

## Medical Legal Summit Addresses Issues of Importance to Physicians and Attorneys

In April, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to participate in an outstanding Medical Legal program which took place at Cleveland Marshall School of Law. Co-sponsored by the AMCNO, the Academy of Medicine Education Foundation (AMEF), and the Cleveland Metropolitan Bar Association (CMBA). The summit began with opening remarks by Carter Strang, Partner with Tucker Ellis, LLC, and Kim Bixenstine, Vice President and Deputy General Counsel, University Hospitals, Cleveland, and a warm welcome by AMCNO President, James Sechler, MD. The first presentation featured keynote speaker Dr. Ezekiel "Zeke" Emanuel discussing his view of the State of Health Care in America. During his presentation, Dr. Emanuel addressed the issue of health care reform head on, providing his insight into the state of health care today and how reform might make it better tomorrow.

According to Dr. Emanuel, the United States federal government spends \$15.65 billion for healthcare, making it the fifth largest health care economy in the world. He noted that national spending on health care from 2011-2012 was over \$100 billion. The largest percentage – one-third of health care spending – goes to hospitals, according to Dr. Emanuel, with the second highest

contribution in health care spending going toward doctor services.

Dr. Emanuel also addressed the common thought that health care reform involves rationing patient care. He noted that Switzerland does not ration care and presented data suggesting that should the US reform its health care system, it will not result in



Co-chairs for the event spend a moment with association leadership and Dr. Emanuel. (l to r – Carter Strang, CMBA President, Dr. Emanuel, Ms. Kim Bixenstine, Mr. Matthew Donnelly and Dr. James Sechler, AMCNO President).

rationing of care. He then moved on to discuss the impact insurance coverage can have on health care, presenting data regarding the five-year survival rate of cancer patients in the U.S. Cancer patients who were covered by private insurance had a 77 percent chance for a five-year survival rate whereas those

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## Ohio Physicians Health Program

### A Confidential Resource for Physicians and Other Healthcare Professionals in Ohio

The Ohio Physicians Health Program (OPHP) is a 501(c)3 not-for-profit organization that assists physicians and other healthcare professionals who may be affected by substance use disorders or other issues impacting their health and well-being. OPHP's mission is *to facilitate the health and wellness of healthcare professionals in order to enhance patient care and safety.*

OPHP began in 1973 as the Physicians Effectiveness Committee (PEC) of the Ohio State Medical Association. Initial activities of the PEC focused on physicians suffering from alcohol and drug addiction. As it began to address other areas of physician health and well-being, PEC evolved to become the Ohio Physicians Effectiveness Program (OPEP). In 2004, the organization changed its name to Ohio Physicians Health Program to better reflect its comprehensive mission and expanded services and

activities. OPHP has expanded its services and activities to support all aspects of the health and well-being of physicians, residents, medical students, physician assistants, dentists, veterinarians, and others.

Program services include assisting with interventions, screening, referring for evaluation and treatment needs, and ensuring the treatment method selected adheres to regulatory guidelines. Monitoring and recovery documentation services are provided as

well as a drug testing program that includes urine drug screening, hair analysis, and blood analysis. Education, support, and advocacy services are also provided through the organization. OPHP provides assistance for issues including substance use disorders, disruptive behavior, mental health, stress, burnout, sexual boundary issues, and other health related problems. The OPHP staff plays a very important role of guidance and advocacy that is often overlooked. The assistance provided to physicians can help ensure a smooth transition from entering into treatment through returning to work. OPHP can provide assurance to employers through

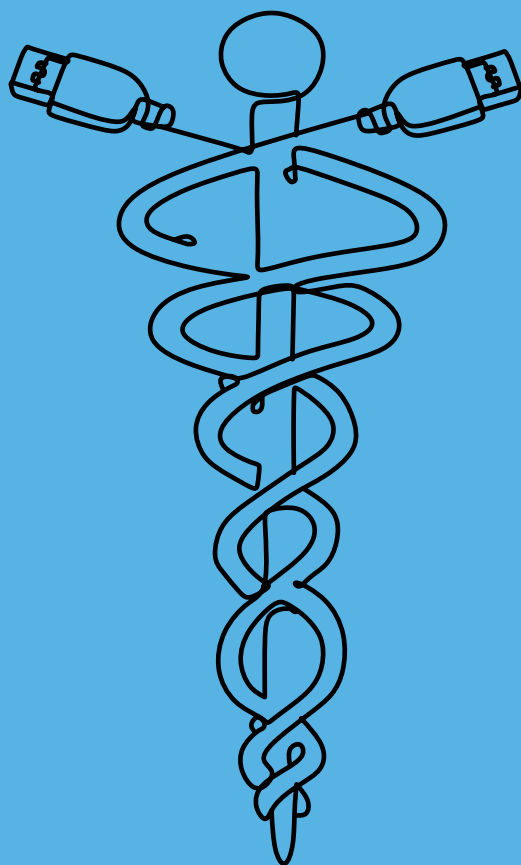
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## Medical Legal Summit Addresses Issues of Importance to Physicians and Attorneys *(Continued from page 1)*

who were on Medicaid or were uninsured had a 12 to 14 percent chance for a five-year survival rate

He also noted that there is an uneven distribution in health care costs stating that younger patients consume 3.2 percent of the costs whereas ten percent of the population that is consuming over two-thirds of the overall costs are the patients with chronic diseases. He noted that the key to saving money is prevention – treat people with chronic illnesses and prevent them from getting sicker.

Tort reform was most certainly on the minds of the physicians and attorneys in the audience. Emanuel mentioned that high-risk specialists, such as neurosurgeons, have a 100 percent chance of being sued during their career, with even low-risk physicians having a 75 percent chance of being sued. There have been many suggestions made to address the topic such as caps on damages, special courts, and other concepts such as the *I'm Sorry* Disclosure Program in Michigan, however, it has also been shown through data that implementing tort reform would not result in significant savings in health care overall, according to Emanuel. He noted that he pushes for safe harbors – a program where a physician uses clinical based guidelines and qualified information technology and if they adhere to these guidelines then the physician is presumed to have acted appropriately – and this information can be used if the physician is sued for the care provided.

Emanuel briefly discussed the implementation of health care exchanges stating that insurance companies will sell to consumers who will buy predominantly based upon price as is the case in Massachusetts where this type of model has already been in place. He also mentioned competitive bidding, noting that historically the government has effectively set prices through Medicare for wheelchairs, hospital beds, and other medical equipment. But a demonstration project begun in 2011 introduced competitive bidding in roughly 100 metropolitan areas to see if market forces could bring down prices. He noted that the results of the project have been dramatic with prices for oxygen equipment, wheelchairs, and hospital beds significantly reduced with no adverse effects on beneficiaries. The Affordable Care Act will expand competitive bidding for these items to the rest of the country in 2016 but Emanuel believes there is no reason to wait to do this and suggests that the concept be rolled out sooner and expanded to include competitive bidding for blood tests and other lab procedures, X-rays, CT scans and pacemakers.

In response to a question about end-of-life-care, Emanuel mentioned there are several things the health care system might consider to try to improve end of life care – and it is possible that these will not save money but they could make a difference. Physicians and nurses should be trained in how to talk to patients and families about end-of-life care since it has been shown that even if physicians are



*The Summit was very well attended by physicians, attorneys, hospital employees and administrators.*

well-trained in communication, these conversations take time and are emotionally draining. In addition, physicians should be paid a one-time fee to talk with patients about their preferences for end-of-life care and every hospital should be required to have palliative care services available. Finally, we need to revise eligibility for hospice care.

Saturday's General Sessions began with *Apologies and Disclosures of Adverse Events: What to Say When Something Bad Happens to a Patient?*. This session made clear that when there is a question of negligence during the care of a patient, it is in the best interest of the physician and the hospital to fully disclose the error to the patient not only because transparency is the best policy but because it is the right thing to do. A skit featuring Cynthia Zelis, MD, University Hospitals Medical Practices; Julia Skarbinski, Director of Patient Safety and Clinical Risk Management, University Hospitals; and Melissa Crum and David Hanson from the Great Lakes Theatre, demonstrated the importance of full disclosure when negligence occurred prior to a new physician taking over a case. The second skit, featuring William Morris, MD, and a nurse, both of the Cleveland Clinic as well as Crum and Hansen, acted out a scenario whereby a patient was in danger of losing his life due to a violation of prescription policy and the nurse's failure to question it. The skit demonstrated the importance of full disclosure of the situation by the physician/nurse team.

The second General Session, a *Debate on End of Life and Other Medical, Legal and Ethical Issues*, featured Bixenstine; Gwendolyn Roberts Majette, Assistant Professor, Cleveland-Marshall College of Law; Browne Lewis, Associate Professor, Cleveland-Marshall College of Law; Russell J. Meraglio, Esq. Reminger Co., LPA; Martin L. Smith, S.T.D., Director, Clinical Ethics, Cleveland Clinic; and Mark P. Aulisio, Ph.D., Director, Center for Biomedical Ethics, MetroHealth, all of whom weighed in on end-of-life and ethical issues ranging from children making medical decisions for parents to living wills to organ transplants for illegal aliens to religious beliefs interfering with treatment.

