carswell's hospital.

Stephen is a Fellow in the American College of Health Care Executives, and has served as a course director and faculty member for health care administration courses for the U.S. Air Force Medical Service.

With 265 beds, OMCT is the largest osteopathic institution in Texas. This non-profit medical center serves as a primary teaching hospital for the University of North Texas Health Science Center at Fort Worth, formerly the Texas College of Osteopathic Medicine. ■

Letters



NORTHEAST OSTEOPATHIC HEALTH EDUCATION FOUNDATION

2101 Bedford Rd.
Suite E
Bedford, Texas 76021
(817) 267-8106

December 6, 1993

Terry Boucher, Executive Director
Texas Osteopathic Medical Association
Suite 100
One Financial Center
1717 I-35
Round Rock, TX. 78664-2901

Dear Terry:

In recent years most of the osteopathic teaching hospitals in Texas, as well as elsewhere, have experienced a decline in the number of applicants for internships and residencies. The reasons for the decline have been widely publicized elsewhere. This is to let you know that a group of osteopathic teaching hospitals here in Texas have formed the Texas Osteopathic Medical Education Consortium (TOMEC) in order to address this decline.

The purposes of the consortium are to 1) attract a larger number of osteopathic medical students to our hospitals and 2) increase the number of primary care residencies, and 3) improve the quality of both our undergraduate and graduate teaching programs. We currently have agreements with both the Kansas City and Kirksville colleges of osteopathic medicine to provide clinical training for junior and senior medical students. Of course, we will continue to welcome students from the UNTHSC, formerly TCOM, as well.

We have hired a full-time executive director of TOMEC; Roger L. Swift, M.A., who has eighteen years of experience in both osteopathic and allopathic medical education and who was with UNTHSC for ten years prior to joining TOMEC, began duties on December 1. We are truly excited to have Roger on board to direct our educational programs.

I you have any questions regarding our efforts, please give me a call at 817-834-7161.

Sincerely,

William Puryear, D.O., President
Northeast Osteopathic Health Education Foundation

Report on the December 11, 1993 TOMA Board of Trustees Meeting

All members were present for the December 11, 1993 meeting of the TOMA Board of Trustees, with the following exceptions: James E. Froelich, D.O., and Larry J. Pepper, D.O.

Present as guests were Jay Sandelin, Danny Jensen, Robert L. Peters, Jr., D.O., John Bowling, D.O., William Dean, Jake Jacobson and Jeff Schmeltekopf.

Several corrections were made to the minutes of the September 18, 1993 Board of Trustees meeting, at which time they were approved.

Danny Jensen, Associate Vice President for Governmental Affairs at the University of North Texas Health Science Center at Fort Worth, reported on the dedication of the Gibson D. Lewis Library, and mentioned that the School of Public Health had received the first $100,000 of the pledged $300,000 from the Carter Foundation. Mr. Jensen also noted that the in-state applicant pool had increased by 15 percent, the out-of-state pool increased by five percent, and several doctorate students are currently enrolled.

Robert L. Peters, Jr., D.O., reported that the 97260-97261 coding was not renamed in the recently published 1994 CPT Book, however, it was an oversight and will be renamed in the 1995 edition. The AOA manual for third party payors explains the E/M part of OMT coding. Blue Cross Select reimbursement was discussed and it was noted that several D.O.s have been successful in receiving reimbursement by submitting a hard copy explanation. Dr. Peters mentioned that physical therapists are seeking to have their own codes established. It was also brought up that due to a 1.3 percent decrease in the Medicare budget, physicians can expect to see a decrease in Medicare reimbursement in 1995.

Jay Sandelin, CEO of Osteopathic Health System of Texas, reported on the need for osteopathic physicians to have an IPA network of fellow physicians to successfully negotiate and contract with third party payors. Since many D.O.s are in rural areas, he said he was confident that carriers would be interested due to the need for their services.

Mr. Sandelin explained that only osteopathic physicians with a hospital affiliation would be eligible to participate, however, Associate Staff Memberships could be granted at several hospitals to physicians without hospitals in their communities.

Terry Boucher, TOMA Executive Director, stated that there is a need for local IPAs to negotiate with osteopathic carriers on the local level.

William R. Jenkins, D.O., chairman of the Governmental Relations Committee, stated the need for TOMA-PAC financial support and explained that only state legislators can be supported by TOMA-PAC. The suggestion was made that new candidates be investigated as to their opinions regarding the osteopathic profession. This would be helpful in that one-third of the House will be new members and also because TOMA-PAC resources are limited.

Dr. Jenkins suggested that TOMA form a committee to investigate all companies it endorses, on an ongoing basis. An Endorsement Review Committee was appointed by TOMA President Brian G. Knight, D.O., consisting of Mr. Boucher, James Froelich, D.O., Arthur Speece, D.O., and Dr. Jenkins.

Jim Czewski, D.O., reported that the next Texas Workers' Compensation Commission meeting would be held January 4, 1994. Efforts are being made to change the current time related system to one that takes into consideration the clinical implications.

The Board approved the 1994 profit sharing pension plan at five percent.

Mr. Boucher presented the Financial Statement and the 1994 Proposed Budget as approved by the Finance Committee. Both were approved as presented. The Board also approved the hiring of the CPA firm of Pena Swayze and Company to manage and audit TOMA bookkeeping beginning January 1, 1994.

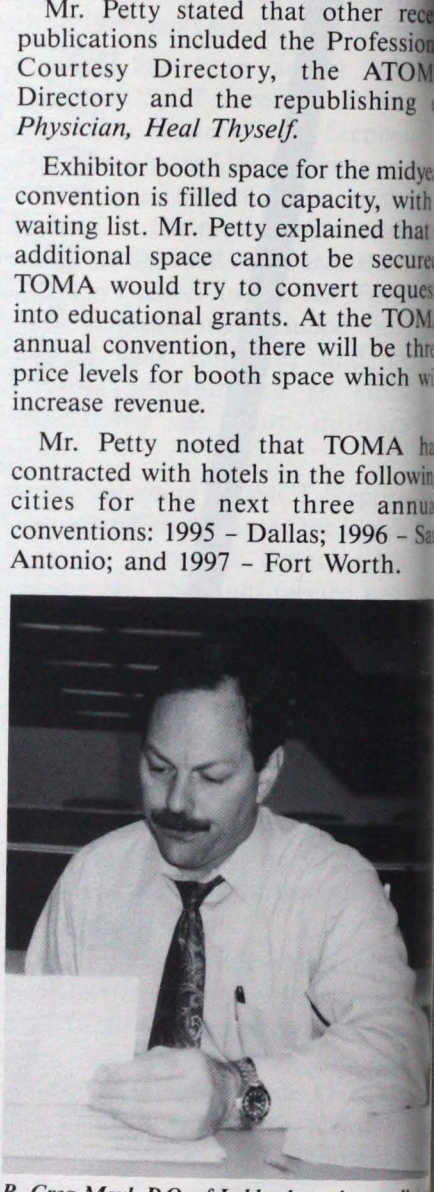
Mr. Boucher reported on the progress of the midyear meeting and outlined the seminar topics. He stated that the five-hour Risk Management Seminar will be classified as Category 1-A as osteopathic physicians are conducting the seminar. He noted that the 15-hour Risk Management requirement is provided to D.O.s through five hours at the midye meeting, five hours at the TOMA ann convention and five hours at the AC annual convention.

