LIV, No. 6

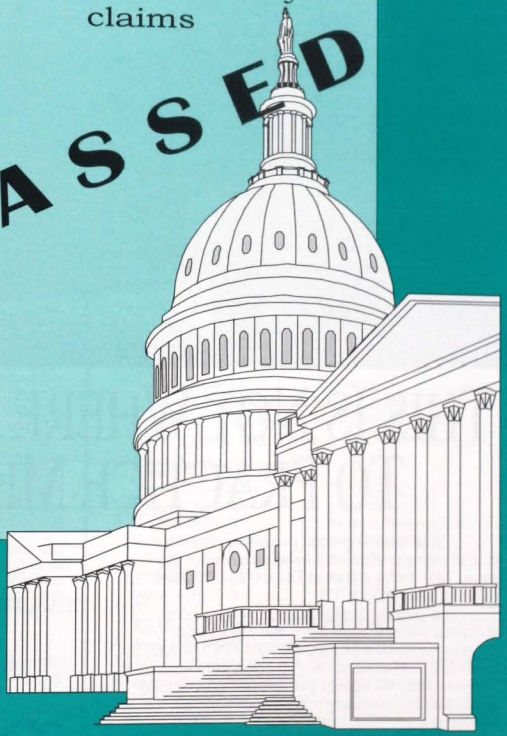
The Journal of the Texas Osteopathic Medical Association

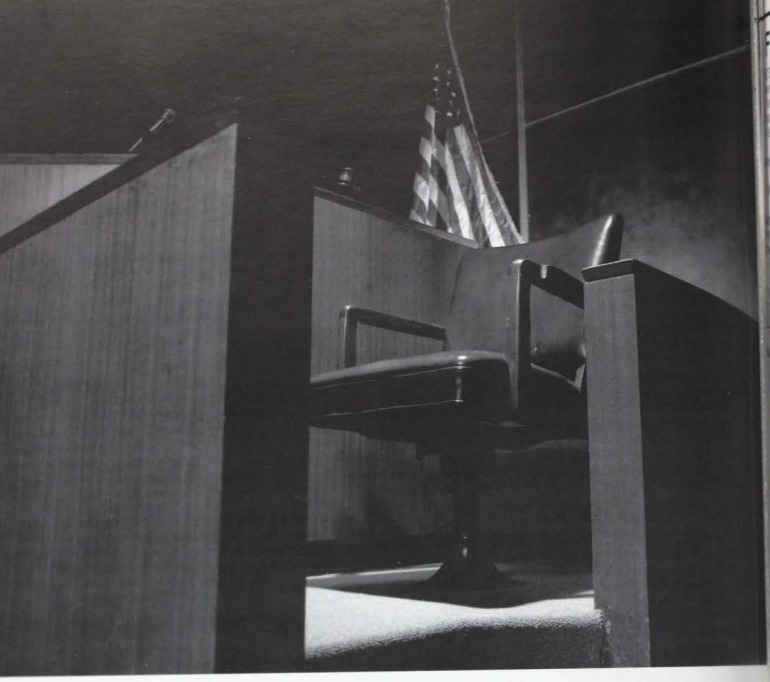
June, 1997

# Senate Bill 386

Relating to HMO health care liability claims

PASSED





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TEXAS D.O.
TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

## FEATURES



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TEXAS D.O.
TEXAS OSTEOPATHIC MEDICAL ASSOCIATION

June 1997

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# Calendar of Events

## JULY 16-19

3rd Annual Primary Care Update
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: Sheraton Uptown Albuquerque, Albuquerque, NM
CME: 24 AOA Hours
Contact: UNT Health Science Center, Office of Continuing Medical Education
800-987-2CME (2263)

## 25-27

Annual Meeting of the Colorado Society of Osteopathic Medicine
Location: Manor Vail Lodge, Vail, CO
CME: 18 AOA Hours and Physician Assistants credits
Contact: Patricia Ellis, 303-322-1752 or 303-322-1956
E-mail: csom@capcon.com
http:\\www.capcon.com/csom

## JULY 31 - AUGUST 3

40th Annual Clinical Seminar
Sponsored by the Texas ACOFP
Location: The Adams-Mark Hotel, Dallas, TX
CME: 29.5 Category 1-A credits
Contact: Janet Dunkle, Texas ACOFP Executive Director, 888-892-2637 or 512-708-9959

## AUGUST 9-10

Sutherland's Methods for Treating the Rest of the Body
Sponsored by Dallas Osteopathic Study Group
Location: Dallas, TX
CME: 16 Category 1-A Credits
Contact: Conrad Speece, D.O., 10622 Garland Road, Dallas, TX 75218
214-321-2673

## SEPTEMBER 26-28

Primary Care Update XIV - Alumni Weekend
Sponsored by the University of North Texas Health Science Center at Fort Worth
Location: UNT Health Science Center, Fort Worth, TX
CME: 18 Hours
Contact: Andrew Crim, UNT Health Science Center Office of Continuing Medical Education
817-735-2644

## OCTOBER 19-23

Annual Convention of the American Osteopathic Association
Location: San Antonio, TX
Contact: AOA, 800-621-1773

## 23-26

TOMA Postconvention Seminar
Location: Cancun, Mexico
CME: 6 hours Category 1-A credits
Contact: Terry Boucher, M.P.H., Executive Director
800-444-8662
512-708-8662
FAX: 512-708-1415



Articles in the *"TEXAS D.O."* that mention the Texas Osteopathic Medical Association's position on state legislation are defined as "legislative advertising," according to 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 D.O."* is required by that law: Terry R. Boucher, Executive Director, TOMA, 1415 Lavaca Street, Austin, Texas 78701-1634.

# Report on the April 19, 1997, TOMA Board of Trustees Meeting

The Board of Trustees of the Texas Osteopathic Medical Association met on Saturday, April 19, 1997, at the TOMA office in Austin.

The following are issues presented during the meeting:

• The district visitation schedule of TOMA President Arthur J. Speece, III, D.O., was noted, with the latest visits including Districts IV, XII, XV, XVII and XVIII. Dr. Speece mentioned an increased turnout at district meetings.

• Dr. Robert L. Peters, Jr., informed the board of the continuing search for an executive director for the American Osteopathic Association. He noted that the AOA Payor Relations department has been placed under the direction of Mike Mallie.

• Dr. Peters also reported on the February meeting of the Blue Cross and Blue Shield Medical Advisory Committee. During the meeting, proposals on reimbursement of E&M and OMT were reviewed.

• TOMA Executive Director Terry Boucher noted that during TOMA's next billing cycle in October, an attempt would be made to bill district dues as well as TOMA annual dues. It is anticipated that this method could increased the total amount of dues collected by each district.

• Jack McCarty, D.O, presented a report on behalf of the Texas Society of the American College of Osteopathic Family Physicians. He mentioned that during the national ACOFP meeting in California, there were no booths representing TCOM or the TCOM Alumni Association in the exhibit area. In addition, there were no receptions hosted by either group. It was requested that TOMA contact the current president of the TCOM Alumni Association and extend an invitation to report on the status of the college's alumni affairs during the next TOMA board meeting.

• The board discussed the status of Trident Holdings/ Physician's Choice, which provides medical malpractice insurance and is endorsed by TOMA. Recently, some physicians have received notices stating their policies would not be renewed. The reason for non-renewal of the policies is due to the fact that Insurance Companies of the West (ICW), the re-insurer for Physician's Choice, is in negotiation with their re-insurer. When a lawsuit is filed in Texas, ICW covers the first $100,000 of losses, and their re-insurer covers 80 percent of everything above that amount. For the past two years, there has not been a lawsuit exceeding $100,000 filed against a physician covered by Physician's Choice. No claims against the re-insurer has prompted ICW to want to lower the level of their responsibility from $100,000 to $20,000. Since the contract between Physician's Choice and it's re-insurer is under negotiation, by law they must contact every policy-holder within 90 days of their policy renewal date to inform them that the contract is not secure.

• A legislative update was presented. It was mentioned that the two most important items to physicians currently being considered by the legislature are the tax bill and managed care reform. It was noted that the naturopathic bill and the homeopathic bills had been left pending.

*(Left to right): TOMA President Arthur J. Speece, III, D.O.; Senator Judith Zaffirini; Robert L. Peters, Jr., D.O.; and Student Doctor Salim Bhaloo during Sen. Zaffirini's "Governor for a Day" reception and luncheon at the State Capitol.*

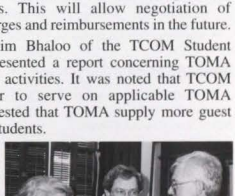
*(Left to right): Joseph Montgomery-Davis, D.O.; Mark Baker, D.O.; TOMA President Arthur J. Speece, III, D.O. (back to camera); Robert L. Peters, Jr., D.O.; Jack McCarty, D.O.; and Student Doctor Salim Bhaloo converse during the reception.*

• TOMA membership applications were presented and approved by the board.

• Physicians were encouraged to submit their same usual and customary charges to Workers' Comp, Medicaid or Medicare, regardless of their allowable charges and reimbursement amounts. This will allow negotiation of increasing allowable charges and reimbursements in the future.

• Student Doctor Salim Bhaloo of the TCOM Student Government Section, presented a report concerning TOMA and the TCOM S.G.A. activities. It was noted that TCOM students will volunteer to serve on applicable TOMA committees. It was requested that TOMA supply more guest speakers to address the students.

• Dr. Nelda Cunniff-Isenberg and her husband, Lewis, presented TOMA with an 1890's Bible, which represents the period in which osteopathic medicine was being developed and organized in America.



*Senator Zaffirini and Mr. Zaffirini meet with Mark Baker, D.O., during the April 19 reception.*

The next meeting of the TOMA Board of Trustees will be held Tuesday, June 10, 1997.

# Learning the Language – A Managed Care Glossary

## Type of Managed Care Delivery Systems

***Health maintenance organization (HMO).*** Provides coverage of agreed-on health services needed by plan members for a fixed, prepaid premium. There are four basic models of HMOs: group model, individual practice association, network model and staff model.

***Group model HMO.*** Involves contracts with physicians organized in groups who receive a fixed payment per patient to provide specific services. These physicians usually see only HMO patients.

***Individual practice association (IPA) model HMO.*** Involves contracts with independent physicians who work in their own private practices and see fee-for-service patients.

***Network model HMO.*** Employs physicians to provide health care to its members. The HMO compensates physicians with salary and incentive programs.

***Preferred provider organization (PPO).*** Contracts are established with care-givers referred to as preferred providers. Usually, the benefit contract requires significantly less co-payment for services received from preferred providers to motivate enrollees to use these providers.

***Exclusive provider organization (EPO).*** Similar to a preferred provider organization (PPO); however, while a PPO provides coverage for non-preferred provider services as well as preferred provider services, an EPO only reimburses for services rendered by a preferred provider.