Attendees were given the choice of four breakout sessions, all of which were designed to address the different issues facing physicians and their legal counsel. A *Frank Conversation with Government Regulators* featured a panel consisting of Constance Nearhood, Senior Assistant Attorney General; Carole



*Dr. James Sechler, AMCNO President, provides opening remarks at the Summit.*

Rendon, United States Attorney, Northern District of Ohio; Ronald Savrin, MD, Medical Director, Ohio KePRO and Past President of the AMCNO; Stephen Sozio, Esq., Jones, Day; and Cheryl Wahl, Chief Compliance Officer, University Hospitals. Each panel member described the role his or her organization plays in the health care regulation arena. During the conversation Rendon noted that her office has been addressing many issues related to drug diversion as a result of the increasing use of heroin in our area. In addition, they have been handling litigation regarding Medicaid fraud and money collection based upon violation of the False Claims Act. Nearhood's division works with the Ohio Attorney General's office with regard to health care fraud issues related to Medicaid and Medicare fraud. She said that it is incumbent upon physicians to be aware of what they are signing or agreeing to for their patients. Savrin provided the group with an overview of the work of Ohio KePRO noting that the group works with physicians and hospitals to help them improve care, reducing adverse drug events, transitions of care, and the adoption and meaningful use of electronic health records. Wahl provided an overview of how she works within the University Hospitals system to provide information on a pre-trial level to guide employees on medical/legal issues related to health care, including privacy issues related to medical records. Attendees left the session knowing that individuals and organizations are in place to help guide them through the ever-changing health care landscape.

*Physician Practice Acquisitions* addressed the different aspects of acquiring a physician practice or related business. Craig T. Haran of Frantz Ward, LLP; Nathan L. Lutz, Assistant General Counsel, Cleveland Clinic; Robert Hauptman, CFA, Director, Stout Risius, Ross; Darrel Ranum, JD, CPHRM, Regional Vice President, Patient Safety, The Doctor's Company; and Raymond J. Marvar, Tucker Ellis, LLP, led the discussion, debating the different reasons why a physician might opt to join a hospital system and why a physician might choose to remain independent. Lutz outlined the different steps a hospital system takes when acquiring a practice or related business. Hauptman addressed non-disclosures, and Ranum presented the process from a physician insurance perspective. In all, the panelists dissected the physician practice acquisition process so that attendees could see it from all sides of the negotiation table.

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## Medical Legal Summit Addresses Issues of Importance to Physicians and Attorneys

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*Protecting Patient Information from Technological Threats* was a well-rounded discussion of data protection in the age of electronic records and cyber security threats. J. Ryan Williams of Walter/Haverfield, LLP, moderated the panel consisting of Ethan G. Leonard, MD, Associate Chief Medical Officer, Medical Director of Quality, UH Rainbow Babies & Children's Hospital; David Morgan, Supervisory Special Agent for Cyber Intrusion Investigations, FBI, Cleveland Division; Michael Lipinski, U.S. Department of Health and Human Services; and David S. Finn, CISA, CISM, CRISC, Health IT Officer, Symantec Corp. Lipinski noted that his office is accelerating Health Information Exchange (HIE) Meaningful Use, care coordination, and patient engagement, as well as extending the E-Donation Exemption through 2013. All of the panelists agreed that cyber security must be done differently than in the past with Finn pointing out that systems are becoming increasingly cloud-based, a concept whereby the word "cloud" is used as a metaphor for the internet, and servers, storage and applications are delivered to an organization's computers via the cloud. It creates an opportunity for cost savings and more efficient workflow but requires more planning for extra security. The FBI's MacFarlane noted that the cloud is a great enabler for good and bad, allowing hackers to pull patient information, put their own infrastructure into place, and use stolen data to target individuals. It was pointed out that another significant source of data leakage is hospital employees. All hospital systems must be able to contain any security breaches and respond to them appropriately.

The significant increase in prescription drug abuses was addressed in *Pain Management in the Face of the Prescription Drug Abuse Epidemic*. Prescription drug abuse is one of the leading causes of death in the United States. According to Orman Hall, Director, Ohio Department of Alcohol and Drug Addiction Services, there is a considerable number of accidental drug overdoses in the state of Ohio alone, resulting in one of the most serious drug epidemics facing the state's treatment system since the establishment of his department.



Judge David Matia provides his comments during the pain management breakout session. (pictured to the right is Mr. Orman Hall)

The addiction problem often begins with opiate prescriptions written for pain management. Patients turn to heroin to feed their addictions when the prescription drugs are no longer available. The Honorable David T. Matia, of the Cuyahoga County Common Pleas Drug Court noted that most overdose deaths are the result of prescription medications or heroin. He then asked audience members to carry a message to their fellow physicians: Please consider the necessity of opiates for treatment. It has been Matia's experience that opiates and heroin kill before a person hits rock bottom, with 35 percent of patients prescribed opiates demonstrating dependency and 50 percent of opiate-dependent Drug Court participants reporting a medical condition being the catalyst to dependency.

According to Bina Mehta, MD, of the Western Reserve Spine and Pain Institute, roughly 20 percent of prescribers prescribe 80 percent of all prescription painkillers. Her practice implements a screening process whereby criminal background checks, notes from other pain clinics, and prescription history reports obtained by the Ohio Automated Rx Reporting System (OARRS) are used prior to prescribing opiates. Her practice also conducts an opioid risk assessment screening every three months and obtains an opioid consent form and a narcotic agreement every six months from patients. Her patients are required to use only one pharmacy. Additionally, they conduct random pill counts, and urine drug screens and saliva testing, and require patients to bring in bottles with unused medications for each refill, disposing of existing medications prior to writing a new prescription. If pain scores remain consistently high after a few months, the Institute considers tapering the medications. While her practice implements stringent pain management procedures, Dr. Mehta does allow that it takes time to find the source of pain and to treat it effectively. However, the goal of treatment is to make the patient independent in managing and dealing with pain.

Joan Papp, MD, FACEP, MetroHealth Medical Center, Department of Emergency Medicine, Cuyahoga County Project DAWN, Medical Director, provided strategies to prevent overdose deaths such as establishing prescribing guidelines for physicians and other prescribers. These guidelines could include the use of prescription monitoring programs such as OARRS, posting the hospital policy on prescribing practices clearly in patient care areas, and having individualized patient care plans for frequent consumers of health care with a documented track record of abuse. Papp also provided details on Naloxone Distribution Programs and the distribution of kits through programs such as Project Dawn.

The AMCNO's Eric Yasinow, MD, ended the panel discussion by providing a detailed overview of the University Hospital guidelines for prescribing opioids for chronic non-cancer pain, noting that their critical considerations include appropriateness, risk assessment, consent, monitoring of therapy, and documentation.

The AMCNO is excited to partner with the CMBA to present the 2014 Medical/Legal Summit which will be appropriately held at the Global Center for Health Innovation, also known as the Medical Mart.

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# PHYSICIAN RESOURCES

## Ohio Physicians Health Programs

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appropriate monitoring terms and regular status reports on the progress of the physician's recovery. There is a certain amount of unknown that physicians encounter as they enter into treatment such as how their license will be affected, if their job will be in jeopardy, will they still be listed on health insurance provider panels, is their malpractice insurance still in effect and how they will begin to put all the pieces of their lives back together. Many clients have found that friends, colleagues and often family members have abandoned them. OPHP provides a support system that assures the professional that they are not alone.

OPHP specializes in providing the services needed to assist healthcare professionals through the treatment and recovery process, specifically those physicians who qualify for Ohio's "One-Bite" Rule. This rule was created in 1987 by the General Assembly which carved out a onetime "one-bite" exception for residents and physicians that allows them to escape the State Medical Board of Ohio (SMBO) intervention, and excuses anyone from reporting their impairment, so long as they complete treatment at a board approved treatment provider, maintain uninterrupted sobriety, violate no other provisions of the Ohio Medical Practice Act, and adhere to all other statutory requirements. As a result of this rule, physicians are able to enter into treatment and private sector monitoring with OPHP and still be unknown to the SMBO. While this niche market is a priority, we will also continue to provide monitoring and advocacy services to healthcare professionals with regulatory involvement.

If the correct regulatory guidelines are not followed, a professional can be subject to a board investigation or disciplinary action. During this process a licensee can be subject to suspension as well as probationary terms. A typical consent agreement for impairment due to a substance abuse/dependency issue may include a suspension period ranging from 90 days to two years. Probationary terms typically include urine drug testing, recovery meeting attendance, and other requirements for a minimum of five years. The National Practitioner Data Bank of the U.S. Department of Health and Human Services has established reportable actions, and in Ohio, that includes any healthcare professional who is found to be impaired due to chemical dependency. In addition to this reporting, the details of all disciplinary actions made by the SMBO are made available to the public.

There are a multitude of challenges that a physician can be faced with following treatment and disciplinary action with a regulatory agency. These challenges may include increased rates or dismissal from malpractice companies, exclusion from insurance panels, credentialing issues, Medicare/Medicaid reimbursement difficulties, employment instability, as well as the overall stigma that can be associated with an individual in recovery. OPHP plays an active role in providing support and advocacy for those involved in the monitoring program to help address these issues. A critical aspect of monitoring is the face-to-face visits completed by our Case Manager, Clinical Director, and Medical Director. These visits allow the clinical staff to evaluate the



The AMCNO was pleased to welcome Dr. David Goldberg, Medical Director of OPHP to a recent AMCNO Board of Directors meeting where Dr. Goldberg provided the board with insight into the one-bite rule and the OPHP program.

status of the individual's recovery and assess how they are doing in life. The information obtained provides valuable insight into their health and wellbeing and establishes a platform for advocacy to be built upon.