Mr. Scott Petty, TOMA Associ Executive Director, announced that TOMA membership directory had b published and mailed. Advertisers h increased from 22 to 29 and classifi ads rose from 24 to 31. Mr. Petty no that Blue Cross/Blue Shield increa their donation for printing the direct from $6,700 to $7,500.

Mr. Petty stated that other rec publications included the Professio Courtesy Directory, the ATOM Directory and the republishing *Physician, Heal Thyself.*

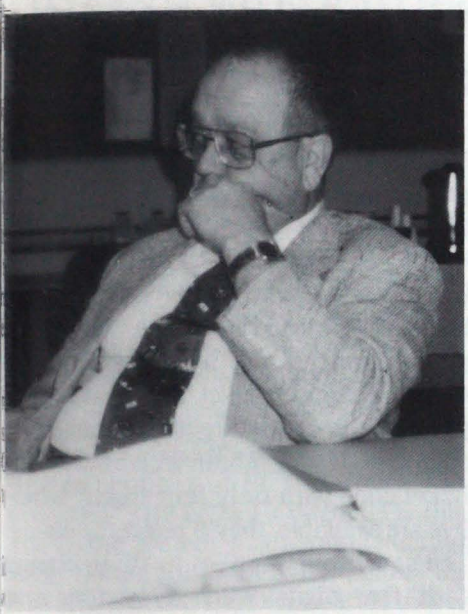
Exhibitor booth space for the midye convention is filled to capacity, with waiting list. Mr. Petty explained that additional space cannot be secure TOMA would try to convert reque into educational grants. At the TOM annual convention, there will be thr price levels for booth space which w increase revenue.

Mr. Petty noted that TOMA h contracted with hotels in the followi cities for the next three annu conventions: 1995 - Dallas; 1996 - S Antonio; and 1997 - Fort Worth.



R. Greg Maul, D.O. of Lubbock, reviews a list 52 new TOMA members. The Board of Trustee approved the new members at the December boa meeting.

R. Greg Maul, D.O., submitted the membership report. All applications were approved as presented with two exceptions; one member was denied a waiver of dues and another was granted retired membership status rather than a waiver of dues.



TOMA President-Elect T. Eugene Zachary, D.O. of Fort Worth, listens to a motion made during the recent Board of Trustees meeting. The board last met at the Dallas Doubletree during the 38th Midyear meeting at the end of January.

A relocation update was presented by Dr. T. Eugene Zachary, who reported that the Relocation Committee had investigated property in Austin. Dr. Zachary stated that although the property was in a good location with ample office space and parking, it could not be considered due to high repair and completion costs.

A discussion began on health reform. Dr. Joseph Montgomery-Davis reiterated what Dr. Peters had reported regarding new codes for 1994. There will be five codes (98925, 26, 27, 28 and 29), one for body region 1 to 2, 3 to 4, 5 to 6, 7 to 8, and 9 to 10. The codes have been consolidated for in and outpatient treatment. Medicaid codes will remain the same as Workers' Compensation codes. Dr. Montgomery-Davis explained that the modifier 25 must be used for management, follow up and evaluation, however, the first visit does not require the modifier.

Dr. Montgomery-Davis reminded the Board of the importance of writing to legislators asking for support of health reform issues.

William Dean of Dean, Jacobson Financial Services presented a program called Strategic Asset Management (S.A.M.) and suggested that TOMA shift assets from the Putman Money Market Accounts due to low yields. Mr. Dean stated that he felt diversification in the S.A.M. program would earn TOMA a better return, and wanted approval to invest an initital $50,000 into the program. The Board authorized the Executive Committee to review the program and approve the investment if deemed appropriate. If approved by the Executive Committee, Mr. Boucher and Mr. Petty will have the authority to set up the account on behalf of TOMA.

The Board discussed a request received from Dr. Scott Fox, Executive Board Member-Resident Section of the AOA, for the formation of a Resident Position on the TOMA Board of Trustees. The Board instructed the Bylaws Committee to develop proposed amendments to recognize a Resident Section in TOMA.

Mr. Boucher was instructed by the Board to rewrite the Reimbursement Policy of the Administrative Guide, to be presented at the January 28, 1994 Board meeting.

John Bowling, D.O., program chairman for TOMA's 1994 convention, presented an update. He stated that there will be an emphasis on prevention and that the programs will be interactive and self-learning. Didactic methods, ethical and social issues and management issues will be included in the programs.

Dr. Bowling suggested that pre-registration be required for some workshops as there will be attendance limits. ■

. . . . . Rural Health Factline . . . . .

Nine counties in Texas that were considered rural are now reclassified as urban.

As a result of the 1990 federal census, nine counties in Texas that were considered rural are now reclassified as urban due to their proximity to Metropolitan Statistical Areas. The counties that were reclassified are Archer, Bastrop, Caldwell, Henderson, Hunt, Hood, Chambers, Upshur and Wilson. This leaves 196 rural counties and 58 urban counties.[1]

Despite a media assault by both supporters and opponents of President Clinton's health care reform plan, many Americans are still uninformed as to the basics of the plan. Sixty-eight percent had never heard of or did not know the meaning of "managed care," while 77 percent had not heard of or did not know the meaning of "health alliance."[2]

The Texas Rural Health Association has named Sister Nancy Hansen, RN, PNP, as the person who made the most difference in Texas rural health this year. Sister Nancy is a Public Health Nurse in Texas Department of Health Region 3. She was recognized for her efforts in helping the mothers and children of Presidio, Texas to get better health care, and for her active support for local efforts to reduce child abuse.[3]

Maurice Wilkinson, M.D., a family practice physician from Shiner, was recently named the Rural Health Practitioner of the Year by the National Rural Health Association. She operates the Fayette-Lavaca County Rural Health Clinic.[4]

Thirteen Texas hospitals were recently awarded Rural Health Care Transition Grants from the federal government. Big Bend Regional Medical Center in Alpine; Deaf Smith General Hospital in Hereford; Fairfield Memorial Hospital; Gainesville Memorial Hospital; Graham General Hospital; Kimble Hospital in Junction; Lavaca Medical Center in Hallettsville; Llano Memorial Hospital; Otto Kaiser Memorial Hospital in Kenedy; Polk County Memorial Hospital in Livingston; Stamford Memorial Hospital; Val Verde Memorial Hospital in Del Rio; and Yoakum County Hospital in Denver City all received $50,000 grants for up to three years to implement new services or expand existing services in rural Texas.[5]

References:

1. *Office of Management and Budget, December 31, 1992*
2. *Community Health Funding Report citing Kaiser Foundation/Howard University survey, October 28, 1993*
3. *The International, Presidio, September 30, 1993*
4. Victoria Advocate, July 3, 1993
5. *Health Care Financing Administration, October 5, 1993*

Reprinted from the Rural Health Reporter, Winter 1993 ■

Self's Tips & Tidings

Don Self & Associates

REVISIONS — GLOBAL FEE PERIODS

On each of the annual updates we generated for each retainer client, we included the 1994 Medicare Global Fee period for hundreds of procedures that each doctor performs. We urge you to particularly note the changes in Global Fees for Medicare for 1994, as this may make a substantial difference in your income this year. Many procedures that had a 10 day global period in 1993 have either a 0 day global period or none at all, in 1994. Again, if you perform a procedure that is indicated to have a 0 day Global period, in 1994, you may charge for any pre-op or post-op care that falls on the day before or the day after the procedure, as they are not included in the reimbursement for the procedure. A 0 day global period does include any evaluation and management services rendered on the same day as the procedure. The December 2, 1993 *Federal Register* lists all of the codes with Global Fee Period changes on Pages 63677 and 63678. Of course, it is much easier to find these on the annual update we provided for all retainer clients.

VENIPUNCTURE CODE CHANGED

Medicare Part B Newsletter #125 listed the new HCPCS code for routine venipuncture for Medicare (G0001). This is a Type of Service 5 for electronic claims and Medicare will continue to only pay for one venipuncture per day.

Unfortunately, they have not increased their reimbursement, as it is still $3.00. Due to OSHA costs and the liability in dealing with blood, we recommend you charge $6.00 for this code, as we suggested for code 36415 in your fee and code update. Of course, you should still use code 36415 for commercial insurance, as they still do not recognize alpha-numeric HCPCS codes.

We still suggest you use code P9605 when you send your nurse or assistant to the nursing home to draw blood on patients. Medicare will continue paying $3.00 for this code also.

NEW PHYSICIAN REDUCTIONS DROPPED

HCFA and Medicare finally recognize their mistake in reducing the approved amounts for physicians in their first four years of practice. Effective January 1, 1994, these reductions will no longer apply.

LAB CODE/FEE UPDATE

As reported in Medicare's *Clinical Laboratory Newsletter # 5*, quite a few CPT codes have changed in the clinical lab area. Codes that are deleted in 1994, with no crosswalk to a new code are:

82812	82817	82961
83790	84246	85575
85720		

The codes that have a crosswalk to a new lab code are:

OLD	NEW
82091	80408
82173	80428
82536	80400-80406
82537	80400-80406
82538	80436
82539	80420
82792	82805,82810
82801 82802	82803
82804 82812	82803
82817	82803
83004	80430
83526	80434,80435
83681	80428
84175	84165
84201	80438,80439
84444 84555	80438,80439
84589 85820	85810
86421-86423	82785,83518,86003,86005
89205	82273

The new lab codes go into effect on January 1, but have a grace period until April 1, 1994.

HCPCS CODE CHANGES — JANUARY 1

The 1994 CPT book lists over 600 code changes, additions and deletions. As reported in our annual fee/code updates, several new codes have been developed in the following areas:

Osteopathic Manipulation
Prolonged Service
Allergy Tests
Nasal Endoscopy
Thoracoscopy
Procto/Sigmoidoscopy

If you do not have a 1994 edition of the CPT & HCPCS codes, we suggest you call PMIC at 800-633-7467, extension 548. Mention to Shannin that you are our client and receive a 10 percent discount. We receive nothing for this referral.

MEDICARE ICD9 REQUIREMENTS

Medicare Newsletter #125 states that Medicare will finally start requiring proper usage of ICD9 codes, on claims. Medicare has repeatedly warned they would deny or reject claims with improper usage of ICD9 codes, but I believe they mean it this time. Therefore, we recommend you review your check sheet or charge ticket and make sure your ICD9 codes are up-to-date and complete. If you submit a claim with an ICD9 code with only four digits, when five are available, they'll reject the claim. The same thing applies to filing claims with five digits when only four are applicable.

LIMITING CHARGES ON INJECTIONS

As of December 22, Medicare was frantically trying to publish a listing of the approved amounts and Limiting Charges for injectable, that will take effect on January 1. Nonpar physicians will be restricted to the L.C. on injections in 1994.

PAYMENT FLOOR CHANGES

As part of Medicare's attempt to get everyone involved in filing claims electronically (ECS), the payment floor changed on January 1. Electronic claims may be paid in 14 days, while paper claims will be held 27 days. We continue to hear from ECS clients that they are being paid in as little as 10 days, due to "Prioritizing" of claims by Medicare Texas.

HCFA 1500 CHANGES — JANUARY 1

Medicare Texas has finally decided to crack the whip, as most carriers have done in years past. Effective for claims received at Medicare on January 1, 1994, or later, PAPER claims not meeting the stringent formatting requirements will be either denied or rejected and returned to you UNPROCESSED. The claims must

be submitted on "red-ink" 12/90 versions of the HCFA 1500. Copies of claim forms will not be accepted. The areas that Medicare has reported that cause the largest number of problems are as follows (numbers below reference the box on the HCFA form):

1A. HICN has to be EXACTLY as it appears on patient's Medicare card, whether Medicare is primary or secondary. Enter the number WITHOUT spaces and/or hyphens.

4. On Medicare primary claims, leave this area BLANK. If another carrier is primary, either enter the insured's name here or enter "SAME."

7. On Medicare primary claims, leave this area BLANK. If you completed box four, enter the insured's address AND phone number.

9. Leave this area BLANK except when the patient has an assigned Medigap policies or BC/BS TEXAS as secondary. DO NOT COMPLETE this area if the patient has a supplemental policy that is not MEDIGAP or BC/BS TEXAS. DO NOT COMPLETE this if another BC/BS carrier is secondary. When the patient has a MEDIGAP policy as secondary, ONLY par physicians should complete this area, as Medicare will not forward Medigap claims for non-par providers. Other supplemental claims that Medicare automatically forwards are already in Medicare's computer, so listing them in this space is unnecessary and could cause your claim to be rejected.

9A. On Medigap claims only, enter the policy and/or group number of the Medigap enrollee, preceded by the word "MEDIGAP."

9C. This field may be left blank ONLY when the unique identifier of the Medigap carrier is inserted in box 9D. If the number is not in 9D, on Medigap secondary claims, you should enter the Medigap carrier's claims processing address, including an abbreviated street address, two letter state postal code and ZIP code.

10D. This box is for MEDICAID information only! If the pt has Medicaid, enter the patient's Medicaid number preceded by the letters "MCD." If the number is not preceded by "MCD" the claim may be rejected.

11. If you leave this box blank, the claim WILL BE REJECTED. If there is insurance primary to Medicare, enter the policy or group number in this box, and proceed to box 11A. If there is NO insurance primary to Medicare, enter the word "NONE" and proceed to box 12.