***Point-of-service (POS) plan.*** Allows the covered person to decide at the time services are needed whether to choose a participating or non-participating provider with different benefit levels associated with the use of participating providers. There are several ways in which this plan may be delivered:

- an HMO may permit limited services from non-participating providers
- HMO may offer a supplemental major medical policy to provide non-participating benefits
- a preferred provider organization (PPO) may be used to provide both participating and non-participating coverage
- various combinations of the above

## Methods of Reimbursement

***Explanation of benefits (EOB).*** The statement sent to covered persons by their health plan listing services provided, amount billed, and payment made.

***Capitation (cap).*** A fixed dollar amount established to cover the cost of health care delivered for a person, usually paid monthly to a health care provider. The provider is responsible for supplying all health services required by the covered person under the conditions of a provider contract.

***Fee maximum.*** The highest amount a provider may be paid for a specific health care service provided to a covered person based on conditions set forth in a contract.

***Fee schedule.*** A listing of codes and related services with fixed payment amounts which could be percentages of billings, flat rates or maximum allowable rates.

***Fee-for-service equivalency.*** The difference between the amount a provider receives from an alternative reimbursement system such as capitation versus fee-for-service payment.

***Modified fee-for-service.*** A policy which pays providers on a fee-for-service basis, however, fee maximums exist for each procedure.

***Prospective reimbursement.*** Any method of paying hospitals, other health care providers for a defined period (usually one year) based on a fixed rate agreed upon in advance.

***Reasonable and customary (R&C).*** The commonly charged or prevailing fees for health services within a specific geographic region. A fee is deemed reasonable if it falls within the limits of the average or commonly charged fee for that service within the specific community.

***Resource based relative value scale (RBRVS).*** Introduced by the Health Care Financing Administration (HCFA), this fee schedule reimburses physicians' Medicare fees based on the amount of time and resources expended in treating patients, with adjustments for overhead costs and geographical differences.

## Contracts

***Cost contract.*** A formal agreement with HCFA to provide health care to Medicare enrollees based on reasonable cost or prudent buyer concepts. Based on estimated costs, the plan periodically receives a capitated amount, which may be adjusted to reflect actual cost. Expenses are audited at the end of the contract to determine the final rate the plan should have been paid.

***Health care prepayment plan (HCPP).*** A cost contract with HCFA that prepays a health plan a flat amount per month to provide Medicare eligible Part B medical services to enrolled members. Members pay premiums to cover all non-Medicare covered services that the plan provides.

***Hospital affiliation.*** A contractual agreement between a health plan and one or more hospitals requiring the hospital to provide the inpatient services offered by the health plan.

***Master group contract.*** A legal agreement between the enrolling unit and the carrier, explaining in detail the rights and duties of the enrolling unit, covered person and carrier, and the specifics of the coverage provided by the contract.

***Risk contract.*** An agreement between HCFA and a managed care plan requiring the plan to supply all Medicare-covered services to Medicare-eligible enrollees at a predetermined monthly payment rate from the government and a monthly premium paid by the enrollee. The managed care plan is then liable for services regardless of their scope or cost.

***Hold harmless clause.*** There are two types of hold harmless clauses. The first type involves a physician's agreement not to pursue a patient for fees in excess of those allowed in an HMO contract. In the second type of hold harmless clause, the physician agrees not to sue the managed care organization for its contribution on a liability claim.

## Government and Medicare-and-Medicaid-Related Issues

***Adjusted average per capita cost (AAPCC).*** HCFA's estimate of the average cost of Medicare benefits for an individual in a given area based on age, sex, residence (whether or not institutionalized), Medicaid eligibility, disability and end-stage renal disease.

***Certificate of authority.*** A certificate licensing the operation of an HMO issued by the state government.

***Certificate of need.*** A government-issued certificate permitting an individual or organization to contract or modify a health facility, purchase extensive new medical equipment or offer a new or different health service.

***Competitive medical plan (CMP).*** An organization meeting specified criteria of the federal government that is permitted to obtain a Medicare risk contract.

***Consolidated Omnibus Budget Reconciliation Act (COBRA).*** A federal law requiring employers to offer continued health insurance coverage to certain employees and their dependents after termination of group health insurance.

***Federal qualification.*** After a careful evaluation of an HMO's entire method of operation, this certification is conferred by HCFA permitting the HMO to be eligible to participate in certain Medicare cost and risk contracts.

***HCFA 1500.*** A universal form, created by HCFA for the billing of professional fees to health carriers by providers.

***Physician Payment Review Commission (PPRC).*** A congressional advisory group that recommends Medicare and Medicaid reimbursement policy to Congress.

***Prospective Payment Assessment Commission (ProPAC).*** Established under the Social Security Act amendments of 1983, this federal commission advises and assists Congress and the Department of Health and Human Services in maintaining and updating the Medicare prospective payment system.

## Premium Calculations

***Age/sex rates (ASR).*** A set of rates used to calculate premiums for group billing purposes for a given group based on age and sex categories. It is often preferred over single and family rating in small groups because it automatically adjusts to demographic changes in the group. Also called table rates.

***Composite rate.*** A single billing rate which applies to all participants within a specified group enrolled for both single or family coverage.

***Expected claims.*** An estimate of a covered person or group's claim level for a specified contract period. This level is a desired loss ratio or break-even point in a relationship to projected premium.

***Rating process.*** Evaluation of a group or individual to establish a premium rate based on the type of risk involved. Factors considered include the age/sex factor, location, type of industry, base capitation factor, plan design, average family size and the administration allowance.

***Standard class rate (SCR).*** Calculation of monthly premium rates by multiplying a base revenue requirement on a per member or per employee basis by group demographic data.

## Types of Ratings

***Adjusted community rating (ACR).*** Community rating as influenced by demographics and the group's previous experience. Also known as prospective rating.

***Community rating.*** A method of determining a premium structure that is influenced by expected benefit utilization by the population as a whole instead of by specific groups.

***Community rating by class (CRC).*** Community rating influenced by the group's specific demographics. Also known as factored rating.

**Experience rating.** Rate setting based in part or in whole on prior claims experience and estimated required revenues for a specific group or groups.

***Modified community rating (MCR).*** A separate analysis of health care services used in a given community using age and sex data, etc.

## Risk Analysis

***Adverse selection.*** A situation in which a plan enrolls a poorer risk than the average risk of the group.

***Human risk management.*** An effort to reduce the need for treatment by anticipating and managing an individual's health risks before treatment becomes necessary. Human risk management is designed to address problems before they become mental or physical crises.

***Member assistance program (MAP).*** A human risk management program (see above) that focuses on enrollees of health plans and insurers.

***Pooling.*** Combining risk for all groups or a number of groups.

***Retrospective rate derivation (retro).*** Insurance coverage that includes risk sharing, with the employer being responsible for all or part of that risk. The employer may be responsible for a percentage of the group's health care cost which exceeds total premium dollars during the contract. On the other hand, the carrier may have to refund to the employer a percentage of premium dollars paid if actual health care costs of the group are less than the premium dollars paid during the contract year.

## Types of Facilities

***Extended care facility.*** A licensed nursing home or nursing center which must honor state and local laws to provide 24-hour nursing care. The facility may offer skilled, intermediate or custodial care, or any combination of these levels of care.

***Home health agency (HHA).*** A facility or program authorized according to state and federal laws to provide a wide range of health care services in the home.

***Intermediate care facility (ICF).*** A facility providing a lesser level of care than a hospital or skilled nursing facility (SNF), but greater than that of room and board.

***Skilled nursing facility (SNF).*** A facility that accepts patients requiring rehabilitation and medical care that is of lesser intensity than that received in a hospital.

## Quality Assurance

***Outcomes management.*** An effort to improve health care results, typically by implementing data acquired through outcomes measurement intended to increase payer and payee satisfaction while holding down costs.

***Outcome measures.*** Evaluation of the results of treatment for a particular condition. Outcome measures include the patient's assessment of overall improvement and quality of life, as well as objective measures of mortality, morbidity and health status.

***Peer review organization (PRO).*** A group charged by the Tax Equity and Fiscal Responsibility Act of 1982 (TEFRA) to review quality of care and appropriateness of admissions for Medicare and Medicaid. These organizations have a mandate to lower admission rates and reduce lengths of stay while ensuring adequate treatment.

***Professional review organization (PRO).*** A physician-sponsored organization that reviews the activities and records of a health care provider to determine if the services rendered were medically necessary, provided appropriately, and in the proper setting.

*Reprinted from "Managed Care I: Learning the Language," an educational collaboration between the American Osteopathic Association and Smith Kline Beecham Pharmaceuticals.*

# HMO Liability Legislation to Become Law

Texas has become the first state in the nation to allow managed care organizations to be held liable for medical malpractice, under a bill that Governor George W. Bush allowed to become law without his signature.

"Given the choice between doing nothing to address a significant problem that impacts the health of thousands of Texans, I have concluded the potential for good outweighs the potential for harm," said Gov. Bush. By allowing the measure to become law without his signature, the potential for an override of his veto is avoided.

His misgivings about the law are said to center on the apparent conflict the bill has with his efforts to limit lawsuits in Texas. "My concern about creating new grounds for filing a lawsuit has been alleviated somewhat by the creation of an independent review panel and by the bill's protections against frivolous lawsuits," Gov. Bush said.

The legislation has followed an arduous path, with fierce and heated debate. Following the 1995 veto by Gov. Bush of the Patient Protection Act, the state insurance commissioner was instructed to adopt some of the act's provisions. To determine whether the managed care industry needed further regulation, Lt. Gov. Bob Bullock appointed the Senate Interim Committee on Managed Care and Consumer Protections, chaired by Senator David Sibley (R-Waco), which held a series of hearings last year. These hearings yielded various proposals concerning the regulation of managed care, which were incorporated into a package of managed care regulation legislation.

The bill's principal focus provides patients with a venue to sue HMOs for malpractice in cases where a patient suffers further injury or death because of decisions made by the insurer. The legislation had been the subject of intense opposition by the Texas HMO Association, Texans for Quality Health Care and some employer groups.

Another measure establishes an independent review committee, to be overseen by the Texas Department of Insurance. Consumers will be able to appeal to the committee when an insurer denies a treatment as not medically necessary.

Senator Sibley, author of the legislation, noted, "I'm proud that Texas will lead the nation in holding HMOs and other managed care organizations responsible for making medical decisions that affect a patient's health." ■

# House Defeats Bicycle Helmet Legislation

A bill which would have required helmets to be worn by bicycle riders younger than age 18 has been defeated by the Texas House of Representatives.

The legislation, authored by Representative Bill Carter (D-Fort Worth), failed by a 77-56 vote. In 1995, a similar measure failed by only five votes.

Those opposing the bill argued that it is a parental decision as to whether children should wear helmets and that such laws are better suited to municipal governments.

Approximately 15 states have passed helmet laws to date. Texas cities with existing helmet ordinances include Fort Worth, Bedford, Benbrook, Coppell, Dallas, Austin and Houston. These ordinances would not have been pre-empted by state law under the legislation.

"These people who voted against it will have to answer to their constituents," said Representative Carter. "They were almost flippant in some of their so-called excuses, like invasion of private rights. If the state can make a seat belt law, it can make a bicycle helmet law."