By increasing awareness of the "One-Bite" Rule, OPHP aims to decrease the likelihood that regulatory involvement and/or disciplinary action is necessary. In an effort to educate the healthcare professionals in Ohio, lectures are provided throughout the state on substance use disorders, opiate prescribing issues, and Ohio's "One-Bite" Rule. Educational presentations are available for hospitals, medical staffs, professional associations, academies, spousal groups, and anyone interested in learning more on this topic. The "One-Bite" Rule aims to encourage self-referrals, voluntary treatment completion, and early intervention to avoid patient care issues. OPHP is not a licensing or disciplinary authority but is required to operate under legislative guidelines. Referrals are accepted from many sources and can also be made anonymously. The sources include: self, professional colleagues, hospitals, medical staffs, office staffs, regulatory agencies, attorneys, treatment centers, family, and friends.

OPHP is supported by a network of volunteer physician monitors who are committed to physician health and create an environment where colleagues are helping colleagues. There are currently over 100 monitors throughout the state of Ohio. The monitors play a valuable role in the recovery and health of the medical professionals in the program, leading to the delivery of consistent, high quality care, thereby improving the safety of all Ohio's citizens. With the assistance of the monitors, OPHP has been able to help countless physicians in recovery reclaim their lives and careers. Below is a testimonial from one of our participants.

"My name is \_\_\_\_\_ and I am an alcoholic. These were not the nine words I expected to be saying and identifying with when I finished medical school and residency. However, this is where alcohol has taken me. Toward the end of drinking, alcohol became my problem and my solution. I used it to cope and escape. I thought I could control it but it controlled and consumed me.

My recovery is dependent on abstinence, a daily reprieve contingent on my spiritual condition, and taking simple but proven actions. The first action I found necessary was getting honest with myself.

This requires the acceptance of the fact that I have a disease. The disease is not curable but is treatable. There are the 12 steps but initially these were overwhelming and just too much.

To get honest I had to do several things. I had to recognize I needed help and ask for it. There was inpatient rehab but that was just a start; a sort of reset button. I had to get a support network of sober friends, sponsor and supportive family. I had to quit asking "why?" am I an alcoholic and simply identify with the program of recovery in AA.

The 12-steps help me learn to live in sobriety without having to be medicated or have a thought, craving or obsession of drinking. The steps also help me learn more about myself, recognize my human flaws and how they affect my decisions and thinking. They direct me to a power greater than me and hold me accountable to meet my flaws head on. I can apply this not only to recovery but also to my day-to-day life and work with the program to help others who suffer from the disease of alcoholism. (In recovery) I am the patient, not the doctor.

OPHP has helped me in many ways to navigate through the early days of urine testing, compliance, re-instatement, step agreements, excess and surplus, documentation, getting insurances back, etc. To this professional, recovery and accountability is almost entirely legal based and complex. This is all new and not easy to do without help. OPHP does a great service to improve recovery and to advocate for the recovering healthcare professional. The recovering healthcare community needs strong advocacy and education that will hopefully continue to improve in the future."

—Anonymous M.D.

If you need more information on program services, Ohio's One-Bite Rule, or to make a referral, please contact the OPHP office at (614) 841-9690. The knowledgeable staff can provide resources to assist you in finding information regarding substance use disorders, treatment options, education, and other issues impacting your and other physicians' health and wellbeing. If you are interested in providing a tax-deductible donation to the organization, please visit [www.ophp.org](http://www.ophp.org) for additional information. ■

# PHYSICIAN RESOURCES

*In accordance with The Academy of Medicine of Cleveland & Northern Ohio's bylaws, the following changes to the Constitution and Bylaws of the organization are published to the membership for 30 days and then the changes are sent back to the AMCNO board of directors for final vote and changes.*

Bylaws changes:

Article I - Membership

## **Section 5. Discipline of Members.**

### **DISCIPLINARY ACTION**

(A) DISCIPLINARY ACTION MAY BE TAKEN BY THE AMCNO AGAINST A MEMBER OF THE AMCNO ONLY UPON WRITTEN CHARGES SIGNED BY THREE (3) OR MORE MEMBERS OF THE AMCNO AND FILED WITH THE EXECUTIVE VICE PRESIDENT/CEO.

*In addition, all complaints/charges will now be referred to an "Ad Hoc Grievance Committee" rather than an "Ethics Committee." This new committee is now referenced throughout the disciplinary proceedings in the AMCNO bylaws.*

## **Article IV – Directors**

### **Section 2. Nomination and Election of Directors.**

(A) Nomination by Committee. Candidates for the office of Director shall be nominated by a Nominating Committee consisting of not less than seven (7) nor more than twenty-five (25) Voting Members of the AMCNO. The Nominating Committee shall be a regular standing committee nominated by the President and appointed by the Board. At a regular board meeting or by any authorized communications equipment the Nominating Committee shall report two (2) eligible members for each vacancy "at large" on the Board of Directors, and two (2) eligible members for each vacancy in each district. In the event that only one candidate is willing to run for a vacancy, then the candidate may run unopposed. These names shall be announced by suitable means.

(B) Nomination by Petition. Upon written petition of not less than three percent (3%) of all the Voting Members, additional nominations for Directors-at-Large may be submitted and upon written petition of not less than three percent (3%) of the Voting Members within any district, additional nominations for Directors from that district may be submitted. Such nominations must be presented to the membership with nominations made by the Nominating Committee, provided that nominations by petition have been submitted to the Secretary-Treasurer on or before the fifteenth day of February.

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## Compliance measures needed by healthcare providers to prevent violations of healthcare billing and compliance with the Affordable Care Act.

By Brian Dickerson, Roetzel, Washinton DC and Jon May, Roetzel, Fort Lauderdale

The Centers for Medicare and Medicaid Services (CMS), the agency responsible for managing the billing of federal health care programs, has drawn criticism from many for what some politicians are calling an abysmal job of maintaining a healthcare system which reduces fraud. While CMS attempts to discover how to investigate fraud, the Department of Justice (DOJ) is not waiting and has committed itself to investigate and prosecute alleged fraudulent schemes, targeting fraud in overpayments to hospitals and other medical providers, such as physician practice groups. The DOJ has targeted large healthcare providers to small health care practice groups throughout the country including in northern Ohio.

On January 4, 2013, the United States Department of Justice intervened for purposes of effectuating the settlement of a qui tam action (filed under the federal False Claims Act or "FCA") against a non-profit community hospital system, an independent physician group and two physicians that practiced in Northern Ohio. The suit was originally filed by a former manager of the hospital's catheterization and electrophysiology laboratory. The complaint alleged that over a five year period the hospital and the physician group performed unnecessary cardiac procedures to Medicare patients. Specifically, the United States alleged that the hospital and the physician group over-prescribed angioplasty procedures, and improperly "unbundled" angioplasty and angiogram services, leading to the routine scheduling of "serial" angioplasties. The Medical Providers were also accused of performing angioplasty and stent services on individuals whose blood vessels were not sufficiently occluded to require such procedures.

The hospital and the physician group agreed to pay the United States approximately \$4.4 million to settle the allegations that they submitted false claims to Medicare. As a result of the settlement, the whistleblower, will receive approximately \$660,000 of the government's recovery.

The word is out that the Department of Justice intends to focus its attention on hospital systems and other medical providers like physician practice groups, and the industry will be surprised by the number of whistleblower suits presently filed and awaiting a decision by the DOJ to intervene. Moreover, the industry is no longer looking at threats from low-level employees who are only aware of what they see in their small part of the company. As the

above complaint reflects, managers, persons with a broader picture of the scope of wrongdoing and access to emails and other kinds of incriminating evidence, are more than willing to cooperate and are incentivized to make such claims.

Most FCA actions are settled before the complaint is unsealed. And in many instances, the settlement is for twice the amount of the overpayment. However, by statute, the government is entitled to recover treble damages plus a civil penalty of from \$5,500 to \$11,000 for each false claim submitted — an amount that could easily bankrupt a business.

Over the last four years, the United States has recovered over \$13 billion dollars from fraudulent billing in Medicare. Because all stakeholders in the coming debate are going to be looking for ways to save money, more and more pressure will be placed on the DOJ to employ all the tools at its disposal, from civil actions under the False Claims Act to criminal prosecutions, in order to put an end to what the government believes is endemic fraud within the medical industry.

To assist healthcare companies in preventing the whistleblower cases and government action, each healthcare provider should implement an effective compliance program, which is designed to prevent fraudulent billing, illegal kickbacks, and activities which subject a provider to healthcare fraud and the False Claims Act. When DOJ is pursuing a civil healthcare fraud case, as with the False Claims Act, or when it believes that fraud is criminal, the United States Attorneys prosecuting the case, must follow the *U.S. Attorney Handbook* and Title 9, "Principles of Federal Prosecution of Business Organizations". Within this title, 9-28-800 sets the parameters which must be

contained within a compliance program for the U.S. Attorneys to evaluate when a company has a compliance program and how the DOJ should analyze the compliance program to determine if it is effective and implemented properly. If the DOJ determines the compliance program has all of the necessary parameters as set forth in 9-28-800 and the act that is being investigated was not intentional or committed with reckless disregard (healthcare provider knew illegal billing or kickback was occurring and just ignored it or covered it up) then the healthcare provider can avoid substantial treble damages and criminal implications.