11D & 15. Leave Blank

17. Enter referring or ordering physician's LAST NAME, first name and middle initial. Since every service a patient receives was either referred by another provider (consultation) or ordered by some physician, this box should ALWAYS be completed. If your computer system places the name in order by first, middle, last, you should call your programmer TODAY! The name must be entered, LAST name first.

17A. List the HCFA assigned UPIN of the physician named in item 17. If the claim involves multiple referring or ordering providers, a separate HCFA form must be used for each.

19. Physicians providing routine foot care, and physical therapists must complete this box. The date the patient was last seen and the UPIN of his/her attending physician must be entered for routine foot care and physical therapists.

22 & 24C. Leave Blank

24E. Enter ONLY ONE number (1, 2, 3 or 4) in this box, per line, to correspond to the diagnosis code referenced in box 21. If you enter multiple numbers, in this box, per line, your claim will be REJECTED.

24H - 24J. Leave Blank

24K. GROUP PRACTICES ONLY — Enter PIN of performing physician in this box.

25. To have participating physician claims transferred to Medigap as secondary, you MUST enter your Federal Tax ID number. Other claims may have either tax ID # or social security number of provider.

32. This box MUST BE COMPLETED. If the name and address where services were rendered is the same as the physician's name and address listed in box 33, the word "SAME" may be entered. DO NOT LEAVE BLANK. If the services were furnished in a hospital, clinic, laboratory or facility other than the patient's home or physician's office, enter the name AND ADDRESS of the facility in this box.

33. Enter the physician's billing name, address, ZIP code, telephone number and Medicare Texas PROVIDER NUMBER in this box. DO NOT ENTER THE UPIN in this box. If box 24K contains the individual provider number, in a group, enter the GROUP NUMBER in this box.

Certain carriers qualify to have their secondary claims automatically transferred by Medicare Texas. These claims, while not Medigap are sent to the secondary carrier, with Medicare's payment determination, without you identifying them on the claim. Once more, do not list these carriers in box 9 on the claim form, as the transfer is automatic and depends on Medicare's tape records in their computer:

Aetna Life & Casualty
American Gen. Life & Accident
American Postal Workers Union
BC/BS of Kansas City
BC/BS OF Texas — See box 9
Government Employees Hosp. Assn.
Humana, Inc.
Kirke-Van Orsdel
Medicaid (Texas) — See box 10D
Metropolitan Life Insurance Co.
Mutual of Omaha
Nat'l Assn of Letter Carriers
Olympic Health Mgmnt Systems
United Commercial Travelers

With the exception of BC/BS of Texas and Texas Medicaid, you do not need to list the secondary claim information on the claim for the above listed carriers.

Should you have trouble formatting your computer generated paper claims to these requirements, we suggest you immediately contact your software company or programmer. Medicare is serious about rejecting or denying paper claims submitted incorrectly.

If you are unable to change the formatting on computer generated claims, rather than manually typing the corrections or claims, you do have another alternative. If your computer can print the claims with the format required in 1993, we are usually able to electronically take the claims from your computer, alter the formatting to the electronic formats and transmit them directly to Medicare and/ or Medicaid on the same day that you enter them. We provide this service for retainer clients at 50 cents per claim. This is a reduction, as we charge non-retainers 70 cents for Medicare or Medicaid claims. Should you so desire, we can also handle all commercial claims for you, which is charged at 60 cents for retainers (70 cents — non-retainers).

THANK YOU

We are pleased to announce that 1993 has been the best year for our business, since 1988, when we opened. We have added several new retainer clients, several hospitals, new employees and new services. Our claims filing divisions have grown beyond our expectations and God has blessed our family immensely. We thank you for being a blessing to us! ■

Public Health Notes

The Mentally Ill Homeless — A National Scandal

Alecia A. Hathaway, M.D., M.P.H.

Recently, I found myself making little trips to the Humane Society Shelter located on Lancaster Avenue. First, I viewed the lovely new facility in concert with the Health Department's animal control activities, and then found the opportunity to adopt a pet. On a return trip to the Humane Society to collect my new pet, I could not help but notice an emaciated man, perhaps in his thirties with long, unkempt hair and a matted beard attempting with great difficulty to cross Lancaster. His gait suggested severe neurologic deficits.

I was struck by this tableau. On one side of the street was this very nice facility housing and comprehensively caring for stray and unwanted animals. On the other was what appeared to be an impaired human being evidently not capable of caring for himself. No practical or humane provisions exist to address this problem in our society. In a society that cherishes maximal personal freedoms we are left with a conundrum. Have we become too individualistic where our personal freedoms have overstepped the good of the group (society) or, is perhaps the premise of how those freedoms are exercised and guaranteed the issue. Before exploring this a bit more in one of the "central mistakes," I would like to share some background statistics to define the scope of the national problem which might shed some light on our own microcosm in Tarrant County.

Approximately one-third of the total (350,000-600,000) population of homeless adults in the United States are seriously mentally ill. Another third are alcoholics and drug addicts (thus dysfunctional) and the remaining third homeless for economic reasons which include inadequate low-income housing. Of course, there is overlap of the three groups, but this rule of thirds fits as a basic division of the adult homeless population. If we consider that approximately two-thirds (230,000 to 400,000 — when grouping the seriously mentally ill, alcoholics and addicts) represents impaired adults among the homeless, this number would comprise a mid-size U.S. city. For the purposes of this discussion, though, I will be focusing primarily on the seriously mentally ill. So somewhere between 116,000 and 200,000 seriously mentally ill individuals live in public shelters and on the nation's sidewalks. This number is greater than that remaining in public mental health hospitals. Homelessness is not only a personal tragedy for these individuals, but a national scandal.

Not surprising, many of the seriously mentally ill (37,500 to 100,000) are confined in jails and prisons often charged with petty crimes simply to get them off the streets. This rotation of street-shelter-jail-street strikes me as woefully backward for a "developed" nation. How did we get here?

Six central mistakes were made. Our failures to implement the "programs" — a continuing failure — is the shame of the American mental health and legal establishments.

*1. **Thirty years ago mental illness was even less well understood than today:*** Many professionals did not believe that they were true entities and that stresses in society, bad mothering and even hospitals were the actual causes. Prominent author Erving Goffman and psychiatrist Thomas Szasz argued that nothing was wrong with these people that discharge from the hospital would not cure. Books emerged such as Ken Kessy's *One Flew Over the Cuckoo's Nest* and movies such as the *King of Hearts*. The message was the same. Open the gates — let the mental patients out — and all will live happily ever after. We know the ending to that story. I don't believe it was as simplistic as that, however. I think it has been a complex tragic problem we face, and, as an individualistic society we were a little bit guilty of practicing denial.