Representative Carter also noted that defeat of the bill could mean higher medical costs that might have been prevented by the wearing of helmets. "Some head injuries to bicyclists can cost up to $4 million over the lifetime of the patient to treat. And the average hospital bill in most cases is $11,000 for an injury that could have easily been prevented," he said.

# David M. Richards, D.O., Re-Elected to National Board of Medical Examiners

The National Board of Medical Examiners has announced that David M. Richards, D.O., was re-elected to a four-year term as a member-at-large of the National Board of Medical Examiners during the board's annual meeting, held March 13-14, 1997. Dr. Richards serves as president of the University of North Texas Health Science Center at Fort Worth.

The National Board of Medical Examiners is a national non-profit organization located in Philadelphia, Pennsylvania, that prepares and administers qualifying examinations that have widespread acceptance within both the licensure system for medicine and the medical education system. The examinations are designed to reflect what is taught in medical schools accredited by the Liaison Committee on Medical Education and are intended for administration to students as they progress through their medical education. Legal agencies governing the practice of medicine within each state may, at their discretion, grant a license without further examination for those who have successfully completed these examinations.

The members of the National Board of Medical Examiners constitute the governing body of the National Board with responsibility for establishing policy for the organization. The board is composed of 80 members representing the academic community, national professional organizations, state licensing boards, students, residents, the federal government and the public.

# AOA Update

## John Crosby, J.D., Named Executive Director of American Osteopathic Association

John Crosby, J.D., has been named the new executive director of the American Osteopathic Association. The appointment became effective May 12.

"I am joining the AOA to help launch the second 100 years of this tremendous organization," stated Crosby. "I hope to focus on member services because they are the lifeblood of any voluntary professional group. Given the outstanding staff that I have inherited and the support of the AOA Board of Trustees, I know we will succeed."

Crosby joins the AOA from the American Medical Association (AMA), where he spent six years as senior vice president for health policy and was actively involved with policy development and strategic planning.

A graduate of Ohio State University College of Law in Columbus, Crosby practiced at the St. Louis law firm, Thompson & Mitchell, from 1972-1977. He then spent five years working as the administrative assistant to U.S. Representative Richard A. Gephardt (D-MO) in Washington, D.C. In 1982, Crosby joined Project HOPE in Millwood, Virginia, as senior vice president of its domestic division. In his tenure there, he directed the Center for Health Information, a "think tank" on healthcare and insurance issues affecting both public and private sectors.

Crosby became senior vice president and general counsel of the National Association of Independent Insurers (NAII) in 1983, and remained at the Des Plaines, Illinois-based organization until 1989. His role included responsibility for all property and casualty issues affecting the NAII's 560 member companies.

In 1990, Crosby joined the AMA, where he served as a vice president for various divisions, including policy liaison; physician profiling and outcomes assessment; and special projects. He also served as staff liaison to the AMA's Council on Legislation, its Council on Long Range Planning and Development, and its Task Force on Quality Care at the End of Life.

Crosby has served on the board of directors of the Chicago Health Policy Research Council and the Health Care Quality Alliance in Washington, D.C., since 1993. His other memberships include the American Association of Medical Society Executives; the American Bar Association, the Chicago Bar Association and the Missouri Bar Association; the American Society of Association Executives; the Healthcare Financial Management Association; and the National Health Lawyers Association. ■

# THANK YOU!

***TOMA would like to thank the following "Texas Stars" who have contributed above the $1,000 donation level:***

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## *The Case for Strategic Asset Allocation*

Although you may believe your best investment strategy is to buy low and sell high, studies of some of America's major pension funds have shown that an asset allocation policy is the major determinant of portfolio performance.

Asset allocation is the decision of what percentage of your assets are invested in various asset classes, such as small company U.S. growth stocks, small company foreign stocks, or short term, high yield bonds. Strategic asset allocation involves establishing different weightings for various asset classes and making few changes in those weightings over the short run, unless there are changes in your investment objectives.

Strategic asset allocation can attribute its positive results to the fact that performance of different asset classes is not always closely related; some do quite well at the same time others are declining.

Stock prices, for example, fell precipitously in October and November 1987 (down 28%), but foreign bonds rose 16 percent at the very same time. 1967 was the worst year in the last six decades for government bonds (down 9.2%) but strangely enough was the best year since World War II for small company stocks (up 83%).

Asset allocation strategies take advantage of this lack of correlation to build portfolios that are unlikely to have assets that all do well or poorly at the same time. As a result, although no investment strategy can guarantee success, a properly allocated portfolio is more likely to participate in positive investment trends while at the same time reducing volatility when the investment climate changes.

## *Personalization*

The asset weighting in your portfolio will depend on your individual needs and financial objectives. As your lifestyle changes and your time horizon shortens, you can, with the help of your investment representative, change the weightings in your portfolio to reflect your changing goals.

For example, in your earlier investment years, you will probably want a larger portion of your assets invested in equities, for long-term growth. Although past performance cannot guarantee future results, equities have historically outperformed other investment vehicles. Because equities also tend to fluctuate more over the short term than bonds or money market instruments, the more time you have to reach your investment goals, the more of your assets you'll want to invest in equities.

As you get older and need to start investing more conservatively, you will probably start to shift more of your assets into less volatile investment vehicles, such as fixed income investments. You will still need some growth so that your investment income can keep pace with inflation, but stocks might represent a smaller portion of your retirement portfolio than they did decades earlier. Fixed income instruments would now make up larger portions of your asset mix, offering the income and stability you require.

As investment representatives, it is our job to help you establish asset weightings tailored to your long-term investment objectives. To accommodate your changing needs, we will periodically change your asset mix. If you would like to learn more about asset allocation and how it might benefit you, contact us today. Together we can explore how asset allocation can help you reach your long-term goals.

**Country Dean, CFP**

**Jake Jacobson, ChFC**

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# In Memoriam

## Kenneth Browne, IV

Mr. Kenneth "Ken" Browne, IV, of Colleyville, passed away May 5, 1997. He was 39 years of age.

Funeral services were held May 8 at Smithfield United Methodist Church, with burial in Bourland Cemetery.

Mr. Browne was born in Bryan. He was a member of Smithfield United Methodist Church and was active as a lay leader, in the Chancel Choir, the Men's Group and the Seekers Class. He was an Eagle Scout and a previous Scoutmaster. He was a soccer coach at the N.E. YMCA. Upon his death he made a gift of his organs, so that others may live.

Survivors include his wife, Carol Browne, D.O., of Colleyville; two sons, David Ladd Browne and Andrew Samuel Browne, both of Colleyville; daughter, Emily Elizabeth Browne of Colleyville; parents, Kenneth and Thelmarie Browne of San Antonio, Mark Browne of Marble Falls; sister, Clair Browne Hease of San Antonio; numerous loving relatives; and his church family at Smithfield United Methodist Church.

Memorials may be made to Smithfield United Methodist Church Building Fund, Smithfield Road & Chapman Rd., North Richland Hills, TX 76180.

## Clifford E. Dickey, D.O.

Dr. Clifford Dickey of Fort Worth, passed away on May 12, 1997. He was 90 years of age.

Funeral services were held May 15 at Lucas Funeral Home in Fort Worth, with burial in Greenwood Memorial Park, also in Fort Worth.

Dr. Dickey was a 1932 graduate of Kirksville College of Osteopathic Medicine, Kirksville, Missouri. He had been a Fort Worth resident since 1950.

He was a life member of the Texas Osteopathic Medical Association; member of TOMA District II; life member of the American Osteopathic Association; and a fellow of the American College of Osteopathic Family Physicians.

Dr. Dickey was also a member of Oakhurst United Methodist Church; Mosiah Temple Shrine; and the Royal Order of Jesters.

Survivors include his wife, Vivian Dickey of Fort Worth; sons, Jerry Dickey, D.O., of Fort Worth, and Jan Dickey of San Antonio; daughter, Ann Haygood of Biloxi, Mississippi; grandchildren, Mark and Daniel Haygood and David and Jennifer Dickey; and great-granddaughter, Madison Dickey.

## Jerome L. Armbruster, D.O.

Dr. Jerome Armbruster of Pearland, passed away on May 23, 1997. He was 56 years of age.

Funeral services were held on May 25 at First United Methodist Church in Pearland, with interment in SouthPark Cemetery.

Dr. Armbruster was a veteran of the U.S. Army, having served in the Vietnam War as Captain and Flight Surgeon. He was a 1967 graduate of Kirksville College of Osteopathic Medicine and was a certified family practitioner.

Dr. Armbruster was very active in various professional and civic organizations. Among those were the Texas Osteopathic Medical Association, of which he was a past president and past chairman and member of numerous TOMA committees; American Osteopathic Association; American College of Osteopathic Family Physicians; Texas State Board of Medical Examiners' Regional Review Board; Golfcrest Country Club; and First United Methodist Church of Pearland.

His loving family includes his wife, Linda C. Armbruster; two children, Jeffry Cormany Armbruster and Stephanie Ross Simmons; two grandchildren, Cody Raine Simmons and Christopher Allen Armbruster; his mother, Evelyn Armbruster; three brothers, David Russell Armbruster, D.O., Paul Hermann Armbruster and Jeffry Joe Armbruster; one sister, Gayle Jane Smith; and numerous nieces and nephews, other relatives and a host of friends.

In lieu of flowers or other usual remembrances, the family requests memorial contributions be made to the American Diabetes Association or to a charity of choice.

# Ten Years Ago in the *Texas D.O.*

• Deweese Y. Campbell, D.O., was presented with the Harris County Society of Osteopathic Physicians' "Physician of the Year" award at their meeting on June 1, 1987.

• William R. Jenkins, D.O., was awarded the 1987 Medical Staff Award from Fort Worth Osteopathic Medical Center. The award recognizes a doctor who has given the institution outstanding leadership and dedicated service.

• The Health Care Financing Administration released new data predicting that by the year 2000, health care spending in the United States would hit $1.5 trillion. This amount was triple that of health care costs in 1986, which were $458 billion.

• David M. Richards, D.O., president of the Texas College of Osteopathic Medicine, was named to a four-year term on a prominent Veterans Administration Advisory Committee, called the Special Medical Advisory Group. The group was created in 1945 to provide the V.A. and Congress with expert advice on health care policy and direction.

• The Texas House and Senate together introduced a record 4,179 bills, in addition to 171 House and Senate joint resolutions. The regular session of the 1987 Texas Legislative session ended June 1, marking the first time since 1961 in which the legislature failed to pass a budget for state government. A special session was called to convene on June 22. ■

# Where to go on the Web

### Pharmaceutical Information Network

This site is filled with a tremendous amount of useful information, but the most useful is a large drug database. Similar in design to the Physicians Drug Reference book, you can look up side effects, drug interaction problems and more

**http://pharminfo.com**

### HealthGate

This site offers health-related links and offerings, most of them free. Some of the links include a huge medical database capable of accessing medical journals worldwide and a medical resource guide for women.