The parameters set forth within the *U.S. Attorney Manual* will have to be the cornerstone of any compliance programs of hospital administration and will become a necessary component of any medical practice that receives money from a federal government health program such as Medicare. Pursuant to the Patient Protection and Affordable Care Act (PPACA), the Secretary of Health and Human Services and the Office of the Inspector General are directed to establish core guidelines for such compliance programs for healthcare providers. Although Congress has mandated that these guidelines take into consideration the size of the practice being regulated, no one knows how complicated or expansive these regulations will be, once put in practice. Thus far the only compliance regime that has been mandated under the law applies to skilled nursing facilities and nursing homes. Although HHS has not yet issued regulations these providers, the statute requires these facilities to have an effective compliance program in place by March 23, 2013 and contain the core principles needed to create and implement such programs.

Section 6102 of the PPACA defines a "compliance and ethics program" as a program "reasonably designed, implemented, and enforced so that it generally will be effective in preventing and detecting criminal, civil, and administrative violations . . . and in promoting quality of care." To that end, a compliance program must include the following elements:



- The establishment of compliance standards and procedures reasonably capable of reducing the likelihood of violations and promoting quality of care;
- The assignment of specific high-level individuals with overall responsibility to oversee compliance, and with sufficient resources and authority to enforce the compliance standards;
- The use of due care to avoid delegating substantial discretionary authority to individuals known to have a propensity to engage in violations;
- The effective communication of compliance standards and procedures to all employees;
- The establishment of monitoring and auditing systems designed to detect violations and, in addition to this, a mechanism through which employees can report violations without fear of retribution;
- The consistent enforcement of compliance standards through appropriate disciplinary actions;
- The establishment of a procedure for responding appropriately to any violation that has been detected and for preventing further similar violations; and
- The periodic reassessment of the compliance program to identify changes necessary to reflect changes within the organization.

Obviously a different set of principles will have to be developed for small medical practices that do not have the infrastructure found in large institutions that have full-time staff devoted to ensuring compliance with every government regulation from Stark III to HIPAA. But it is clear that at a minimum medical practices, no matter how small, are going to be held accountable for having procedures in place to educate each employee on the laws proscribing fraud and abuse and a means to alert the owners of the practice to any unlawful conduct. Even in the absence of any fraud, failure to have an effective compliance program will lead to exclusion from Medicare.

It is important for Ohio healthcare providers to implement an effective and proper compliance program and examine its business operations to ensure that the provider and its employees, agents and third party contractors are in compliance with federal and state billing practices. Otherwise, it could be the employee or former employee of any provider in Northern Ohio reporting the provider to the United States Attorney's office as a whistleblower and recovering part of the settlement obtained from the provider by the United States Department of Justice. So surely, the best message is to take preventative measures to insure your healthcare business is in compliance with applicable laws. ■

1. False Claims Act, 31 U.S.C. §§3729-33 (the "FCA" or the "Act").
2. §3729(a)(1).
3. See Press Release, Office of Pub. Affairs, U.S. Dept. of Justice, Acting Associate Attorney General Tony West Speaks at Pen and Pad Briefing Announcing Record Civil FY 2012 Recoveries (Dec. 4, 2012), <http://www.justice.gov/iso/opa/asg/speeches/2012/asg-speech-1212041.html>.
4. Sec. 6401(a)(7), Patient Protection and Affordable Care Act, Pub. L. No. 111-148, §2702, 124 Stat. 119, 318-319 (2010).

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## Patient Navigation Initiative Continues to Expand in Northern Ohio

### AMCNO Physician Leadership Adopts Patient Navigator Guidelines

#### What is a Patient Navigator?

In the eyes of a patient, especially one with a chronic or complex illness, the health care system can feel overwhelming. The role of the navigator is to help the patient understand their disease and treatment process and assist patients in becoming engaged in their care plan. For example, navigators can help patients with addressing barriers to care such as transportation and child care; understanding treatment and care options; finding doctors; serving as coordinator for the healthcare team; working with family members and caregivers; accessing resources and managing paperwork.

Patient navigators can help with the complexities of the healthcare system and the variety of barriers and difficulties patients can face. The model uses specially trained navigators who work closely with both patients and caregivers in order to efficiently and effectively overcome barriers, find solutions to challenges, and assist patients with the logistics of their care. In doing so, navigators not only improve patients' experiences, and even, potentially, their outcomes, but they can also help the health care system function more efficiently and cost effectively. Patient navigators, whose main job is to guide patients through the complex medical system and help them overcome any barriers to care, are being used in growing numbers to ensure patients successfully complete their treatment.

The concept of patient navigation was founded and pioneered by Dr. Harold P. Freeman in 1990 for the purpose of eliminating barriers to timely cancer screening, diagnosis, treatment, and supportive care. Since then the model has been expanded to include the timely movement of an individual across the entire healthcare continuum from prevention, detection, diagnosis, treatment, and supportive, to end-of-life care.

A patient navigator is someone whose primary responsibility is to provide personalized guidance to patients as they move through the health care system. The term patient navigator is often used interchangeably with the term "patient advocate" and the role may be filled formally or informally by individuals with clinical, legal, financial or administrative experience, or by someone who has personal

experience facing health care related challenges. Patient navigator or patient advocacy services can be categorized as having one of the following goals:

- Reducing health care disparities and increasing access to care
- Improving patient outcomes for a specific illness or chronic disease
- Helping patients negotiate the complexities of administrative and clinical decisions associated with the healthcare system

Navigators work in a variety of settings — community, hospital, home, primary care, and tertiary care, for example — to guide patients through the treatment process and keep the healthcare team apprised of all facets of the patient's care. The navigator's role is to provide a consistent point of connection and assist patients with any problems they may face.

#### The Expanding Role of the Patient Navigator Under Health Care Reform

The Patient Protection and Affordable Care Act (ACA) formalized and strengthened the role of patient navigators in the health care system. Going forward every state health insurance exchange is required to establish a "navigator program" to help individuals and businesses make informed decisions about enrolling in health insurance through the exchange. The ACA outlines responsibilities for these navigators noting that they will provide expertise on eligibility, enrollment and coverage details for each plan; provide fair and accurate information; facilitate the enrollment process; and provide referrals for conflict resolution services for enrollees with complaints or concerns.

In Ohio, there is already discussion taking place in the legislature to pass legislation that would provide for the certification and oversight of Ohio health exchange navigators. In the last General Assembly a bill was passed in the Ohio House that would establish certification guidelines for health exchange navigators but due to timing the bill never made it to the Ohio Senate. The bill has now been re-introduced by Representative Barbara Sears in this General Assembly as HB 3. HB 3 specifies licensing and continuing education requirements for insurance agents involved in selling, soliciting, or negotiating sickness and

accident insurance through a health benefit exchange and to make changes to copayments, cost sharing, and deductibles for health insuring corporations. The bill also provides for certification of navigators for the purpose of assisting individuals purchasing health insurance through a health exchange, specifies eligibility requirements and duties for this type of health exchange navigator, prescribes duties for the Superintendent of Insurance in relation to the certification of this type of navigator, and requires a health insurance exchange to maintain a list of licensed insurance agents that are also certified as navigators.

#### Northeast Ohio Patient Navigation Collaborative

Assisting patients with the myriad issues they may encounter during the course of their medical care is at the core of a recently formed initiative aimed at helping patients successively navigate the health care system. The Northeast Ohio Patient Navigation Collaborative (NEOPNC) was borne out of a cooperative effort between the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), and The Center for Health Affairs, (CHA). The Collaborative comprises health care systems, hospitals and community organizations seeking to reduce barriers to timely, quality care, and connecting patients and their families to important community resources to help them navigate the health care system.

The Collaborative recently created The Navigator Network, which is comprised of patient navigators or those working in comparable roles. The Navigator Network supports patient navigators as a career path by providing networking opportunities for navigators to discuss common issues, learn from each other and share resources; providing educational opportunities and programming of interest patient navigators; and leveraging technology to support navigation. There are also metrics being developed around the following: reducing no-show rates, appropriately re-routing emergency department patients, reducing preventable hospital admissions, increasing patient compliance rates and outcomes, improving patient and employee satisfaction, decreasing provider workload, and increasing patient access to community support.

The AMCNO is pleased to participate as a stakeholder in this community effort. Through our physician leadership the AMCNO plans to help the project partners coordinate with other stakeholders; build cooperation and acceptance of this project, and educate and

# AMCNO BOARD ACTIVITIES

support physicians in the use of patient navigators within their practice. In addition, the AMCNO would work with the project partners to assist in communicating to patients and the community about the positive impact of the patient navigator role. Physician members of the AMCNO that would like more information about working with a patient navigator or to find out more about this project may contact the AMCNO.