*2. **Failures of community mental health centers:*** Under President John Kennedy, 789 Community Mental Health Centers (CMHCs) eventually received more than $3 billion in federal funds, and, were clearly charged in the 1963 & '6[illegible] congressional hearings (which led to their funding) to provide community treatment facilities for individuals released from, or scheduled for state mental hospitals. In any event, the CMHCs failed to be the cornerstones of after care as they were chartered. With few exceptions the CMHCs became, instead, counseling and psychotherapy centers for people with less serious problems. Rather than treating patients with schizo-affective psychosis and providing a vigorous outreach program, they counseled people with self-esteem issues and marital problems. The president's noble attempts to enhance the lives of the hospital based mentally ill became an expensive federally subsidized counseling service for the worried well. The failure of the CMHC program, permitted and overseen by the National Institute of Mental Health (NIMH), is a major reason de-institutionalizing action crumbled and the shelters and streets are crowded today with mentally ill homeless.

*3. **Lack of mental health manpower:*** In 1945, when the initial congressional hearings created the NIMH, there were as few as 7,000 mental health workers in the nation. Over the next 40 years NIMH invested more than $2 billion along with several billion dolalrs from state programs to train mental health workers. Today more than 150,000 psychiatrists, psychologists and psychiatric social workers, the vast majority of whom received public subsidizing, go into mental *health* professions (which I support too) rather than into mental illness work. They went into private practice of counseling and psychotherapy, avoiding practice in public clinics and state hospitals among patients with serious mental health problems. There was no payback obligation attached to

he public training programs and foreign medical graduates (often speaking little English and with differing cultural ways) were imported to fill the gaps. Today over half of all psychiatrists manning public clinics and hospitals are foreign medical graduates. In addition, these public positions pay from $60,000 to $110,000 whereas their private practice counterparts can earn twice that. Managed care could rectify some of this, but, we should be especially cautious with regard to health reform since well intentioned federal involvement created the homeless situation, an unforeseen fiasco but not entirely unpredictable.

4. Fiscal shell game: After the Feds devised the CMHC program, it began other public support programs for mentally ill persons. Medicaid, Medicare, Supplemental Security Insurance (SSI), and Social Security Disability Insurance (SSDI) were extended to cover these folks. But, each had special requirements. Medicaid pays for a patient treated in the psychiatric ward of a *general* hospital, but not in a state hospital. Consequently, a massive incentive to shift the fiscal burden from the states to the federal level was created. The most effective way of doing so was to simply empty the state hospitals.

5. Legal loopholes: The 1960's civil rights movement gave birth to a coterie of well-meaning lawyers who took up the mission of legally protecting psychiatric patients. They were so effective that almost all states tightened their laws making it very difficult to involuntarily commit or treat patients. So the catch 22. Large numbers of seriously mentally ill living on streets and parks cannot be hospitalized or treated involuntarily; and, they cannot voluntarily exercise informed consent if not capable of rational thought or simple judgment. They do not oftentimes possess the necessary self-awareness or competency to contract as evidenced by their predicament. The standard is that they must have demonstrated "dangerousness" to themselves or to others. The psychiatrist Charles Krauthammer observed, "the standard should not be dangerousness but helplessness." So, while we have protected the "rights" of the seriously mentally ill, we have at the same time forsaken them. What about their "right" for compassionate treatment. We have more human provisions for other helpless persons and creatures in our society.

6. Failure to conduct needed research: The federal government failed to support adequate research on the causes and treatment of serious mental illness. Much of that is attributed to the National Institute of Mental Health (NIMH), which in 1969 split from its parent, the National Institutes of Health (NIH). NIMH had originally been designated as a research institute. Training and services were ancillary but minor support functions. With the new CMHC program in its portfolio, NIMH changed course and embarked on the mission of solving such social and public health problems as violence, poverty, drug abuse, etc., certainly worthy endeavors, but the success of which over the years is questionable. By the 1980's, schizophrenia and manic-depressive psychosis were more neglected by researchers than any other major disease. For every diagnosed patient with schizophrenia, $20 per year was spent on research compared with multiple sclerosis ($161 per patient), cancer ($300 per patient), or muscular dystrophy (over $1,000 per patient). It has improved some. Due to the efforts of better NIMH leadership and interest on the part of congressional leaders, support for research on serious mental illness has increased, but still lags far behind for a condition affecting so many in our society, both directly and indirectly. It is difficult to estimate the financial and emotional impact on our country either through direct costs or from years of productive life loss or "waste."

$17 Billion Worth of Chaos:

Basically, the public mental health system has grown steadily more disjointed and ineffective over the past 30 years. The lack of humane care for the mentally ill homeless is extraordinary in a country which spends approximately $17 billion annually in public funds for mental health programs and leads the world in the proportion of gross national product spent on health. And, the problem continues as state mental hospitals discharge patients who then become homeless within six months. How do we as a nation, as a community, get out of this spiral? Proposed solutions next issue. ■

FDA APPROVED

New Drugs Approved by FDA

On January 3, the Food and Drug Administration announced approval of an epilepsy drug that can be used in combination with other drugs taken for the disorder. Developed by the Parke-Davis division of Warner-Lambert Company of Morris Plains, New Jersey, it will be marketed under the brand name Neurontin.

Additionally, the FDA recently approved a breakthrough orphan drug, Betaseron (Interferon beta-lb), for treatment of relapsing-remitting Multiple Sclerosis. This is the first drug to be approved for the treatment of MS. It is estimated that 300,000 Americans suffer from MS, and approximately 150,000 of them have the relapsing-remitting form of the disease.

Betaseron is manufactured by the Chiron Corporation for sale by Berlex. This drug was awarded FDA approval so quickly that the manufacturer was caught unprepared, thus, during the first year on the market, there will only be enough Betaseron for 12,000 to 20,000 people. Patients can call the Betaseron information line at 1-800-580-3837 to add their name to a waiting list.

Texas ACFP Update

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

I want to start off this article with a reminder regarding the new OMT codes effective January 1, 1994. These new codes replace HCPCS Codes M0702-730; however, they will not replace the policy third party payors have requiring reimbursement for OMT. For Medicare, you still have to use modifier 25 with follow-up office visits when OMT is provided on the same day. If the patient is coming back for OMT services only, an office visit on the same day will continue to be disallowed.

CPT Codes	Procedures Description
98925	OMT one to two body regions
98926	OMT three to four body regions
98927	OMT five to six body regions
98928	OMT seven to eight body regions
98929	OMT nine to ten body regions

The OMT codes are for use in outpatient or hospital settings. Body regions are defined as head, cervical, thoracic, lumbar, sacrum, lower extremity, upper extremity, pelvis, ribs, abdomen and viscera.

There were several important Medical Practice Act changes made by the 73rd Texas Legislature. First, the 90-day grace period for paying the renewal for a physician's license has been eliminated and there are stiff penalties for late registration. Renewals must be received by the board on or before the day the annual registration expires. Application form and fees for the March 1, 1994 through the February 28, 1995 renewals must be received on or before Monday, February 28, 1994.