**http://www.healthgate.com**

### American Cancer Society

This site offers the ultimate online resource for information about cancer. Other offerings include a list of local offices, breast cancer research, support groups for different types of cancer, and so forth.

**http://www.cancer.org** ■

# S/D Steve Cavanaugh Wins AAO Case Presentation Competition

Student Doctor Steve Cavanaugh, Class of 1999, of the University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine, was the 1997 winner of the A. Hollis Wolf Case Presentation Competition. The annual competition is held during the Convocation of the American Academy of Osteopathy, and took place in Colorado Springs this year. Richard Koss, D.O., of the Department of Manipulative Medicine, served as a judge for the 1997 competition. As the winner, S/D Cavanaugh receives an all-expense paid trip to Belgium to deliver the case presentation.

This marks the second consecutive year of the competition in which a student from UNTHSC/TCOM has won. Student Doctor Bobby Johnson was the winner in 1996.

The Undergraduate Academy of Osteopathy, as well as the Texas Osteopathic Medical Association, are proud of their entries and the standards set by these students. ■

# Governor Signs Castration Bill

Texas Governor George W. Bush has signed a bill that allows repeat child molesters in prison to undergo voluntary surgical castration. The governor noted that the bill is intended for people "too sick to cure their illness."

Effective immediately, the law gives Texas the distinction of being the first state to offer the surgery as the primary method of castration for prisoners. California has passed a chemical castration law that allows molesters to choose surgical castration as an alternative.

"The bill provides a voluntary means -there is no coercion - for people who are obviously too sick to cure their illness," Gov. Bush said. "If this legislation saves just one child from the horror of a sexual assault, it will have accomplished its purpose."

Prisoners requesting the surgery will have to admit their guilt, be screened by a psychiatrist and psychologist, and provide written consent. Castration cannot be used as a condition of parole or an exchange for good time credit. ■

# The 10 Commandments of Firing

### *Commandment I*

Hire carefully! Many employees who are fired should have never been hired in the first place. The key to a successful (and, hopefully, litigation free) termination begins at the time of hire. Think about what you're saying and doing from the outset of the employment relationship: do not give up your status as an at-will employer or enter into an employment contract of definite duration. Do not send offer letters quoting annual salaries; quote all rates of pay in the smallest increments of time possible, i.e., hourly or weekly. Avoid any references to guaranteed, lifetime employment, or that the employment relationship will last "as long as work is satisfactory."

### *Commandment II*

Carefully review all company handbooks, policies, memos and letters to make sure that all clearly state that you are an at-will employer and that nothing in any document alters that status. Have all employees sign off on a document indicating that their employment is at will, i.e., of indefinite duration, and that nothing in any document changes that status or creates a contract of employment.

### *Commandment III*

Establish reasonable standards of conduct for your company and communicate them to your employees in writing in the simplest, most understandable, straightforward manner possible. You can have the most comprehensive, beautifully written handbook in the world stashed away in your file cabinet, but if you haven't given it to your employees, you've got nothing. Have your employees sign off on your policy handbook to acknowledge that they have read, understood, and agree to be bound by the rules and regulations you have established, and that failure to abide by the rules can lead to discipline up to and including termination.

### *Commandment IV*

Document, document, document! Paper the files. If there is a discipline problem that needs to be addressed, put it in writing (i.e., chronic tardiness, absenteeism, insubordination, etc.). A good rule of thumb: if there is no paper in the file, the (mis)conduct did not occur. Another good rule of thumb: don't put anything in your employees' personnel files you wouldn't want a jury to see. Be factual, objective and fair.

### *Commandment V*

There are five magic words that you should use when warning an employee that he or she is in danger of being terminated: **Your job is in jeopardy**. Put all "job in jeopardy" warnings in writing and ask the employee to sign the warning. If they refuse to do so, try to make sure that there are two of you representing the employer in the disciplinary counseling session; simply write on the document, "This final warning was given to John Doe on June X, 19XX; he refused to sign the document, but he is aware that his job is in jeopardy." Put the document in the employee's personnel file and be prepared to provide it as evidence if the employee is ultimately fired and files for unemployment benefits with the Texas Workforce Commission.

### *Commandment VI*

If you decide to conduct regular performance evaluations, be honest. Do not engage in "grade inflation" and rate everyone in the company as excellent if they really aren't. Evaluations are your opportunity to let your employees know what they're doing well, where they need to improve, and what's going to happen if they don't. If you are ever sued, all of these documents are discoverable. Imagine yourself explaining to a jury why an employee who has been evaluated as "excellent" in all categories for the past five years was suddenly fired for substandard performance. Either make performance evaluations work for you, or don't do them at all.

### *Commandment VII*

Use progressive discipline. Short of serious criminal activity on your premises, there is almost nothing an employee can do a single time which will amount to work-related misconduct. Let your employees know the stages of your disciplinary policy and follow them (i.e., they'll be verbally reprimanded, followed by a written final warning that their job is in jeopardy, followed by termination). There is no federal or state law that requires three written warnings; however, if you have promised three written warnings in your policy handbook, certainly follow your policy. Say what you mean, and mean what you say.

### *Commandment VIII*

Appoint a "czar" or "czarina" of discharges who will objectively review the reasons for each and every termination to ensure that your company's actions are consistent, fair, legal and in compliance with your policies. If you do decide to have an exit interview, candidly and honestly state the reasons for discharge to the employee face to face. Many employees don't know why they were fired, and decide to sue. Be brief: the less you say, the less you may have to explain down the road. Don't argue and don't try to justify your decision.

### *Commandment IX*

Good manners never go out of style. Preserve the employee's dignity and confidentiality throughout the termination process. This is not the time to make an example of an employee, no matter how angry you may be. Frequently, it is the manner in which a termination is handled, rather than the termination itself, that leads to litigation. Even if a worker has clearly demonstrated they cannot function as a satisfactory employee, they should still be treated with dignity and respect. Courtesy, common sense and discretion will go a long way in preventing embarrassment and avoiding emotional distress. Remember: an employee who is treated with respect and dignity during the termination process will be less likely to sue you; further, courtesy on your part will help you appear "fair" to a jury of 12 average people, most of whom will be employees rather than business owners or managers.

### *Commandment X*

Monitor all post-employment claims with various state and federal agencies. Make sure that you tell the same story each time you are called upon to explain your actions. Don't destroy your credibility by telling one story to the Texas Workforce Commission and an entirely different version of the facts to OSHA, the EPA, the EEOC or the Texas Commission on Human Rights. This is why it is so important to have one individual designated as czar(ina) of termination; you want to present your facts consistently and honestly each time you are called upon to do so. ■

*By Renee M. Miller, Legal Counsel to Chairman Bill Hammond; reprinted from Texas Business Today, Second Quarter, 1997.*

# New Members

*TOMA would like to welcome the following new members who were approved at the April 19, 1997, Board of Trustees meeting:*

## Regular Members

**Gerald A. Krupp, D.O., Anesthesiology:** 4203 Chrismacway, Colleyville, 76034. Medical education: University of North Texas Health Science Center at Fort Worth/Texas College of Osteopathic Medicine (UNTHSC/TCOM), 1988. Internship: Grandview Hospital, Dayton, OH, 1988-89. Anesthesiology residency: University of Tennessee, 1991-92. DOB 11-24-61.

**Joseph M. Perks, D.O., Family Practice:** 5404 Vale, Greenville, 75402. Medical education: Oklahoma State University/College of Osteopathic Medicine, Tulsa, OK, 1978. Internship: Oklahoma Osteopathic Hospital, 1978-79. DOB 10-25-46.

**Frank W. Schroeder, Jr., D.O., Orthopedic Surgery:** 2402 Cornerstone Blvd., Edinburg, 78539. Medical education: University of Osteopathic Medicine and Health Sciences/College of Osteopathic Medicine and Surgery (UOMHS/COMS), 1985. Internship: Memorial Hospital, York, PA, 1985-56. Orthopedic Surgery residency: Brighton Medical Center, 1987-91. DOB 4-17-59.

**Linda J. Taylor, D.O., Adult Psychiatry:** 5806 Mesa Dr., #220, Austin, 78731. Medical education: Western University, Pomona, CA, 1990. Internship: University Hospital of Rochester, NY, 1990-91. Psychiatry residency: St. Lukes Hospital,1991-94. DOB 5-02-50.

**Jeffrey C. M. Wong, D.O., OB/GYN:** P.O. Box 1279, Alice, 78333. Medical education: UOMHS/COMS, 1991. Internship: Pacific Hospital, Long Beach, CA, 1991-92. OB/GYN residency: Doctors Hospital, Massillion, OH, 1992-96.

**Caroline E. Woodland, D.O., Family Practice:** 4137 Coral Trail, Fort Worth, 76126. Medical education: UNTHSC/TCOM, 1989. Internship: Dewitt Army Community Hospital, Fort Belvoir, VA, 1989-90. Family Practice residency: Dewitt Army Community Hospital, 1990-92. DOB 9-30-60

## Non-Resident Associate Members

**Dan Alkadi, D.O.**, 6701 NW Maole, #408, Lawton, OK 73505.

**John B. McElroy, D.O.,** 3578 Moultrie Ave., San Diego, CA 92117. ■

# Medicare Tip

Claims will be returned to you as unprocessable if you perform services in any setting other than your office or a patient's home and if Box 32 of the Health Care Financing Administration (HCFA) 1500 claim form is not completed. Box 32 requires the name and address of where the services were rendered. Medicare has been accepting claims that do not carry this information, even though the services were not rendered in the office or home, but it will begin returning them. Although no formal date has been set for returning claims, it is a good idea to begin making adjustments and checking that Box 32 of the claim form is properly filled in. ■

# NHIC to Resolve Claims Filing Problems

The National Heritage Insurance Company (NHIC), administrator of the state Medicaid program, has developed a three-step process to address physicians' concerns over problems in filing Medicaid claims after implementation of TexMedNet, the new electronic claims filing system. Many physicians have been receiving numerous rejections of their claims and have had a hard time correcting the rejections. The three steps are:

- Call the TexMedNet help desk at 888-863-3638. NHIC officials have told TOMA that new staff members have been added to handle calls.
- If you cannot get through to the help desk, call your designated provider representative.
- If your provider representative is unavailable, call the regular customer service line at 800-873-6768.

If all three options prove unsuccessful in correcting your problems, call Terry Boucher, TOMA Executive Director, at 800-444-8662. ■

# *These Doctors Are Driving Free Cars From Nutrition For Life!*

Dr. Peter Lazarnick & Family

Dr. Timothy & Christie Graupmann

Dr. Kurt Mechler

Dr. Paul Liechty

Dr. John Clark

Dr. Ray & Tuchie Adorable

## *Here's What Doctors Are Saying About Nutrition For Life!*

As an optometrist, I had to ask myself, was managed care going to help me achieve my financial freedom and allow me more time to enjoy my family? The answer was obviously no! Since I became involved in NFLI 16 short months ago, I am now earning thousands of dollars of monthly residual income part-time, I am driving a Grand Sport Corvette for free and no longer have a single worry about managed care deciding my future.