*At a recent AMCNO board meeting, Ms. Carol Santalucia from the Santalucia Group was invited to provide the AMCNO board with a presentation about the current activities of the Northeast Ohio Patient Navigation Collaborative (NEOPNC). Portions of this article were taken from her presentation to the AMCNO board, handouts from the NEOPNC that were provided to the AMCNO Board and from a recent publication from the Center for Health Affairs Issue Brief entitled "The Emerging Field of Patient Navigation: A Golden Opportunity to Improve Healthcare." This article also includes excerpts from an American Medical Association publication entitled "Improving the Health Insurance Marketplace – Patient Navigators." ■*

## AMCNO PHYSICIAN LEADERSHIP ADOPTS AMERICAN MEDICAL ASSOCIATION (AMA) GUIDELINES FOR PATIENT NAVIGATOR PROGRAMS

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) realizes that the use of patient navigators and patient advocates is on the rise and that these services are meant to help improve access to care and assist patients with the myriad aspects of the healthcare system. The AMCNO also understands that given the diversity of roles and responsibilities assigned to a patient navigator it is important to note that patient navigators should refrain from any activity that could be construed as clinical in nature, therefore, the AMCNO physician leadership has adopted the following AMA guidelines for patient navigator programs:

- The primary role of a patient navigator should be to foster patient empowerment, and to provide patients with information that enhances their ability to make appropriate health care choices and to receive medical care with an enhanced sense of confidence about risks, benefits and responsibilities.
- Patient navigator programs should establish procedures to ensure direct communication between the navigator and the patient's medical team.
- Patient navigators should refrain from any activity that could be construed as clinical in nature, including interpreting test results or medical symptoms, offering second opinions or making treatment recommendations. Patient navigators should provide a supportive role for patients and, when necessary, help them understand medical information provided by physicians and other members of the medical care team.
- Patient navigators should fully disclose relevant training, experience and credentials in order to help patients understand the scope of services the navigator is qualified to provide.
- Patient navigators should fully disclose potential conflicts of interest to those whom they serve, including employment arrangements.

## 'Choosing Wisely' In Northeast Ohio

**Better Health Greater Cleveland** is one of 21 organizations that have been funded by the **American Board of Internal Medicine (ABIM) Foundation** to help advance its national Choosing Wisely initiative. The two-year grant began April 1, and *Better Health* is moving forward quickly.

The ABIM Foundation's *Choosing Wisely* campaign aims to encourage conversations between patients and doctors about unnecessary tests and treatments. The hope is that its portfolio of recommendations from national medical societies on low-value tests and treatments to avoid will help.

The recommendations take the practical form of compact one-pagers dubbed *Five Things Physicians and Patients Should Question*. So far, 130 recommendations from 26 medical societies have been promulgated for Choosing Wisely. Many are accompanied by a suite of companion materials for patients, employers and employees. Consumer Reports and the National Business Coalition on Health are among the numerous campaign partners of the ABIM Foundation that have produced

complementary communication materials directed at non-physician stakeholders.

The campaign that *Better Health* proposed in its successful application primarily targets generalist physicians (General Internal Medicine, Family Medicine, Geriatrics) and their trainees (medical students, residents) while simultaneously engaging relevant specialty disciplines (e.g., Radiology, Cardiology) to help develop and disseminate digital and in-person educational materials and teaching. A synergistic and parallel effort will be developed to reach 'consumers,' both the public at large and patients.

*Better Health's* Choosing Wisely partners reflect the goals of its proposal, and we are pleased that the **Academy of Medicine of Cleveland and Northern Ohio** is among 18 partner organizations. Our partners include other regional and statewide medical societies and associations, health plans, employers, medical schools, residency programs and media, including ideastream. In addition, the ABIM Foundation and the Network of Regional Healthcare Improvement

Collaboratives also are helping grant recipients and other regional healthcare improvement collaboratives explore opportunities to coordinate activities to augment messages and share dissemination models.

In Cleveland, the first order of business is to select about five recommendations to promote. To help whittle down the list for our community's focus, an External Advisory Committee has been established with representatives from each of *Better Health's* Choosing Wisely partners. *Better Health* is gathering responses from a survey it fielded to these committee members to help establish priorities and triage the list of recommendations for future endorsement and dissemination. [Robert Hobbs, a Cleveland Clinic cardiologist and member of the AMCNO board and executive committee, represents AMCNO on Better Health's External Advisory Committee.](#) ■

**Editor's note:** *The AMCNO has been a partner in the BHGC initiative since 2007 and we also have physician representation on the BHGC Leadership Team and Clinical Advisory Committee.*

## AMCNO Hosts Meetings with CGS Administrators Physician Leadership

In March, the Academy of Medicine of Cleveland & Northern Ohio (AMCNO) was pleased to host several meetings with CGS physician leadership. Physicians and staff from the AMCNO met with Dr. Michael Montijo, CGS Medical Director for Part A Services, Dr. Earl Berman, CGS Medical Director for Part B Services, and Mr. Jim Szarzynski the new Director for Medical Review at CGS.

The physicians representing CGS said that they plan to meet more face-to-face with providers and interact more with associations like the AMCNO. They believe that physicians tend to review information that is sent to them from their associations rather than what is sent from the carrier. Therefore, they plan to meet more often with the AMCNO and other associations and leverage these types of relationships.

One of the key issues addressed with the AMCNO was recordkeeping by physicians and how notes and entries are placed into patient charts. CGS representatives noted that some physicians have been letting another individual write notes in the medical record for them, and then the physician merely follows behind and signs the note. This may be inappropriate and education is especially important with the increased implementation of Electronic Medical Records (EMRs).

If a nurse or Non-Physician Practitioner (NPP) acts as a scribe for the physician, the individual writing the note or entry in the record should note "written by (Jane Doe), acting as scribe for Dr. (Smith)." Then, Dr. (Smith) should co-sign, and indicate the note accurately reflects work and decisions made by the physician. The scribe is functioning as a "living recorder," documenting in real time the actions and words of the physician as they are done. If this is done in any other way, it is inappropriate. The real time transcription must be clearly documented as noted, by both the scribe and the physician. Failure to comply with these instructions may result in denial of claims.

Increasingly, CGS is seeing components of evaluation and management services completed or updated by nursing or other medical staff in the EMR. For example: In the past medical or family/social history sections, there is an electronic note stating "updated by Nancy Jones, Medical Technician" or an electronic statement of "medication list updated by Mary Smith RN." If the physician does not review and address these components as well;

and the only documentation relating to these components is the entry from the nurse or a medical technician, then these components may not be used in determining the level of E&M service provided as they do not reflect the work of the physician.

It is also inappropriate for an employee of the physician to round at one time, make entries in the record, and then for the physician to round several hours later and note "agree with above," unless the employee is a licensed, certified NPP billing Medicare for services under the NPP name and number. Record entries made by a "scribe" should be made upon dictation by the physician, and should document clearly the level of service provided at that encounter. The physician is ultimately accountable for the documentation, and should sign and note after the scribe's entry the affirmation above, that the note accurately reflects work done by the physician.

Electronic Health Records also allow providers to copy forward clinical documentation. This process of copying existing text in the record and pasting it in a new destination is often used by clinicians to save time when updating notes on an existing patient, it is also known as copy and paste, cloning, and carry forward, among other terms.

Cloning occurs when medical documentation is exactly the same from beneficiary to beneficiary. It would not be expected that every patient had the exact same problem, symptoms, and required the exact same treatment. This "cloned documentation" does not meet medical necessity requirements for coverage of services rendered due to the lack of specific, individual information.

Identification of this type of documentation will lead to denial of services for lack of medical necessity and recoupment of all overpayments made. CGS representatives noted that for Medicare, the medical necessity of a service is the overarching criterion for payment in addition to the individual requirements of a CPT

code. Documentation should support the level of service reported. The CGS representatives also noted that providers using electronic records should conduct regular self-audits to be sure your documentation meets the above mentioned criteria.

Entering information into patients' medical records in a timely manner is important for many reasons. The Centers for Medicare & Medicaid Services (CMS) provides some guidance regarding what is considered "timely," for Medicare purposes. CGS representatives noted that they strongly encourage all health care providers to enter information into the patient's medical record at the time the service is provided to the patient; that is, **contemporaneously**. In all cases, regardless of whether the documentation is maintained or submitted in paper or electronic form, any medical records that contain amendments, corrections or addenda must: 1. Clearly and permanently identify any amendment, correction or delayed entry as such, and 2. Clearly indicate the date and author of any amendment, correction or delayed entry, and 3. Not delete, but instead, clearly identify all original content.

CGS representatives also noted that they are aware that at times a patient is admitted to the hospital for elective surgery and upon review the medical record at the hospital does not provide documentation for the procedure — it may be in the physician's office or their chart and right now if this occurs the Part A portion is getting denied and the physician claim (Part B) is getting paid. Going forward if there is a lack of documentation in the chart for elective surgeries CGS will be denying both the Part A and Part B portions of the claim — so CGS is cautioning physicians to be sure there is documentation in the patient's hospital chart for elective surgeries.

The AMCNO was also pleased to host and attend the Carrier Advisory Committee (CAC) which met at the AMCNO offices immediately following our meeting with CGS representatives. The CAC meets three times a year and is made up of physicians that are nominated to serve by their respective state specialty societies. The AMCNO plans to continue to meet with CGS on a regular basis and provide updates to our members. ■

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## The Health of Your Online Reputation

By David Valent, Esq., Reminger Co., L.P.A.

### Introduction

Do you ever think about how online patient reviews may be impacting your bottom-line? What is the state of your online reputation? Have you taken steps to improve and/or bolster your online presence? Is your online reputation important to your success? Do you have a plan to combat negative patient postings?