Failure to comply will result in the following:

One day to 90 days late:	A penalty fee of $400 in addition to the annual registration fee
91 days to 365 days late:	A penalty fee of $800 in addition to the annual registration fee
After one year, without notice:	Your license will be considered canceled. Reinstatement of your license after this year may require that you pass an examination.

Second, the Board will be required to adopt, monitor, and enforce a reporting program for Continuing Medical Education (CME) of Texas licensees. Listed below are the adopted rules requiring Texas physicians to complete at least 24 hours of CME in the following categories:

1. At least one-half of the hours are to be from formal courses that are:
   A. designated for AMA/PRA Category I credit by a CME sponsor accreditated by the Accreditation Council for Continuing Medical Education or the Texas Medical Association;
   B. approved for prescribed audit by the American Academy of Family Physicians;
   C. designated for AOA Category 1 credit required for osteopathic physicians by an accredited CME sponsor approved by the American Osteopathic Association;
   D. approved by the Texas Medical Association based on standards established by the AMA for its Physician's Recognition Award; or
   E. approved by the Council on Medical Specialty Societies.
2. The remaining hours may be composed of informal self-study, attendance at hospital lectures, grand rounds, or case conferences and shall be recorded in a manner that can be easily transmitted to the board upon request.

Physicians will be required to report the number of CME hours completed (even if it is 0) on their next annual registration form. Completion of the required 24 hours per year will be effective January 1, 1995.

Third, Board rules were adopted effective December 24, 1993, requiring physicians to provide notification to their patients on how to file complaints to the Medical Board. Physicians can provide such notification by means of a sign displayed in their place of business, in a bill for services, or on each registration form, application, or written contract for services. The Medical Board provided a notice in the Fall/Winter 1993 Newsletter, Pages 7-8 in both English and Spanish, which may be displayed in the physician's office. Remember, like it or not, it is mandatory for Texas physicians to comply with this provision.

The TSBME will review the complaint notification at its January 15 Board meeting. If the complaint notification signs are approved, TOMA will reprint and mail copies to all TOMA members.

Some other actions taken by the Medical Board were:

1) Copies of medical records (or a summary or narrative of the records) must be furnished pursuant to a written request within 30 days after the date the physician received the request. If the physician denies such a request, in whole or in part, the physician will be required to provide a signed and dated statement to the patient stating the reason for the denial and place a copy of such statement in the patient's medical record. The copy of the records or summary may be provided on paper or on microfilm, microfiche, computer hard disk, magnetic tape, optical disk, or other appropriate means if the person who is providing the information and the person to receive the information agree to the form.

2) Language providing for disciplinary action for prescribing or dispensing narcotic drugs, controlled substances, or dangerous drugs to a person who the physician should have known was a "habitual user" of the drugs has been changed to "an abuser" of the drugs. An exception for the treatment of intractable pain under the Intractable Pain Treatment Act is also specifically set out in addition to the previous exemption for physicians treating persons for narcotic use after notifying the Board.

3) Disciplinary action against physicians for overcharging or overtreating patients will no longer be based on both persistent and flagrant acts. The language of the statute now allows for disciplinary action based on persistent or flagrant overcharging or overtreating.

There were also significant changes to drug laws as a result

of the 73rd Texas Legislature. Both the Texas Dangerous Drug Act (DDA) and the Texas Controlled Substances Act (CSA) were amended to allow a pharmacist to exercise professional judgment to dispense an emergency (less than 72 hour) supply of a drug without practitioner approval for the refill. This practice is limited to situations where the practitioner cannot be contacted and interruption of therapy may harm the patient. This includes any prescripition drug except Schedule II controlled substances. In addition, the pharmacist must inform the practitioner of the emergency refill at the earliest reasonable time.

At the recent MCAC meeting in Austin, Texas, on January 13, 1994, the committee reviewed new rules regarding consent to medical treatment in nursing facilities. Senate Bill 322, passed by the 73rd Legislature, provides for a surrogate decision-making process for incompetent adults who need medical treatment in nursing facilities. This will make the physician's task easier and is long overdue. The time schedule calls for final rules to be published in the *Texas Register* in March 1994, and the effective date to be April 1, 1994.

The proposed rule changes are as follows:

§19.219. Documentation for the Delegation of Long Term Care Resident's Rights.

(a) The delegation of resident rights may occur in three cases:

(1) when a competent individual chooses to allow another to act for him, *with a Durable Power of Attorney, for example;*

(2) when the resident has been adjudicated to be incompetent by a court of law *and a guardian has been appointed;* or

(3) when the physician has determined that, for medical reasons, the resident is incapable of understanding and exercising such rights.

(A) As provided in Chapter 313, Health and Safety Code, if an adult patient in a nursing facility (NF) is comatose, incapacitated, or otherwise mentally or physically incapable of communication, an adult surrogate from the following list, in order of priority, who has decision-making capacity, is available after a reasonably diligent inquiry, and is willing to consent to medical treatment on behalf of the patient, may consent to medical treatment on behalf of the patient:

(i) the patient's spouse;

(ii) an adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker;

(iii) a majority of the patient's reasonably available adult children;

(iv) the patient's parents; or

(v) the individual clearly identified to act for the patient by the patient before the patient became incapacitated, the patient's nearest living relative or clergy.

(B) Any dispute as to the right of a party to act as surrogate decision-maker may be resolved only by a court of record having jurisdiction under Chapter V, Texas Probate Code.

(C) Consent must be based on knowledge of what the patient would desire, if known.

(D) A surrogate decision-maker may not consent to:

(i) voluntary inpatient mental health services;

(ii) electro-convulsive treatment; or,

(iii) the appointment of another surrogate decision-maker.

(E) The attending physician shall document the following in the patient's medical record:

(i) resident's comatose state, incapacity, or other mental or physical inability to communicate;

(ii) proposed medical treatment;

(iii) the physician's reasonably diligent efforts to contact or cause to be contacted persons eligible to serve as surrogate decision-makers;

(iv) if a surrogate decision-maker consents to medical treatment on behalf of the resident, the date and time of the consent will be recorded and signed by the physician in the medical record and countersigned by the surrogate decision-maker. A consent form may be signed by the surrogate decision maker.

(iv) surrogate decision-maker's consent to medical treatment that is not made in person shall be reduced to writing in the resident's medical record, signed by the nursing facility staff member receiving the consent, and countersigned in the resident's medical record or on an informed consent form by the surrogate decision-maker as soon as possible.

(F) surrogate decision making does not apply to:

(i) a decision to withold or withdraw life-sustaining treatment from any individual;

(ii) a health care decision made under a durable power of attorney for health care;

(iii) consent to medical treatment of minors;

(iv) consent for emergency care; or,

(v) a resident's legal guardian who has the authority to make a decision regarding the resident's medical treatment.

(G) When no surrogate decision-maker is available, physician documentation is as required by subsection (d).

(b) In order to assure preservation of rights, the physician and the facility must document specific information concerning the incapability of the resident to understand and exercise his rights even if there is an extant Durable Power of Attorney.