*Dr. Robert Sherer, MT*

As a surgeon, I have to work very long hours everyday. So my wife and I can only work our NFLI business part-time. In a short period of time we are making a great monthly residual income, working less hours and driving a free car. If you'd like to take control of your life back, become healthier in the process and be around positive, motivated people, this is the business for you. This is an amazing opportunity. Don't let it pass you by!

*Drs. Neal & Linda Rogers, MT*

As the owner of two busy practices, I found that in many ways, the businesses owned me. Even though the income was nice, I did not have any free time to enjoy it. Now after only 18 months in NFLI, I have more time to spend with my wife and 6 children and we are enjoying a lifestyle most people only dream about. We now own a free Mercedes and a van through NFLI. Joining NFLI was definitely one of the best decisions we have ever made.

*Dr. Tim Graupmann, S.D.*

This is the only part-time business opportunity I have ever seen that makes sense for professionals. This is the retirement fund I could never afford to fund through my practice. I am making a monthly income that will continue long after I stop being a doctor. Every health care professional will be looking at this opportunity in the future.

*Dr. Russ Hauser, WI*

**To learn how you can benefit, call 1-800-200-9511.**
**Ask For Dr. Sandknop.**

The above testimonials are individuals who do not necessarily represent what you will earn with Nutrition For LIfe.

# News from Osteopathic Health System of Texas

## Osteopathic Medical Center of Texas Pioneers Latest Heart Bypass Surgery Procedure

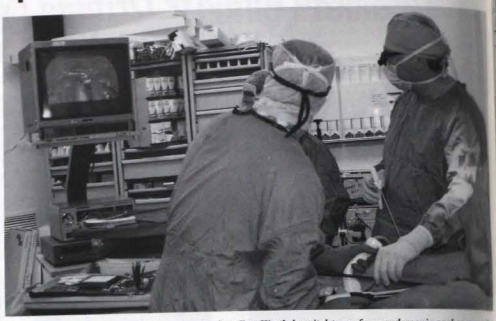
Osteopathic Medical Center of Texas was the first Fort Worth hospital to perform the latest surgical technique to remove a vein used in coronary bypass surgery. The new technique, called endoscopic saphenous vein harvest, speeds the recovery period for patients and leaves less of a chance of wound infection. Experts say the procedure is especially useful for patients who tend to have trouble healing, including diabetics and those with blood vein problems.

"Recently we operated on a diabetic patient whose results were spectacular," said Albert Yurvati, D.O., a cardiothoracic vascular surgeon at OMCT. "She had four, one-inch incisions which healed very rapidly. Prior to endoscopic harvesting, she would have had an 18- to 24-inch incision with high potential for wound infection. I am very pleased with our results."

Just a year ago, a patient having heart bypass surgery would have to endure two major invasive procedures to carry out the operation; one to remove a vein used to bypass the blocked artery and the other to repair the heart itself. The vein of choice is the long saphenous vein that runs from the foot to the groin. The body uses it to drain blood from the feet. It is favored to bypass blocked arteries in the heart because it is a long, continuous vein that is relatively easy to remove. To take out the vein, the leg was typically cut from groin to ankle, in one long incision. Waiting for the leg to heal meant lengthy hospital stays and a high rate of infection.

Endoscopic saphenous vein harvest is a relatively new procedure that allows surgeons to make three smaller incisions on the leg - at the groin, knee and ankle. With special equipment, a tiny camera, a television and a trained surgeon, patients can now get back on their feet faster, their leg wounds take less time to heal and there is less chance the wound will get infected.

The procedure has only been used in the Fort Worth area since February, and representatives from Ethicon, the company that makes the surgical equipment used in the procedure, confirmed that OMCT was the first Fort Worth hospital to perform the new surgery.



*Osteopathic Medical Center of Texas was the first Fort Worth hospital to perform endoscopic saphenous vein harvest, a new procedure for heart bypass surgery patients that reduces chances of wound complications. William Wallace, D.O., far right, assisted Burke DeLange, D.O., foreground, during a recent operation at OMCT.*

"It takes a lot of dexterity to do it," said Burke DeLange, D.O., a sixth-year vascular surgery resident at OMCT. "It's difficult the first time because you're operating from a television monitor."

The procedure is effective because of the special equipment doctors use in the operation. The surgeon starts with incisions at the knee and groin. Working from the knee up, he or she will insert a tiny probe (called an endoscope) inside the leg. Attached to the probe is a light and one-eighth-inch Olympus camera, which allows the doctor to view the procedure on a television screen. During the surgery, the doctor uses the probe to tunnel through the leg, and the vein is pulled away from the leg tissue as the probe continues its trek along the leg, just under the surface of the skin. Once the vein is free of tissue, it is "harvested" (pulled out) through an incision, much like a piece of thread is pulled out of a hem.

Endoscopic saphenous vein harvest adds about 15 minutes to the entire coronary bypass operation, which normally lasts four to five hours, Dr. DeLange said. OMCT staff members William Wallace, D.O., and Dr. Yurvati are also now performing the new procedure.

To date, about 10 OMCT patients have undergone the new procedure since February.

## Common Sleep Disorder May be Right Under Your Nose

The first time many people realize they have a sleep disorder is when their sleep partner moves out of the bedroom. Whether it's snoring, tossing and turning or kicking, the impact that poor sleep has on a domestic situation can be disastrous. In fact, it is not uncommon for a person who has a sleep disorder to be unaware of that fact until someone tells them.

"Snoring can sometimes cause some major domestic difficulties," said David Ostransky, D.O., medical director for sleep disorders at Osteopathic Medical Center of Texas. And more than half of all Americans, both male and female, are snorers.

While couples may think that some people are naturally inclined to snort their way through bedtime, snoring is potentially an indication of a serious underlying medical problem or sleep disorder, according to Dr. Ostransky. Snoring may be a symptom of sleep apnea, a condition in which the sleeping person's throat muscles relax during sleep, blocking the airway and waking up the person, sometimes hundreds of times a night.

"Sleep apnea affects millions of people, and having the condition means the person is at risk for heart attacks," Dr. Ostransky said. It's a deadly condition that slowly decreases a

person's life span. In fact, sleep apnea also leads to impotence and depression. For this reason, Dr. Ostransky emphasized that patients and doctors should take sleep disorders seriously. "What people don't realize is that if you leave a sleep disorder untreated, it's going to cause major medical problems down the road," he said.

If you are among the 50 million Americans who suffer from a sleep disorder, experts at OMCT's Sleep Disorder Center can help. OMCT's sleep lab has specially trained sleep disorder experts who can diagnose and treat problems so you and your sleep partner can get good, quality sleep. Dr. Ostransky is board certified in sleep disorders by the American Board of Sleep Medicine and practices sleep medicine at the North Texas Lung Clinic.

For more information about the Sleep Disorder Center, call 817-735-6566.

## OMCT Ranks Highest in Tarrant County on Great One Hundred Nurses List

Seven nurses at Osteopathic Medical Center of Texas were named to the Texas Nurses Association's 1997 "Great One Hundred Nurses" list, the most from any hospital in Tarrant County. The nurses were selected from more than 300 candidates in the region, which covers a 14-county area.

This year's OMCT nurses include Gina Carroll, R.N., B.S.N., cardiac rehab; Leslie Haas, ICU-CCU; Cindy Paris, R.N., surgery; Becky Personett, Ph.D., R.N., nursing administration; Annette Weathers, R.N., nursing office; Aletha Williamson, R.N., One Day Surgery Center; and Lou Young, R.N., M.S.N., 6 Tower. Six OMCT nurses made the 1996 list.

Nurses are selected on the basis of qualities including being role models, leadership abilities, service to the community, being compassionate caregivers and making significant contributions. They can be nominated by physicians, co-workers, patients and even family members.

"The fact that OMCT is the best represented hospital from Tarrant County speaks volumes about the number of high quality nurses who have chosen to work here," said Lucy Norris, R.N., senior vice president of Patient Care. "I am proud to have so many excellent nurses on our staff."

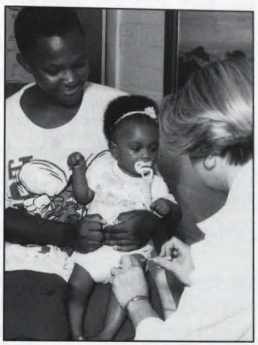
Personett said she was surprised to learn of the honor. "It's like the Academy Awards," she said. "To be in a position where people within your own field recognize you, it's just wonderful."

Nurses on the list receive a pin in recognition of the honor. "It will be one of the things I wear with the most pride," Personett said.

Williamson was proud as well. "This is the first time I've received an award like this," she said. "It's an honor to know that your co-workers think highly enough of you to nominate you."

The Great 100 honorees were treated to a May 5 reception during Nurses Week at OMCT and on May 6 at the Morton H. Meyerson Symphony Center in Dallas.

The program is sponsored by the Texas Nurses Association Districts 3 and 4, the Dallas-Fort Worth Hospital Council and the Dallas-Fort Worth Nurse Executives. ■



# Upcoming Changes to School and Day Care Immunization Requirements

*By Kristin Hamlett*

The Texas Board of Health recently approved changes to the ***Immunization Requirements for Children and Students.*** Except as noted, these changes take effect August 1, 1997. The new requirements reflect recent recommendations from the Advisory Committee on Immunization Practices (ACIP) of the Centers for Disease Control and Prevention (CDC).

Receipt of two doses of measles vaccine will be required of children who are 5 years old or older and born on or after September 2, 1991. Children entering kindergarten this fall will be affected immediately, as will pre-kindergarten students who turn 5 during the 1997-98 school year. Children born before this date must continue to show proof of a second measles dose at 12 years of age.

The ACIP-recommended "sequential schedule" for polio vaccination increases to 12 months the age at which the third dose of polio vaccine is received. Consequently, the number of doses required of children 6 through 11 months old has been reduced from 3 to 2. Health care providers, in consultation with parents, may choose to follow the sequential schedule or to use an IPV-only or OPV-only schedule. New language replaces all mentions of OPV and IPV with "polio vaccine" to clarify that any combination of vaccines is acceptable.

Licensure of DTaP for use as the primary series necessitated a similar change of language. References to DTP/DT/Td now include DTaP in all age groups.

Effective August 1, 1998, children who are 5 years old or older and born on or after September 2, 1992, must have received three doses of hepatitis B vaccine. Children entering kindergarten in the fall of 1998 will be affected, as will pre-kindergarten students as they turn 5 during the 1998-99 school year.

For further information about these changes, contact Kristin Hamlett, Immunization Compliance Coordinator, Texas Department of Health, at 800-252-9142 or 512-458-7284. ■

# "Long-Term Care"

## *SOME SURPRISING STATISTICS:*

- According to The New England Journal of Medicine (1991), **43%** of people who turned age 65 in 1990 can expect to spend some time in a nursing home during their lifetime. Of that number, **21%** can expect a nursing home stay of five years or more.