These are just a few of the questions facing physicians today, in this social media era. As with any business, medical providers are subject to online scrutiny now, more than ever. It is important to note however that you need not sit idly by with regard to managing your online reputation. There are many resources available and actions you can take to improve your online reputation, and to combat negative online postings. This article is intended simply to help open your eyes to the issues facing the management of online information with regard to your health care practice, so that you may be better prepared to handle this evolving, social media driven market place.

### What is the State of Your Online Reputation?

If you have not done so already, I challenge you to “Google” yourself. There is likely an array of positive and/or potentially negative information already on the internet concerning you and/or your practice. Nowadays, whether you like it or not, physicians are commonly reviewed on websites such as: Yelp, Complaints Board, Ripoff Report, Doctor Scorecard, Angie’s List, RateMDs, Vitals, HealthGrades — and approximately 40 others.

If searching your name reveals information regarding your practice that is all positive, consider yourself in good luck. Even the best of providers can find themselves subject to negative comments and/or postings on the Internet.

To that end, even if your online reputation is currently very strong — be aware — it can change in an instant. As Warren Buffet once famously said, “It takes 20 years to build a reputation and five minutes to ruin it.” It is recommended that you review your online reputation frequently. Also, take some comfort in knowing that there are steps you can take to further improve and/or promote your online

presence, and to minimize the impact of negative postings.

### Will a Negative Online Reputation Impact Your Practice?

According to Insight Marketing Group, a full service healthcare marketing company:

- More than 92% of buyers regularly check reviews online before making a purchase or service decision.
- More than 100 million people choose Healthgrades.com to determine who their physician will be — and that number is growing.
- Searching for healthcare information is the third most common online activity.
- 75% of searches don’t go past the first page of Google to get their information.

As the above would suggest, consumers, whether of health care services, or other, use the Internet to gain information before making their purchasing decisions. In light of this evolving trend, it is not just marketing companies who are looking at impact online postings can have on the service industry — but also Harvard researchers.

Harvard University has created the “Digital Media Project,” which aims to resolve emerging and outstanding problems revealed by recent social and technological changes. In researching these topics, the *Harvard Business Review* found that a “one star increase on Yelp leads to a five to nine percent increase in revenue.” While this particular study did not relate specifically to services provided by physicians, the numbers nevertheless show the importance and/or impact an online reputation can have on a business’ bottom line.

### What Can You Do To Improve Your Online Reputation?

Since online reviews and ratings have gained importance in recent years, the market has responded with the emergence of many companies that now specialize in providing services/resources to improve a healthcare provider’s online reputation. Listed in no particular order, these companies include: Reputation 911.com, Reputation.com, and Physiciansreputationdefender.com. These websites often offer not only services for helping to improve your online reputation — but also offer advice for improving your reputation — short of hiring an expert.

Most reputation management experts/companies encourage providers to work to disseminate positive online information, as one of the primary means of improving the provider’s online status. It is encouraged that providers garner support from their patients, and request positive feedback and/or online reviews from patients who have had positive experiences. Also, positive postings will often outweigh and/or push to the bottom negative postings — such that the negative information will become marginalized.

Another resource to consider, if you plan to self-manage your online reputation, is the book: *Establishing, Managing, and Protecting Your On-Line Reputation, A Social Media Guide for Physicians and Medical Practices*, by Kevin Pho, M.D. and Susan Gay.

### What Options are Available In the Event of a Negative Online Posting

Most media experts suggest that you do not engage in a public battle over a negative comment and/or factual dispute with a disgruntled patient. Oftentimes adding information to the website and/or responding publicly can result in further attention to the issue, and result in additional negative publicity. The overwhelming agreement among experts is that you handle these issues privately. Simply because the disgruntled patient has taken to the Internet, does not mean you have to respond in the same fashion.

One way to handle a negative posting is to contact the patient directly to discuss their concerns and do what you can to rectify any issue. This of course may also be done with the assistance of legal counsel, depending on the nature of the complaint.

Also, as mentioned above, often times positive postings can be used to outweigh and/or bury negative postings. For those physicians who work hard to bolster their online reputation, it is likely that one or two negative postings will go unnoticed.

In some cases, a cease and desist letter from a lawyer may help encourage the patient to retract their comments and/or change their position. In the event that initial efforts to resolve the negative posting are unsuccessful, additional legal measures can be pursued.

Such legal measures include lawsuits against the person posting the information and/or the website hosting the information.

## **Have Doctors Been Successful With Legal Challenges Brought In Response To Negative Online Postings?**

The primary argument a physician can make with regard to challenging negative information posted online would be to argue that the information is “defamatory.” Generally speaking, defamation is a term defined as: A legal claim involving injury to reputation caused by false statements of fact, and includes both liable (written or recorded statements) and slander (spoken statements).

If the information posted online is defamatory, there is better chance that you will be able to either convince an opposing party pre-suit, or during litigation, that the information must be taken down, or a penalty will be faced. If the information is however not defamatory, but merely a negative “opinion,” it will be more difficult to challenge the posting. In such an instance, it will likely become more important to hire a consultant or expert, to find ways to promote the positive portions of your online profile, and to help marginalize the negative information available.

In New York, a physician by the name of Dr. Tener recently sued over a comment posted to the physician review website, Vitals.com. The comment, posted April 12, 2009, was as follows: “Dr. Tener is a terrible doctor. She is mentally unstable and has poor skills. Stay far away!!!” As advised you should do herein, Dr. Tener discovered this posting when performing a Google search. Through the course of litigation, Dr. Tener’s claims were met with the defense that the statements were merely an opinion, and not a defamatory factual statement. The case was ultimately dismissed on technical ground regarding the timeliness of the lawsuit, but the Court nevertheless went on to state that “even if this action was found to be timely, dismissal is warranted for failure to state a cause of action, as the alleged defamatory statements are statements of opinion, and, thus, are not actionable.” This case example shows how the specific nature of the negative comments can impact the difficulty in pursuing a legal claim.

A similar result occurred in a case involving an Oregon dentist. A dentist recently sued a

former patient who posted on Yelp.com, Dr. Oogle.com, and Google, negative comments concerning the provider. Ultimately, the Oregon Court held that the communication was protected by statutory law, and not subject to penalty. The statutory basis that allowed the negative comments to exist was derived from what is known as an anti-SLAPP legislation. SLAPP stands for Strategic Lawsuit Against Public Participation. It refers to a lawsuit filed in retaliation for someone speaking out on a public issue or controversy. The purported purpose of a “slapp” is to intimidate and silence the target through the threat of an expensive lawsuit. In an effort to prevent slapp suits, and to err on the side of protecting the First Amendment Freedom of Speech and to encourage public debate, anti-slapp laws exist in many states, not including Ohio, and serve to protect public comments/opinions. To that end, in states such as Oregon, it is even harder for a doctor to prevail on a claim related to an online posting — as such public comment is often protected by anti-slapp legislation.

In another recent case, the Supreme Court of Minneapolis addressed the issue of a doctor’s complaint after a former patient posted, “Dr. McKee is a real tool!” In this case, the doctor filed suit alleging more than \$50,000 in damages arising out of claims based on a theories of defamation. Unfortunately for the doctor, the Minneapolis Supreme Court ultimately held that the statements were substantially innocuous and that the statements were a matter of opinion and therefore, “cannot be proven true or false.” This decision again highlights the real difficulty with presenting a legal case against a patient who posts a negative opinion concerning you and/or your practice.

Although the above examples reflect the challenges with bringing a lawsuit arising out of a negative online posting, there have indeed been many instances throughout the United States where a physician has been successful in challenging a negative posting. In many of the successful cases, the disgruntled person making the posting and/or the website is forced to take down the post and/or pay for their act of defamation. Though it is often an uphill battle, defamatory statements and/or negative posting should be challenged in the appropriate circumstances.

## **Other Considerations**

As previously mentioned above, if you find yourself the subject of a negative posting and/or believe you need to take action to respond to information you read about yourself on the Internet, it is recommended that you consult an online reputation specialist and/or an attorney.

Often times an expert is needed for consultation, because it is not only your business reputation on the line, but also because there are other privacy considerations and/or other possible legal implications to your actions. On that note, one reason experts do not encourage providers to fight back online, with a public debate regarding the care rendered, is because such may constitute a violation of HIPAA laws. Although a patient may air their dirty laundry online — a physician should err on the side of protecting the patient’s confidentiality — and not giving a public acknowledgment that a patient / physician relationship exists.

For these reasons, it is advised that you enlist the support of an expert, to ensure that you do not further make matters worse by responding in such a way that could open yourself up to additional exposure.

## **Conclusion**

Be aware of your online reputation. To ignore it, may result in negative postings and/or negative consequences to the success of your practice. There are things you can do to optimize your positive postings and/or highlight the positive reviews, such that the negative reviews become less consequence. Moreover, in the instance where additional action must be taken, there are resources available to either promote and/or improve your online reputation, as well as legal options to challenge the statements. Although legal options may be difficult to pursue, each set of case facts is different, and each circumstance warrants an independent analysis as to whether you have good standing to pursue a potential claim.