(c) *Facility* documentation:

(1) the relationship of the resident to the person assuming his rights and responsibilities;

(2) *under what authority* the responsible person can act for the resident;

(3) **delete**

(4) *resident assessments, care plans and progress notes that address the resident's inability to exercise his rights and responsibilities;*

(5) *assurance that the resident who is mentally capable of understanding and exercising his rights, but physically incapable of doing so, receives interventions which facilitate the exercise of his rights.* ▶

(d) Physician documentation:

(1) *resident's comatose state, incapacity, or other mental or physical inability to communicate.*

(2) *proposed medical treatment or decision*

(3) **delete**

(4) periodic assurance that there has been no essential change in the resident's mental function;

(5) reevaluation whenever a significant change in resident status occurs or for orders that impact on resident rights (e.g. "No CPR").

Additionally, delete Licensure Standard §90.41(b)(16), as found below, and replace §90.(b)(17) with the identical language found in §19.219.

If the resident has been adjudicated incompetent, or has been found by the attending physician to be, for medical reasons, incapable of understanding these rights, the resident's rights are to be exercised as outlined in this subchapter. Documentation to support delegation of rights must be according to the provisions of this title.

As you can see, there are a lot of changes in health care here in Texas. The Texas ACFP and TOMA will do its best to keep osteopathic physicians informed as to significant changes that affect your medical practice. Stay tuned. ■

Mail Forwarding System To Be Changed for Safety Purposes

The U.S. Postal Service, in an effort to protect persons who do not want their new address disclosed, is currently working on two new rule changes. The first change will be to modify the current system under which the new address of a person can be obtained by anyone paying a $3 fee.

The second change will involve the elimination of automatic address corrections for mail sent to persons under court protection, such as battered women. Although new address information for such people will still be used to forward their mail, it will be excluded from adddress correction services provided by the post office. Currently, these services provide the new address to mailers, generally businesses, who pay a fee. ■

Blood Bank Briefs for Physicians

Use of Autologous Blood

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

Autologous transfusion is the collection and reinfusion of the patient's own blood. Autologous blood transfusion is the treatment of choice of appropriately selected patients. Since most planned surgical procedures do not result in enough blood loss to require transfusion, autologous blood strategies are not appropriate for all patients. In deciding whether or not to use autologous blood services, the physician should consider the likelihood of transfusion during or following the operation. The transfusion experience of patients who have undergone similar procedures can serve as a guide. If transfusion is likely for a planned surgical procedure, there are several options for autologous transfusion:

1. Preoperative autologous blood donation
2. Perioperative blood salvage
3. Acute normovolemic hemodilution

The appropriateness of these procedures varies with the clinical situation. They can be used alone or in combination to reduce or eliminate the need for allogenic blood.

The appropriateness of these procedures varies with the clinical situation. They can be used alone or in combination to reduce or eliminate the need for allogenic blood.

Preoperative autologous blood donation is performed at Carter Blood Center and with sufficient advanced planning, the process of collecting, storing and shipping autologous blood is relatively simple. As a rule, autologous blood donations are likely to be used for those patients whose surgical procedures require crossmatch orders for blood. Patients should not be encouraged to donate autologous blood for surgery that is unlikely to require transfusion.

The ideal patient for preoperative donation is one who has two or more weeks before surgery, is likely to need a blood transfusion during or after surgery, and has a hemoglobin of greater than 11 grams per d/L (hematocrit 33 percent). Patients with possible bacteremias are not eligible for preoperative autologous blood donations since bacteria may proliferate during blood storage.

Special considerations are given to the following patients:

1. Orthopedic surgical patients — Patients undergoing elective orthopedic surgery are ideal candidates for autologous blood donation. Preoperative autologous blood donation is contraindicated for patients with osteomyolitis.

2. Cardiac and vascular surgical patients — Donations are appropriate for properly selected patients with stable coronary artery disease, stable valvular disease and congenital heart disease as well as those undergoing aortic surgery and leg revascularization. The risk of blood donation is high for patients with unstable angina and severe aortic stenosis and are not candidates for preoperative autologous blood donation at Carter Blood Center.

3. Elderly Patients — Age alone does not exclude a patient from autologous blood donation. As with all patients, the underlying disease and the patient's condition are the determining factors. Our experience, to date, shows that elderly patients, even those who have never donated blood before, can successfully participate in the preoperative autologous blood program.

4. Pediatric Patients — Autologous blood has been collected from children. Children can safely donate, but the volume drawn at each donation is reduced in proportion to the body weight. Factors such as venous access and emotional tolerance to venipuncture occasionally limits the pediatric patient's ability to donate blood.

5. Obstetric Patients — Few mothers need transfusion during or after delivery, so autologous donation should not be routinely encouraged for pregnant women. On the other hand, certain obstetrical situations, such as placenta previa, may be indications for autologous donation.

Autologous blood donations are tested the same as allogenic blood donations. Eight specific tests for infectious disease markers are performed and include the hepatitis B surface antigen, the antibody to human immunodeficiency virus 1, antibody to human immunodeficiency virus 2, antibody to human T lymphotropic virus I/II, antibody to hepatitis B core antigen, serological test for syphilis, the liver enzyme, Alanine Amino Transferase and the antibody to hepatitis C virus. In addition, the ABO and Rh is performed as well as a red cell antibody screen. The physician ordering the blood is informed of test results on the autologous blood.

Autologous donation can provide some and all of the blood components needed by the surgical patient. However, autologous donations may not completely eliminate the possibility that the patient might need additional allogenic blood. Thus, during the discussion of the surgical risks and benefits with the patient, autologous donation should not be presented as a guarantee against other transfusions.

In conclusion, autologous blood should not be infused indiscriminately to the asymptomatic patient merely because it is available. It is better to discard autologous blood than risk circulatory overload by transfusing units unnecessarily. Although the advantages of autologous blood are obvious, all transfusions involve health risk and health care cost. The physician's clinical assessment of risk and benefits is important in deciding either to request autologous blood donation or transfuse autologous blood. ■

CDC Calls for Tough Measures in TB Cases

In response to a significant increase in the number of drug-resistant cases of TB, the Centers for Disease Control and Prevention is urging forcible isolation of TB patients who are either unwilling or unable to pursue treatment programs. Approximately one-third of the TB cases in New York City are drug-resistant strains.