- According to the Health Care Financing Administration, 1993, **$70 million** was spent on nursing home care in 1993. Only **9%** was Medicare's share of that $70 million. **33%** was paid directly out-of-pocket by patients.

- According to the Health Insurance Association of America's, "*Guide to Long-Term Care Insurance*," 1994, the average annual cost of nursing home care is **$36,000**. Assuming an inflation rate of 5%, the projected annual nursing home cost in 10 years will be near **$60,000.**

**Clearly, paying for long-term care can be a serious problem if you haven't planned for it. Even so, long-term care insurance is not for everyone. The most important thing to remember is this: the longer you wait to purchase a long-term insurance policy, the more expensive it will be. Don't wait until you need long-term care to talk to us because then it will probably be too late.**

**TO DISCUSS LONG-TERM CARE INSURANCE AND ITS APPROPRIATENESS FOR YOUR FINANCIAL FUTURE, CALL US TODAY.**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# News from the University of North Texas Health Science Center at Fort Worth

## UNT Health Science Center Names Alumni Affairs Manager

Janis Huneycutt has been named alumni affairs manager at the University of North Texas Health Science Center at Fort Worth.

A graduate of Fort Hays State University in Hays, Kansas, Huneycutt earned a bachelor of arts in liberal arts and spent time in Lakin, Kansas, and Zweibruecken, Germany, teaching English and journalism. Huneycutt was with the American Lung Association for 13 years, serving as the regional director of the Fort Worth office for nine years. Most recently, she was associated with Respiratory Connection, a medical company located in Bedford.

"Janis' addition is crucial for the advancement of our alumni association and for providing new programs and opportunities for the more than 1,700 alums of the health science center's Texas College of Osteopathic Medicine," said David M. Richards, D.O., president of the UNT Health Science Center. Huneycutt, who resides with her husband, John, in Weatherford, joins the health science center's office of institutional advancement.

## UNT Health Science Center Students Named to National Who's Who

The distinction of *Who's Who Among Students in American Universities and Colleges* was awarded to 23 students from the University of North Texas Health Science Center at Fort Worth. Recipients of the honor included students from both the Texas College of Osteopathic Medicine and the Graduate School of Biomedical Sciences.

Students were selected by a committee of administration, faculty and student body members. They were selected based on academic achievement, service to the community, leadership in extracurricular activities and potential for continued success.

"These students have taken responsibility to give to others and lead others to more fulfilling ways of life," said Dr. David M. Richards, president of the health science center. "They honor the UNT Health Science Center by their achievements, and we are very proud of their accomplishments."

The students join an elite group of students from more than 1,900 institutions of higher learning in all 50 states. *Who's Who Among Students in American Universities and Colleges* has been one of the most highly regarded higher education honor programs for 57 years.

The Texas College of Osteopathic Medicine recipients include:

- Cynthia Ball, Amarillo, TX
- John Biery, Jr., Ottawa, OH
- Matthew Crawford, Houston, TX
- Daralynn Deardorff, Fort Worth, TX
- Arnold Alexander, Houston, TX
- Kevin Gallagher, San Antonio, TX
- Scott Hees, Fort Worth, TX
- Ty Maddox, Trophy Club, TX
- Lori Miller, Newton, IA
- Andrew Mleynek, Saginaw, TX
- Leonor Osorio, Wichita Falls, TX
- Jigar Patel, Fort Worth, TX
- Stephen Sellers, Tyler, TX
- Mark Sij, Beaumont, TX
- Lynn Speaks, San Antonio, TX
- Michael Thornton, Dallas, TX
- Jennifer Weatherly, San Antonio, TX
- Kin Sing Wong, Hong Kong, China

The Graduate School of Biomedical Sciences recipients include:

- Kristin Bryant, Bryan, TX
- Paul Brittain, Fort Worth, TX
- Kimberly Krueger, Fort Worth, TX
- Rustin Reeves, Plano, TX
- Jonathan Tune, Fort Worth, TX ■

# Federal Issues

• Prospects may be improved for consumer protection legislation that regulates managed care plans. Senator Alphonse D'Amato (R-NY) and Representative Charlie Norwood (R-GA) have introduced a bill that would give people the right to choose their own doctors, to ban gag rules, to hold plans liable for a patient's wrongful death or personal injuries, to assure access to emergency services, and to provide other protections. Many legislators who are sympathetic to managed care consumer protection prefer comprehensive legislation such as this bill rather than piecemeal regulation on individual issues.

• President Clinton has offered an additional $18 billion in Medicare spending reductions over five years in response to the Congressional Budget Office estimate that his previously proposed "$100 billion" in spending reductions fell $18 billion short. His modified budget proposal includes a one-year hospital prospective payment (PPS) freeze, despite an earlier statement by Health and Human Services Secretary Donna Shalala that the Administration would not propose a PPS freeze.

• Senators John Chafee (R-RI) and John D. Rockefeller, IV (D-WV) have introduced legislation to expand Medicaid to cover 5 million additional children. The bill demonstrates continuing Congressional interest in health coverage for children. Representative John D. Dingell (D-MI) is introducing similar legislation in the House. The Chafee bill joins several other bills to improve coverage for children, including a bill sponsored by Senators Orrin G. Hatch (R-UT) and Edward Kennedy (D-MA).

• The Institute of Medicine of the National Academy of Sciences has issued a report requested by the House Committee on Ways and Means "On Implementing a Medical Education Trust Fund." Among the report's recommendations is a per-resident direct graduate medical education (GME) payment on a standardized basis such as a national average. This recommendation is consistent with the long-held view of the osteopathic profession. The report also suggests that if a medical education fund is supported not only by Medicare but also by other funding sources, there is an opportunity to provide GME payments without tying the amounts to Medicare caseloads, and to provide payments, as appropriate, to selected non-hospital training sites or entities such as "medical and osteopathic schools, health maintenance and managed care organizations, group practices, ambulatory centers, universities, and consortia." The report specifically notes the "American Osteopathic Association's plan to structure osteopathic GME into mandatory consortia." Medicare's indirect medical education payment is for the support of teaching hospitals, and should continue to be paid only to hospitals, says the report. But it suggests that a study be undertaken to explore the possibility that indirect payment eligibility may need to follow direct GME funding out of the hospital. ■

*Source: AOHA Washington Update*

# Public Health Notes

## "Protecting Our Children Against Hepatitis B"

*By Alecia Anne Hathaway, M.D., M.P.H., F.A.C.P.M.*

Hepatitis B is a serious problem that affects persons of all ages. It is spread via bodily fluids, placing many diverse groups of persons at risk, and it is acknowledged as an STD which is vaccine preventable. Each year more than 240,000 persons in the United States are infected with this disease. The causative agent, hepatitis B virus (HBV), is highly infectious and is the main cause of severe liver damage and liver cancer. At least five percent of all primary cases of hepatitis B results in fulminate hepatitis leading to death. Another five percent go on to develop chronic carrier states in which they remain infectious to others.

There is an effective split and deactivated vaccine to prevent HBV infection. Universal vaccination was added to the recommended routine childhood vaccine schedule by the Texas Board of Health in 1993. HBV immunization has been given to newborns before hospital discharge for the past several years, and in 1998, will be required of all students entering kindergarten. The health departments currently immunize all children born on or after 11-1-1991 with HBV vaccine.

Historically, vaccination programs have focused on infants and pre-school children and have been effective in reducing childhood vaccine preventable diseases. Because of the focus on more recent cohorts of younger children, many adolescents and young adults have been left unprotected. A new strategy involving the immunization of 11 year olds with the HBV vaccine has been undertaken to lower the incidence of infection and reduce HBV transmission in the United States. The goal is to educate parents about the importance of this vaccine for their adolescents and encourage participation in preventing this damaging disease. This vaccine does require a series of three immunizations spaced one month and six months apart. Adverse reactions are usually local in nature. As a side note, the vaccine also prevents expression of hepatitis D (the delta agent), since this virus can only replicate in and cause illness of persons infected with hepatitis B. The hepatitis D virus requires a coat of hepatitis B surface antigen to become infectious. Therefore, immunity to hepatitis B eliminates potential reservoir/hosts for hepatitis D. It is imperative that this window of opportunity for all 11 year olds not be missed. Parent education is the key to reaching this population and that requires that all health care providers be informed and participate.

Local health departments provide state vaccine (for all the recommended childhood immunizations) to qualifying health providers under the State Vaccines for Children Program. For more information please contact the vaccine coordinator at your nearest health department. To report diagnosis of HBV hepatitis please contact the Epidemiology Department of your health department. We encourage all health care providers to advocate prevention of infection with this virus through immunizing or referring their clients for proper immunization. ■

# Self's Tips & Tidings

*Don Self & Associates*

With the advent of Medicare paying for home health care and the fact that home health care agencies are popping up so quickly, you have to be careful of your liability. We have had numerous questions posed to us concerning HHA care plan oversight:

***Q. We had a nurse call for a prescription for an orthosis that was ordered by the physical therapist. Are we legally responsible if we sign that prescription?***

*A. If the physician signs the order for home health services, the physician is legally responsible for ordering them. Offices should work out systems for identifying and signing the forms for patients for whom the physician is ordering such services.*

If the physician has not actually seen the patient and decided that home health services are necessary, he or she should not even consider signing the order at all. If the home health agency is asking for authorization of services that are broader or more frequently provided than the physician thinks necessary, the physician should not sign the order as it stands.

The fraud and abuse auditors are out there looking, and home health is a prime target. Doctors have to remember that if their signatures are on the forms, they're buying responsibility. I appreciate that careful scrutiny of the forms can sometimes inconvenience legitimate and honestly run home health agencies; but in today's environment, any physician who is careless about what he or she signs takes big risks.

## Hospital Owned Physician Offices/Clinics

With more and more hospitals actually buying physician practices, staffing them and providing all of the equipment and supplies, there are differences in claims filing that need to be pointed out. Normally, if you provide services in your office, the place of service is 11 for office. If the physician is an employee of a hospital, and the office staff are paid by the hospital, then the correct place of service should be 22 (Out-patient Hospital). This means the approved amount will be considerably lower than if the physician owns the practice (due to site-of-service reductions), but it is the correct way to file for the services. If your clinic is owned by a hospital, we highly recommend you bring this to their attention, so as to avoid costly fines and fraud charges by the carriers.

## The Doctor Isn't the Only One Held Liable for Coding

Last summer, the Kassebaum-Kennedy bill was passed almost unanimously by Congress. It is the latest healthcare reform bill, and incorporates most of Hillary's ideas on "fraud and abuse," definitions, identification and penalties. The real scary part is that the billers, claims coders, insurance clerks and office managers can be legally held responsible for fraud and abuse charges, in that they can go to jail, lose their house and savings, etc. It is a real scary bill for which everyone in Congress voted except Stark, who thought it wasn't tough enough.

With this in mind, we encourage not only physicians to stay on top of changes in laws, regulations, codes and coverage issues, but also the folks actually completing the claims.