Should you have any questions regarding the management of your online reputation and/or responding to negative postings, please contact: David Valent, [dvalent@reminger.com](mailto:dvalent@reminger.com), a Healthcare Law Attorney, at Reminger Co., L.P.A. ■

## Ohio Health Information Partnership Update

By year end, the Ohio Health Information Partnership (The Partnership) — the nonprofit that manages CliniSync — estimates 60 hospitals will be live and 15 more in implementation. Recently, more than half a million transactions occurred among a handful of hospitals and physicians. As each hospital goes live, at least 10 physician practices go live with them. More than 1,100 physicians have contracted to use the software at no charge, enabling them to get results and reports from their local hospitals. The software also allows them to exchange encrypted emails and referral documents among themselves in a secure environment. The numbers go up daily. This rapid movement forward in HIT advancements occurred with the HITECH Act of 2009 when the nation's states received federal funding to help primary care physicians adopt electronic health record systems. Ohio received \$14.9 million to create the technological infrastructure that allows hospitals, physicians, clinicians and others involved in a patient's care to communicate electronically and share patient information. An additional \$29.4 million in federal funding and \$8 million in state funds assisted The Partnership in providing education and support to 6,500 primary care physicians during the selection of and preparation for an electronic health records.

## Clinisync Connects with Michigan Health Connect

Two of the nation's fastest-growing health information exchanges — Michigan Health Connect and Ohio's CliniSync — can now help physicians in both states securely exchange patient information using Direct. The medical records of Michigan patients who receive care in Ohio can be sent securely through Direct, using encrypted email to the doctor who is providing treatment — and the same goes for Ohioans who cross the border for care in Michigan.

The partnership means non-electronic communications — faxing, telephone calls, or mail — are replaced with faster, more comprehensive, encrypted emails in a trusted environment among authorized physicians and personnel, so physicians have information when and where they need it. Health records can include such information as patient discharge summaries from hospitals, radiology or imaging reports, medication lists, annual physicals, lab results, immunization or vaccination reports and other information enabling physicians to provide better care. The exchange of complete patient health information means physicians can reduce duplicative tests and get a "whole" picture of a patient.

## Clinisync Releases Policy For Exchange of Health Information

Both the Board of Directors and the CliniSync Advisory Council have approved a policy related to the exchange of health information, making it clear what can and can't be exchanged through CliniSync. This will become particularly important when The Partnership turns on the ability for providers to search for and find information about a particular patient who has been treated in the past by other physicians and clinicians. Patient consent will be necessary to search for that patient's information.

CliniSync is providing this information in light of a new Ohio law passed last summer that eases restrictions on mental health and HIV information exchange. Federal law still asks for express consent from patients for certain drug and alcohol information, for certain information about minors over the age of 14 and for those who pay out-of-pocket for services.

For more information on this topic and to view the entire policy and educational materials go to the Policy tab under About Us at [www.clinisync.org](http://www.clinisync.org).

**Editor's note:** *The AMCNO is privileged to work with CliniSync as a member of their Clinical Advisory and Physician Association Outreach committees and we are pleased to provide information regarding the Ohio Health Information Partnership to our members. ■*

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6/10/13	6-9 pm	Patient Access Specialist Fundamentals – Mon & Weds	\$475	CCE
6/25/13	6-9 pm	Essentials of Electronic Health Records – Tues & Thurs	\$309	UTC
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## NORTHERN OHIO PHYSICIAN

### THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

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# AMCNO LEGISLATIVE ACTIVITIES

## Ohio Statehouse Update

### *Medicaid Expansion Discussion Continues at the Statehouse*

The AMCNO submitted written testimony to the House Health and Human Services Subcommittee and met with area legislators to advocate for Medicaid expansion in Ohio. The AMCNO believes that increasing the number of insured through the Ohio Medicaid program has the potential to increase the overall health of our state while providing additional benefits to our economy. By expanding Medicaid now, Ohio can leverage existing state and federal resources to improve Ohioan's health coverage.

Throughout the past few months, the AMCNO has monitored the considerable discussion about whether Ohio should expand Medicaid to 138% of the federal poverty level, as outlined in the ACA. In recent studies released by the Health Policy Institute of Ohio (HPIO), the Ohio State University, the Urban Institute, and the Regional Economics Models, Inc., (REMI), estimates have been provided outlining the effects the Medicaid expansion will have on Ohio. Along with showing a pronounced benefit for uninsured Ohioans in the form of increased coverage, the studies also show that Ohio can anticipate substantial benefits from the proposed Medicaid expansion in the form of budget savings and the addition of new jobs.

The AMCNO informed the committee that we believe that the Medicaid expansion is vital to our region and the state as a whole. It is our hope that Ohio will decide to support the Medicaid expansion provided under the ACA in order to improve patient access to care and establish a more efficient and complete health care delivery system for the citizens of Northern Ohio and the rest of the state.

Leaders in the Ohio House unveiled a budget plan that removed Governor John Kasich's proposal to expand Medicaid coverage to Ohioans making up to 138 percent of the federal poverty level which would have brought



*The AMCNO staff attended a rally that took place at the Ohio Statehouse recently where advocates for the Medicaid expansion urged Ohio lawmakers to support extending health care benefits through Medicaid.*

in an estimated \$13 billion in federal funds over seven years. House Republicans stripped that proposal out of the two-year budget, citing federal uncertainties and concerns about federal deficit spending. House Democrats attempted to get Medicaid expansion back into the budget through an amendment, but that amendment failed. Representatives did unanimously approve an amendment to give lawmakers time to study the Medicaid issue and allow the state to pursue other options. The Kasich administration has been negotiating with federal officials for months over the details of possibly providing private health coverage to some people who would be eligible for Medicaid under the expansion. The amendment directs administration officials to assist lawmakers in developing Medicaid reforms and to submit a Medicaid plan to the Legislature by this fall. It says state lawmakers would have to sign off on any Medicaid proposal that has federal approval before it gets implemented. The amendment passed unanimously with the reluctant support of Democrats, who had tried unsuccessfully to restore Kasich's proposal into the budget. The AMCNO will continue to work on this issue as the budget bill debate continues in the Senate and we will continue to work with other members of the healthcare community and organizations to educate lawmakers on this important issue.

### *State Medical Board of Ohio Increase in Physician Fees*

The AMCNO also submitted testimony addressing the issue of the State Medical Board of Ohio (SMBO) budget request. The State Medical Board of Ohio (SMBO) has indicated that their budget proposal is predicated on promoting Board fiscal accountability and establishing a new way of operating for the next biennium. Through the FY 14/15 operating budget, the SMBO seeks to streamline its operations in a manner that provides for more expeditious delivery of services to applicants/license holders, reduces steps in the public complaint process; and refocus resources on the core functions of the agency. It is also our understanding that the SMBO plans to enhance their accountability, streamline their processes and increase productivity, and identify any non-essential functions and positions.

The SMBO testified before the House subcommittee a few weeks ago and made the request to raise certain license fees for physicians. Recently, the SMBO had an internal review conducted on their complaint process by the Lean Ohio Division of the Department of Administrative Services. This review showed that by making process and staffing changes in their complaint department the SMBO could reduce annual expenditures and realize significant savings in their budget. Based upon the results of the



*Ms. Elayne Biddlestone, AMCNO EVP/CEO (right) met with Rep. Marlene Anielski on several occasions to talk about the AMCNO position on Medicaid expansion.*

Lean Ohio review, the AMCNO is of the opinion that it is possible that additional cost savings and reductions could be realized if the SMBO were to review other internal processes as well.

The AMCNO informed the committee that we believe that the SMBO should consider reinventing how they operate in order to achieve additional savings rather than increase physician fees or implement additional monetary penalties against physicians. At a time when the nation may be facing a physician shortage the AMCNO does not believe that this is the right time to add additional cost burdens on practicing physicians in order to increase SMBO revenues.

The AMCNO might reconsider our position if the SMBO were to follow through on initiatives to reduce their annual expenditures and make internal changes, inclusive of staff reductions, in order to reduce their operating costs; develop and provide detailed reports showing SMBO performance measures for their investigative and licensure processes and continue to publish an annual report for dissemination to all licensees; and distribute any fee increases across all SMBO licensees rather than imposing additional licensure fees or monetary penalties solely upon physicians in order for the SMBO to obtain additional funds.

The SMBO budget request for additional physician licensure fees was not included in the budget bill or the substitute bill. The SMBO has indicated that they plan to continue to push for the licensure fee increase as the bill moves through the Ohio Senate. The AMCNO will continue to monitor this issue and voice our position on this issue.

### **AMCNO Testifies in Support of SB 49 – Physician Designations**

Dr. John Bastulli, vice president of legislative affairs for the Academy of Medicine of Cleveland & Northern Ohio, recently testified before the Senate Insurance and Financial Institutions Committee in support of SB 49 — a bill that would address the issue of physician designations/rankings. He noted that the concept of ranking physicians must be done

*(Continued on page 18)*

in a way to ensure the results are accurate and verifiable. The rankings should be based on quality or quality and cost but never on just cost.

"This legislation would prevent health insurance companies from ranking physicians based solely on the specific criteria to persuade a consumer to choose one physician over another," he said. "Under this legislation, the designations would be made based on cost efficiency, quality of care, or clinical experience, and it would establish standards for the physician rankings."

Dr. Bastulli said the crux of the debate is balancing the rights of physicians to have accurate reporting with the desire of health insurers and consumers to access information about their treating physician. SB 49 requires that a physician designation program operated by a health care insurer or a third-party administrator use the most current patient charter for physician performance measurement, reporting and tiering programs developed by the Consumer-Purchaser Disclosure Project or a version of the charter. The Patient Charter arose in response to concerns expressed by some clinicians that health plans' physician rating initiatives lacked methodological rigor and transparency, and favored "low-cost" physicians, rather than considering both quality and costs.