Opportunities Unlimited

PHYSICIANS WANTED

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

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

PRACTICE AVAILABLE — loyal family practice available in resort community with mixed staff hospital near metroplex. Physician desiring to travel. Inquire 800/437-7112. (42)

DALLAS AREA GP CLINIC needs associate doctor on locum tenens. 6-50 hours per week. Call 214/941-9200 (02)

HIGH INCOME — successful GP clinic in Dallas area for sale. Will consider lease with option to buy and/or will finance to individual practitioner. Call 214/941-9200. (18)

FORT WORTH — Immediate opening for BE/BC physician to work full or part time in family practice/minor emergency clinic. No OB, week-ends or call. Potential for future partnership if desired. Contact Robert Hames, D.O., 817/237-3333. (25)

FAMILY PRACTICE DOCTOR NEEDED for county seat community of Spearman, Texas. Pheasant capital of Texas. Modern medical facilities with a 28-bed hospital and an 84-bed nursing home attached. For complete information concerning this opportunity contact Jerry Lewis of The Lewis Group at 1-800-666-1377. (20)

FAMILY PRACTICE PHYSICIANS needed for smaller communities throughout Texas. Many of these towns, with populations ranging from 5,000 to 100,000, are located within an hour of large metro areas. Excellent guarantees and all expenses paid. If you are interested in providing your family with the serenity and security of a smaller community, please call us for details. Bennett & Associates, 800-550-9096. (08)

OB/GYN needed for a beautiful, "Picturesque" community, within 90 miles from DFW area. All the simplicity, security, and serenity of this smaller town, yet within 1½ hours of all the conveniences of the metro area. Lakes, hills, trees, lots of antique stores and friendly people. Excellent guarantee and all expenses paid. For this excellent opportunity call Bennett & Associates, 800-550-9096. (30)

OB/GYN'S needed for smaller communities throughout Texas. Many of these towns, with populations ranging from 5,000 to 100,000, are located within an hour of large metro areas. Excellent guarantees and all expenses paid. If you are interested in providing your family with the serenity and security of a smaller community, please call us for details. Bennett & Associates, 800-550-9096. (32)

WANTED — Associate with ultimate goal to take over established family practice in Denton. Contact: TOMA, Box 4, One Financial Center, 1717 IH-35, Suite 100, Round Rock, TX 78664-2901. (04)

PRIMARY CARE PHYSICIANS NEEDED. No OB/night calls unless desired. Fully furnished clinic available in Rural Central Texas location which allows for an excellent opportunity to reap such benefits as nice churches, excellent schools, low pressure scheduling, and no traffic jams. Consider this area if you are family and recreationally minded. Reply to: TOMA Box 10, One Financial Center, 1717 I.H. 35, Suite 100, Round Rock, TX 78664-2901. (10)

RURAL 34-BED FACILITY located in North-Central Texas is seeking a FP/GP for solo practice. Guarantee is competitive. Package includes fully furnished office and staff. Guaranteed salary of $120,000 per year, moving allowance, portion of liability insurance paid, no upfront expenses. Enjoy a practice environment that is relaxed and supportive. For further details send CV or contact Linda Hall, Administrator, Chillicothe Hospital, 303 Avenue I, Chillicothe, Texas 79225; 817/852-5131 (work), 817/552-7095 (home), or FAX 817/852-5252. (29)

RAPIDLY EXPANDING FAMILY PRACTICE in East Texas, near Tyler, needs Associate immediately. Please contact: Steve E. Rowley, D.O., FAAFP, P.O. Box 368, Chandler, Texas 75758; (903) 849-6047. (01)

FAMILY PRACTICE D.O. — Practice opportunity for physician at 54-bed facility in beautiful Tyler, Texas. Active staff of over 30 physicians with 8 specialties represented. Office space available near hospital or may share established, very active practice 20 minutes from Tyler. Outlying clinics located in 4 nearby communities. Hunting, fishing, watersports, country clubs, university, junior college, many recreational facilities, civic and social opportunities. Contact Olie Clem, C.E.O., at 903/561-3771. (33)

INTERNAL MEDICINE — Immediate opening for BE/BC internal medicine D.O. at 54-bed hospital in Tyler, Texas. Approximately 30-member referral base with multiple specialties. Office space available within medical complex or in outlying clinic. Hunting, fishing, watersports, country clubs, university, junior college, many recreational facilities, civic and social opportunities. Contact Olie Clem, C.E.O., at 903/561-3771. (34)

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. (2

BOARD CERTIFIED GENERAL PRACTITIONER — working as independent contractor. Ten years experience. Available by appointment. $100 per hour plus expenses. Will furnish liability insurance. No obstetrics please. Contact: TOMA, Box 27, One Financial Center, 1717 IH 35, Suite 10 Round Rock, TX 78664-2901. (27)

OFFICE SPACE AVAILABLE

FOR LEASE — 1,250 sq. ft. medical office in hospital district between Rosedale and Magnolia; also, will build to suit up to 3,000 sq. ft. medical building on Hulen between Vickery and West Fwy., Fort Worth (817) 338-4444 (12)

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

MEDICAL CLINIC available for lease in Irving, Texas, corner MacArthur Blvd. & Grauwyler. 4300 sq. ft. freestanding clinic in medical park complex with day surgery center. Completely equipped & furnished for medical/surgical clinic. 7 treatment rooms, conference room, consultation rooms, large lobby. Complete X-ray and auto processing clinical lab. Ideal for large or small clinic. Call 214/579-8815. (65)

FULLY STAFFED & EQUIPPED SUITES for all medical & surgical subspecialties. Available daily, weekly or monthly. Includes all utilities. No long term obligation necessary. At MacArthur Medical Park, corner of MacArthur & Grauwyler, Irving, Texas. Call 214/579-8815. (64)

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. Medequip-Scientific, Dallas, 214/630-1660. (14

FOR SALE — Late model X-ray equipment and accessories; complete ob/gyn tables; waiting room chairs; hydraulic stretcher; transport stretchers; culture counter and diluter; storage cabinets; office desks; treatment tables; wheelchairs; and assorted other items — very good condition. Contact Dr. Glen Dow or Office Manager 817/485-4711. (48)

How do you treat severe paralysis of the paycheck?

Medical school probably covered everything except how to deal with a disability. It can happen to anyone. Even you. In fact, if you're 35 now, you have a 45 percent chance of becoming disabled before age 65.[1] Without disability insurance, that's a 45 percent chance your income could wind up in critical condition. Should disability strike, how long could you keep your home? Make car payments? Provide for your family?

Provident, the nation's leader in individual non-cancellable disability insurance,[2] can provide the perfect prescription, offering comprehensive "your occupation" protection. That means Provident pays if you can no longer work in your own medical specialty regardless of how much you earn working in a new career or a new specialty. And the policy is non-cancellable, so your premium rate will be guaranteed for as long as you own the policy.[3]

Make an appointment for a disability insurance checkup. Call Dean, Jacobson Financial Services for more information about this important coverage. We have more than 25 years of experience in the medical profession. Discounts are available to TOMA members.

[1] 1985 Commissioner's Individual Disability Table-A, Seven-day Elimination Continuance Table. Rates are male only. Disability rates are higher for females.

[2] Life Insurance Marketing and Research Association, 1992 survey, individual, non-cancellable disability income insurance as measured in annualized premium in force, new paid annualized premium, new paid policies, and policies in force.

[3] Coverage for mental disorders can be limited in certain circumstances for a reduced premium.

Dean, Jacobson Financial Services

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

Dallas/Fort Worth metro area:
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