## Diabetic Education Coding

Many physicians are not clear on how to bill for those visits that are mainly education counseling for diabetic patients. In the office under physician supervision, incident to services such as diabetic teaching can be billed as 99211. However, if the incident to person is a licensed Nurse Practitioner, Clinical Nurse Specialist, or a Physician's Assistant, they can bill a 99212 through 99215, using the code selection based on time if it is documented that counseling or coordination of care was more than 50% of the total time, indicating total time, etc. Of course, under the "incident to" rules, the physician must be in the same suite or on the premises, even if they personally do not see the patient during the encounter.

## What Does that Managed Care Contract Include in Fine Print?

Many physicians are enrolling in dozens of managed care plans without even reading the fine print. Physicians should be aware that some of the "clauses" may include the following:

1. A claims processing fee to be deducted from the physician's payment. One such contract included the clause that the claims processing would be performed by a third party, payable from the proceeds of the physician's payment.

2. The stipulation that the provider may not refuse treatment to the insured for any reason, regardless if co-pay has been made. In other words, the patient may never have to pay his or her portion, yet the physician is prohibited from divorcing the patient for any reason.

3. Thirty, sixty or ninety-day time limits on claims properly being filed to the managed care intermediary. This is a common clause found in managed care contracts, and basically means that if the physician does forward the claim to the carrier within 30 days of the date of service, then the physician may collect zero on the claim.

My advice to every physician is to have every managed care contract reviewed by an attorney that you trust. To not do so is inviting non-payment of your claims, lawsuits by the managed care plan or exclusion from the plans.

## Injection Codes and Medigap Carrier List Now on Web

For those who have gotten onto the web, you can now read or download information helpful to your practice. Our web site now includes articles helping your practice, information about our newsletter subscription program and our claims filing services, as well as a complete listing of Medigap carriers with their payor numbers and a listing of all 1997 HCPCS Injection codes. Drop by our web at your convenience and take advantage of this free information: **http://www.gower.net/donself**

## Billing for Venipuncture when the Physician is not Present

It is important to realize that the venipuncture charge is considered to be an "incident-to" service. Per HCFA regulations, the physician must be on the premises when "incident-to" services are rendered if a bill is to be submitted to Medicare. Unfortunately, we do not have documentation concerning non-Medicare patients (G0001 for Medicare) 99000 for Medicaid and 36415 for private), so use your own judgment in these circumstances. ■

# Texas ACOFP Update

**By Joseph Montgomery-Davis, D.O., Texas ACOFP Editor**

The ultimate power within professional organizations such as the Texas ACOFP and TOMA resides not in the hands of a few individuals, but in the hands of its membership. However, these organizations speak with one voice only on one day - during the annual Texas ACOFP meeting or the TOMA House of Delegates meeting.

On this special day, the policy of the organization can be changed and the mechanism to bring about that change is called the "resolution" process. Voting members can submit resolutions to establish new organizational policies, modify existing organizational policies or get rid of old organizational policies.

It takes a lot of networking to get the votes needed to pass resolutions, especially if those resolutions are controversial. It helps to have sufficient lead time to touch all the right bases, so one should never wait until the last minute to mobilize support for a specific resolution.

My main reason for raising this issue now is to alert the membership to what I perceive as a flaw in the "resolution" process. What happens to a resolution once it is passed? To pass a resolution at the grassroots level is only a skirmish in the battle. This is especially true if you want to effect the national policy of the ACOFP or the AOA. Fortunately, this has not been a major problem within Texas. When the Texas ACOFP annual session or TOMA House of Delegates meeting is adjourned, the task of running the organization shifts to its board. Therefore, the actual implementation of organizational policy decisions is left up to executive directors and board members, rather than the major policy-making bodies.

From my past experience, it seems that osteopathic professional organizations need to do a better job of letting their membership know where the organization stands on vital health care issues. Also, once a resolution is passed by an osteopathic professional organization, there has to be a better accounting system to keep track of it. Too many resolutions have gotten lost once they passed; they have simply disappeared! It seems like the attitude of some of the key players is to let you pass whatever you like, but they will decide what goes forward and what gets left behind. The will of the majority is effectively thwarted by the few!

Now is the time to stop fighting skirmishes and win the battle. Our instrument will be the "resolution." We can no longer be satisfied with sitting still and spinning our wheels.

This is the reason a specific resolution is being introduced in the 1997 TOMA House of Delegates addressing this problem. This resolution, if passed, will be forwarded to the AOA House of Delegates for its consideration. The resolution is entitled, "TOMA Resolution Action Plan" and reads as follows:

## Resolution 97-7
## TOMA Resolution Action Plan

***Whereas,*** *many Texas osteopathic physicians donate their time to represent the profession at the TOMA House of Delegates, and*

***Whereas,*** *their actions represent the best intentions of the membership for this organization. Therefore, be it*

***Resolved,*** *that the TOMA House of Delegates directs the TOMA Executive Director in the annual report to the TOMA House of Delegates to report all actions and on-going activities reflecting the due diligence of the TOMA Board in accomplishing its approved resolutions. The report shall include information pertaining to each and all resolutions passed by the TOMA House of Delegates until it reaches final disposition, including actions taken by agencies and/or committees to whom any resolutions may have been referred. And be it further*

***Resolved,*** *that the TOMA House of Delegates submit a similar resolution to the American Osteopathic Association House of Delegates for adoption.*

We need to be especially vigilant when it comes to protecting and defending the heritage of our osteopathic medical profession and the unique terminology that is used to describe what osteopathic physicians do. We owe it to those osteopathic physicians who came before us and in whose footsteps we now stand to get the facts right. This is the reason why several resolutions have been introduced in the 1997 TOMA House of Delegates to amend or delete portions of the AOA *Protocols for OMT in Patient Management*, dated January, 1997, and in the AOA position paper on Osteopathic Manipulative Treatment (OMT) and Evaluation and Management Services (E & M), dated January, 1997.

Some excerpts from those resolutions are listed below and read as follows:

This AOA position paper included the following statement:

- "Texas chose to bundle OMT with the office visit but assign a higher work RVU for the total encounter. In other words, physicians who performed OMT and E&M on the same date of service were instructed to simply bill a higher level E&M to reflect the additional work of the OMT."

The Texas Osteopathic Medical Association has never had a policy of bundling OMT with E&M for reimbursement purposes. Therefore, the TOMA House of Delegates calls upon the AOA to amend that portion of its OMT and E&M position paper which refers to Texas having a policy of bundling OMT with E&M for reimbursement purposes.

An accurate description of OMT is needed when dealing with third party payers over reimbursement issues, and the AOA *Protocols for OMT in Patient Management*, dated January, 1997, state the following: "Ongoing treatment of chronic problem - If a patient has more than one recurrent episode related to their original complaint within one year, it should not be classified or treated as

an acute problem. In this circumstance, it would be classified as a chronic recurrent problem...".

"Chronic recurrent" somatic dysfunction is not a palpatory diagnosis while "acute" and "chronic" somatic dysfunction are palpatory diagnoses, and an "acute exacerbation of a chronic problem" is more appropriate osteopathic terminology than "chronic recurrent" since acute palpatory tissue changes are found.

Therefore, the TOMA House of Delegates calls upon the AOA to amend that portion of its *Protocols for OMT in Patient Management*, dated January 1997, by substituting the phrase "acute exacerbation of a chronic problem" for the term "chronic recurrent" when discussing the diagnosis and treatment of somatic dysfunction utilizing OMT.

Somatic dysfunction is a palpatory diagnosis, and the AOA *Protocols for OMT in Patient Management*, dated January 1997, states that "acute, sub-acute, and chronic refer to the phase of illness at the time of initial presentation to the physician." Additionally, these protocols for OMT use time frames instead of palpatory findings to establish the phase of illness, and "sub-acute" somatic dysfunction is not a palpatory diagnosis while "acute" and "chronic" somatic dysfunction are palpatory diagnoses.

Therefore, the TOMA house of Delegates calls upon the AOA to amend that portion of its *Protocols for OMT in Patient Management*, dated January, 1997, to delete the term "sub-acute" when discussing the diagnosis and treatment of somatic dysfunction utilizing OMT.

My generation of osteopathic physicians has devoted a lot of time and effort towards changing the direction of their professional organizations by passing resolutions designed to get rid of some old devisive policies. Now, it is up to the younger generation of osteopathic physicians to finish the job. They must demand accountability from their leaders to insure that when the majority speaks, action is either taken or the reason for inaction is explained.

I want to update the membership on S.B. 386 dealing with HMO liability. At the time of this article, it has passed the Senate and the House and is on the way to the governor. Gov. Bush will decide whether to sign, veto or allow the legislation to take effect without his signature.

Don't forget the Texas ACOFP breakfast meeting for active members on Saturday, June 14, 1997, at TOMA's annual convention at the Radisson Plaza Hotel in Fort Worth. Gear up to celebrate the 44th anniversary of the Texas Society of the ACOFP. Remember, it is scheduled for 7:00 - 8:00 a.m. Also, don't forget to stop at the Texas ACOFP booth in the exhibit area to sign up for our special door prize. ■

# Blood Bank Briefs for Physicians

## "Testing of Donor Blood – 1997"

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

Testing of a sample of donor blood is required before units of blood or blood components are available for transfusion. A sample from each donation intended for allogenic use must be tested by the Food and Drug Administration licensed tests as required by the FDA and the American Association of Blood Banks (AABB) Standards. A brief review of current testing is provided.

***Determination of ABO Group and Rh Type:*** ABO grouping is determined by testing donor red blood cells with anti-A and Anti-B reagents and testing the donor's serum or plasma with $A_1$ and B red blood cells. The Rh type is determined by testing donor red cells with anti-D serum. If the initial test for anti-D is negative, the blood is tested by a method designed to detect weak D. When either test is positive, the blood is labeled "Rh Positive." When tests for both D and weak D are negative, the blood is labeled "Rh Negative." Previous donor records are checked against current test results and discrepancies are resolved before units are acceptable for labeling and release.

***Test for Detecting Unexpected Antibodies to Red Cell Antigens:*** Serum or plasma from donors with history of transfusions or pregnancy must be tested for unexpected antibodies to red cell antigens. Because it is impractical to segregate blood that must be tested from units that need not be tested, all donor units are tested at Carter Blood Center by methods that demonstrate clinically significant antibodies.

***Serological Test for Syphilis:*** The PK7100 Micro-Hemagglutination Assay - Treponema pallidum is the test performed at Carter Blood Center. Donor units reactive are not used for transfusion.

***EIA Tests for Specific Viral Antigens (HBsAg, HIV-1-Antigen):*** The enzyme immunosorbent assay (EIA) is the test of choice for screening donor blood for hepatitis B surface antigen (HBsAg) and human immunodeficiency virus 1 antigen (HIV-1-antigen). EIA tests are highly sensitive which makes them useful as screening procedures but are subject to false positive reactions. Before a donor is designated antigen positive, it is important to determine whether the screening result is repeatable. If the initial test is reactive, the test is repeated in duplicate and if one or both of the duplicate tests are reactive, the specimen is described as repeatedly reactive and the blood unit and all its components destroyed.

***EIA Tests for Antibodies (Anti-HIV-1, Anti-HIV-2, Anti-HBc, Anti-HCV, Anti-HTLV-1):*** The enzyme immunosorbent assay method is used to screen for the presence of antibodies to HIV-1, HIV-2, HBc, HCV and HTLV-1. Samples giving non-reactive results on the screening tests are considered negative. Samples reactive on the initial screening test must be repeated in duplicate. Reactivity in one or both of the repeated tests constitutes a reactive result and the blood is destroyed.

***Alanine Amino Transferase (ALT):*** ALT is an enzyme present in cells of many tissues but highest concentration in hepatocytes. Elevated circulating levels of ALT occur when the liver has sustained damage of many kinds. Although no longer required by the AABB Standards, ALT testing is performed at Carter Blood Center and units with elevated ALT levels are destroyed.

With the sensitivity of these licensed assays, each month approximately three to four percent of the blood collected must be discarded. All of the above tests are done along with a detailed medical history to help assure the safest blood currently possible is available for your patients.

***References:***

*Klein H ed Standards for blood banks and transfusion services. 17 ed. Bethesda, MD: American Association of Blood Banks, 1996.*

*Code of Federal Regulations, Title 21, CFR 600-796. Washington, D.C.: US Government Printing Office, 1996.*

*Code of Federal Regulations, Title 21, CFR 200. Washington, D.C.: US Government Printing Office, 1996.*

# HCFA to Fight Fraud With "Operation Restore Trust Plus"

A successful five-state pilot program called "Operation Restore Trust" has been expanded to the entire United States in an effort to halt health care fraud. Operated by the Health Care Financing Administration and renamed "Operation Restore Trust Plus," it is a joint operation of several federal and state agencies, including the Department of Health and Human Services, the Federal Bureau of Investigation and state attorneys general. The program's computers will scrutinize records of medical treatment paid for by Medicare, enabling auditors to spot patterns of possible fraud by hospitals, physicians and other health care providers.

When computers uncover something suspicious, government auditors will follow up by checking Medicare records and/or checking those maintained by the hospitals or providers in question. Individual cases of suspected fraud will be referred to the Justice Department for possible prosecution.

During the two years of "Operation Restore Trust," $1.30 million in fraud from both Medicare and Medicaid providers was recovered. One of the keys to its success was what the government is counting on in its expanded new program: individual Medicare beneficiaries themselves. Beneficiaries made 12,614 calls to a toll-free number during the two-year pilot program, that warranted follow-up efforts. These calls led to 3,367 cases against fraudulent providers; as a result, the government has so far recovered $7.7 million from these consumer tips.

According to the General Accounting Office, fraud and abuse account for approximately 10 percent of all dollars spent on health care.

# TEXAS STARS

*The following people have made pledges or have contributed to TOMA's Building Fund Campaign. These people are now known as "Texas Stars" because of their commitment to the osteopathic profession.*

Rene Acuna, D.O.
Bruce Addison, D.O.
Ted C. Alexander, Jr., D.O.
Richard Anderson, D.O.
Sara Apsley-Ambriz, D.O.
ATOMA
ATOMA District II
Aus-Tex Printing and Mailing
Mark Baker, D.O.
Rita Baker
Elmer Baum, D.O.
Kenneth Bayles, D.O.
James Beard, D.O.
Terry Boucher
Jan Bowling
John R. Bowling, D.O.
Daniel Boyle, D.O.
Frank Bradley, D.O.
Joanne Bradley
Dale Brancel, D.O.
Robert Breckenridge, D.O.
John Brenner, D.O.
Lloyd Brooks, D.O.
Mary Burnett, D.O.
Jeffrey Butts, D.O.
D.Y. Campbell, D.O.
Catherine Carlton, D.O.
Ross M. Carmichael, D.O.
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Samuel Coleridge, D.O.
Robert Collop, D.O.
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Michael Cowan, D.O.
Nelda Cunniff-Isenberg, D.O.
B. J. Czewski
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George DeLoach, D.O.
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Doctors Hospital
Iva Dodson
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Richard Friedman, D.O.
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D. Dean Gafford, D.O.
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Bret Holland, D.O.
Joel D. Holliday, D.O.
William D. Hospers, D.O.
Houston Osteopathic Hospital Foundation
Bobby Howard, D.O.
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# Opportunities Unlimited

## PHYSICIANS WANTED

FORT WORTH AREA FP-GP CLINIC needs an additional GP for full or part time. No OB, no hospital required. 817-924-7978. (02)

EXCELLENT OPPORTUNITY IN DALLAS SUBURB for young doctor in field of family practice and physical medicine. Starting salary negotiable, with full ownership of a large, very productive practice in four years. Send resume with brief statement of your personal philosophy of life to: Opportunity, P.O. Box 180653, Dallas, Texas 75218. (04)

SEMI-RETIRED PART-TIME GP — Accident and Injury Clinics - Dallas/Fort Worth area. Call 972-647-4591; FAX 817-424-1059. (05)

PART-TIME/FULL-TIME PHYSICIAN NEEDED for busy clinic in Richardson. Excellent opportunity. Call Michael Margolies of Crown Health Management at 972-238-1976 Or 972-849-5329. (08)

HIGH VOLUME CLINIC - Patient Mix, Medicaid and Fee for Service. Spanish with a touch of reality a plus. Compensation dependent upon production. Call 817-574-2777 or 800-767-1007. (09)

BOARD CERTIFIED FAMILY PRACTITIONER to join 2 Family Practitioners in established Grand Prairie metroplex practice. Light hospital (Baylor-Irving), no OB. Flexible work schedule (currently rotating work 2 days with 3rd day off). No weekend office. Share calls. Managed Care experience a plus. Call Jeff Thompson at 972-262-1425 or 817-429-4711. (10)

ONLY IN ARLINGTON! 3 D.O. F.P. group seeks 4th BC/BE practitioner. 6% Medicare, 9% Medicaid (including Dr. Dennis's deliveries), 3% W/C, no weight or HMOs. 1 admission/month at Columbia Med. Ctr., 1 weekend group call/month. Our patients get quality medical care in a fun and loving atmosphere, and pay us. We have set a collections goal every year. Call Dean Peyton, D.O., Sharon Dennis, D.O., or David Gouldy, D.O., at 817-277-6444 or leave Voice Mail at 817-530-0200. (13)

RADIOLOGIST: BC/BE Interventional radiologist needed to join growing practice of 8 radiologists in Texas. Would prefer fellowship training in Interventional or Neurointervention. Primary responsibility would be in Special Procedures with some general diagnostic radiology. Full benefit package with liberal CME and vacation time. Salary commensurate with experience. Direct CV and inquiries to Richard Schellin, D.O., Department of Radiology, OMCT, 1000 Montgomery St., Fort Worth, TX 76107; 817-735-3220. (15)

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)

HILL COUNTRY — Established and flourishing Women's Health & Fitness Center in Boerne, Texas, searching for dynamic, motivated D.O., GYN or Cosmetic Surgeon. Opportunity as working partner or straight office lease available. Need is immediate... patients are waiting. Call Phyllis today - 210-816-2946 or 210-249-9063. (18)

DOCTOR NEEDED in various parts of Texas to work small hospital emergency rooms on weekends. Also, full-time/part-time primary care opportunities available. For more information, call Jerry at the Lewis Group at 800-460-8159. (20)

ACADEMIC GERIATRICIAN OPPORTUNITY - The University of North Texas Health Science Center at Fort Worth seeks a fellowship-trained geriatrician to join the Division of Geriatrics, Department of Medicine. Professional opportunities are enhanced through the following efforts: Geriatric Medicine and Dentistry Fellowship Program, Teaching Nursing Homes, In-Patient Teaching Service, Home-Care Program, Ambulatory Geriatrics Clinics, and Gerontology Assessment and Planning Program for Frail Elders. Interested candidates may be Family Practice or Internal Medicine trained geriatricians and Board Eligible or Certified in the primary field. Teaching and research responsibilities are included along with clinical participation in the continuum of care. The Geriatrics Division has plans to expand into several dementia long term care facilities within the year. Candidates with interest and/or experience in Alzheimer's Dementia are encouraged to apply. Salary and benefits package are competitive. We invite interested candidates to apply. Send curriculum vitae and three letters of recommendation to: Janice A. Knebl, D.O., FACP, Chief - Division of Geriatrics, Department of Medicine, UNT Health Science Center, 3500 Camp Bowie Boulevard, Fort Worth, TX 76107; 817-735-2108. An EEO/Affirmative Action Institution. (22)

FAST TRACK CLINIC OPENED JANUARY, 1996 — Primary Care Physician needed. Flexible schedule with malpractice provided and competitive salary. Send CV to: OPEM Associates, P.A., 4916 Camp Bowie Blvd., #208, Fort Worth, TX 76107; 817-731-8776; FAX 817-731-9590. (24)

DALLAS/FORT WORTH — Physician Opportunity to work in low stress, office based practice. Regular office hours. Lucrative salary plus benefits. No call, no weekends, and no emergencies. Please call Lisa Abell at 800-256-6425 or FAX CV to 972-256-1882. (25)

WANTED — Physician interested in Bariatrics to work part-time in Dallas area clinic. Contact Pat at 214-638-4923. (33)

AMBULATORY FAMILY PRACTICE has opportunities for FT/PT BC/BE FP. Full benefits package for FT including malpractice, paid time off, expenses for CME/Lic. fees. Flexible schedule, no night call, no hospital work, no administrative hassles. Enjoy the lifestyle afforded by the Metroplex. Please FAX CV to 817-283-1059 or call Shannan at 817-283-1050. (36)

FAMILY PRACTICE D.O.s — Practice opportunities for physicians at 54-bed facility in beautiful Tyler, Texas. Active staff of over 80 physicians with 8 specialties represented. Office space available near hospital or must share established very active practices in communities near Tyler. Outlying clinics located in 4 nearby communities. P.H.O. with approximately 120,000 insured individuals. Hunting, fishing, watersports, country clubs, university, junior college, many recreational facilities, civic and social opportunities. Contact Olie E. Clem, C.E.O., at 903-561-3771. (52)

## OFFICE SPACE AVAILABLE

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

FOR SALE: 2,800 square foot medical office facility in Mineola, Texas. Prime location. Eleven offices with large reception area. Agent 1-800-484-6879 (6981) four digit code. (27)

## MISCELLANEOUS

WANTED: used McManis table, Therapy equipment or X-ray equipment. Call or write Donald L. Dingle, POB 118, Atoka, OK 74525. 405-889-3338 or 405-889-6457. (12)

FOR SALE — Late model MA X-ray and processor with view box and accessories, hydraulic stretcher; transport stretcher, Coulter counter and diluter; storage cabinets, office desk; assorted other items - very good condition. Contact: Dr. Glen Dow or Office Manager, 817-485-4711. (48)

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