He said many insurers analyze the cost of care compared to the expected and average cost to determine "efficiency," but the definition they use for efficiency is "contentious." Several national medical groups have expressed concern that rankings could be used to steer patients to the least expensive providers, rather than being based on quality. The AMCNO will continue to push for support of this legislation.

## **Concussion in Youth Sports: Ohio's Return-to-Play Law**

Ohio's return-to-play law, (ORC 3313.539 and ORC 3314.03), which addresses concussion for youth athletes goes into effect on April 26, 2013. The law impacts those participating in interscholastic (school-based) athletics at public and private schools and youth sports organizations. The Ohio Department of Health has published FAQs about the new law and provided detailed resources on the website: <http://www.healthyohioprogram.org/concussion.aspx>

The return-to-play law prohibits an athlete from returning to play on the same day as he/she is removed. The law also specifies that a physician must provide **WRITTEN** clearance for an athlete to return to play. A school district or youth sports organization may also authorize a licensed health care provider who is not a physician to make an assessment or grant

clearance to return to play if the provider is acting in accordance with one of the following, as applicable to the provider's authority to practice in Ohio:

1. In consultation with a physician;
2. Pursuant to the referral of a physician;
3. In collaboration with a physician;
4. Under the supervision of a physician.

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) strongly supported the passage of this law and we are now encouraging our members to learn more about this important topic by visiting the Ohio Department of Health website. The ODH website includes links to information from the Centers for Disease Control and Prevention (CDC) to assist health care providers in helping to identify, diagnose and manage concussions. Links to these important topics can also be accessed on the AMCNO website at [www.amcno.org](http://www.amcno.org) under the Practice Management tab.



*Dr. John Bastulli, AMCNO Vice President of Legislative Affairs, presents proponent testimony on SB 49 to the Senate Insurance and Financial Institutions Committee.*

## **Mandatory Payment Reductions in the Medicare Fee-for-Service (FFS) Program – "Sequestration"**

The *Budget Control Act of 2011* requires, among other things, mandatory across-the-board reductions in Federal spending, also known as sequestration. The *American Taxpayer Relief Act of 2012* postponed sequestration for 2 months. As required by law, President Obama issued a sequestration order on March 1, 2013.

In general, Medicare FFS claims with dates-of-service or dates-of-discharge on or after April 1, 2013, will incur a 2 percent reduction in Medicare payment. The claims payment adjustment shall be applied to all claims **after determining coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments.** Payment adjustments required under sequestration are applied to all claims after determining the Medicare payment including application of the current fee schedule, coinsurance, any applicable deductible, and any applicable Medicare Secondary Payment adjustments. All fee schedules, pricers, etc., are unchanged by

sequestration; it's only the final payment amount that is reduced.

Though beneficiary payments for deductibles and coinsurance are not subject to the 2 percent payment reduction, Medicare's payment to beneficiaries for unassigned claims is subject to the 2 percent reduction. The Centers for Medicare & Medicaid Services encourages Medicare physicians, practitioners, and suppliers who bill claims on an unassigned basis to discuss with beneficiaries the impact of sequestration on Medicare's reimbursement. Questions about reimbursement should be directed to your Medicare claims administration contractor.

**The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) has written to Congress urging them to take prompt action to address the current budget uncertainty and the economic hardships imposed by sequestration.** We believe that the arbitrary sequestration approach is not the appropriate policy to attain our nation's long-term health care goals.

The AMCNO informed Congress that we are concerned because Medicare physician payments have lagged behind about 20 percent below the rate of practice cost inflation over the past 10 years and an additional 2 percent payment cut will only accelerate reduced access to care for Medicare patients. We further noted that in addition to Medicare physician payments, Medicare funding for graduate medical education will be reduced by two percent. Other federal health care spending will be cut by over five percent. The AMCNO believes that a more targeted approach is necessary to maintain funding levels for graduate medical education and for key research, public health and prevention programs administered by various government agencies and we urged Congress to act on this important issue.

## **Ohio Receives Federal Award to Improve Health System Performance**

Ohio has received a competitive federal award to accelerate the state's work to improve overall health system performance through payment innovation and service delivery improvements. The \$3 million State Innovation Model (SIM) Design Award will be used to develop and implement evidence-based health care strategies that improve the health of individuals rather than simply treat disease. Over the next 6 months, the State of Ohio will receive up to \$3,000,000 to develop its State Health Care Innovation Plan. Funding will be subject to successful completion of the terms and conditions for the State Innovation Model initiative. Ohio will use the SIM grant to develop a comprehensive plan to expand the use of patient-centered medical homes (PCMH) and episode-based

# AMCNO LEGISLATIVE ACTIVITIES

payments for acute medical events to most Ohioans who receive coverage under Medicaid, Medicare and commercial health plans. The Governor's Office of Health Transformation will lead the design team in partnership with the Governor's Advisory Council on Payment Innovation, which includes representatives from prominent Ohio employers, health plans, health systems and consumer advocates. The design phase will last six months and conclude with a plan to implement both models statewide.

## State Legislation Update

The AMCNO legislative committee is tracking many health care related bills currently under review in the legislature. Listed below are a few of these bills with the AMCNO legislative committee position:

**House Bill 3 Insurance Navigators** – this bill will specify licensing and continuing education requirements for insurance agents involved in selling, soliciting, or negotiating sickness and accident insurance through a health benefit exchange and to make changes to copayments, cost sharing, and deductibles for health insuring corporations. This bill is moving very quickly through the legislature and at press time the bill had already moved through both the House and the Senate. The AMCNO legislative committee supports this legislation.

**House Bill 93** – Syringe Exchange – this bill would authorize the establishment of syringe exchange programs.

The bill would allow communities to offer syringe exchange programs that minimize the transmission of diseases and potentially help limit the use of drugs. Programs in northern and southern Ohio have resulted in a reduction in needle sharing, and have also minimized the number of needles that are improperly disposed in public places. Programs would be established by and at the expense of local health departments. The AMCNO legislative committee position on this bill is support with technical assistance.

**Senate Bill 49 Physician Designations** – To establish standards for physician designations by health care insurers. The AMCNO strongly supports this legislation (see related story above.)

**Senate Bill 54 Mammograms** – this bill would require a physician interpreting a mammogram who determines that the patient has dense breast tissue to specify this in the mammography report sent to the patient. The AMCNO legislative committee opposed this bill noting that there is no protocol in the bill for follow up management and yet there is a mandate to follow the patient with counseling and guidance.

For more information on the legislative initiatives of the AMCNO please contact E. Biddlestone at the AMCNO offices ■



Over the past three years, the Academy of Medicine of Cleveland and Northern Ohio (AMCNO) and the Ohio State Medical Association (OSMA) have worked together on several advocacy initiatives, political activities and health care forums without an organizational connection between the groups. Recently, physician leaders from both organizations created an Ad Hoc Committee to discuss future opportunities for collaboration and establishing a better working relationship between the two organizations. In March, the Committee met for the first time at the AMCNO offices with the intent of better defining the goals for the Ad Hoc Committee and what each organization hoped to gain from this experience. The Committee members asked the AMCNO and OSMA staff to further develop the initial ideas discussed at the meeting and then reconvene the group to commit to specific opportunities to move the collaborative relationship forward. (Pictured left to right: Dr. Laura David, AMCNO Past President, Dr. Mary Wall, OSMA President-Elect, Dr. James Sechler, AMCNO President, Dr. George Topalsky, AMCNO President-Elect, Dr. C. Kafalas, OSMA representative, Dr. John Bastulli, AMCNO VP of Legislative Affairs and Past President, and Dr. Thomas Bralliar, AMCNO and OSMA member.)

## AMCNO Participates in Investing in Tobacco Free Youth Advocacy Day at the Statehouse

Recently the AMCNO was pleased to be a participant in the Investing in Tobacco Free Youth Advocacy Day at the Ohio Statehouse. Joining the AMCNO were numerous anti-tobacco volunteers including high school students dressed up as "tobacco zombies." The day began with an issue briefing prior to the participants meeting with their legislators from their respective districts.

Participants in the event were asked to press legislators to consider increasing the cigarette tax and equalizing the "other tobacco products" (OTP) tax in order to fund tobacco prevention and cessation programs across the state. Legislators were informed that the use of non-cigarette forms of tobacco is rising, especially among youth since these products are candy flavored and cheap because of the low OTP tax rate. Equalizing the OTP tax to the current cigarette rate would generate \$50 million annually. This funding should be used to continue tobacco prevention and cessation programs. Participants in the Advocacy Day reminded their legislators that through sustained state investments in tobacco prevention, Ohio can save Medicaid dollars by giving Ohioans on Medicaid the tools to stop smoking and reduce the burden that tobacco related illnesses are taking on the state budget and every taxpayer.

In the meetings with our area legislators, it became clear to the AMCNO representatives that adding new taxes or raising taxes may not be an easy option at this time, however, legislators seemed open to further discussion on looking at other options as the budget process moves forward. The AMCNO has also signed onto a letter that was sent to the entire Ohio House of Representatives urging legislators to close the loophole on the other tobacco products tax, and use the increased taxes for prevention and cessation programs. The AMCNO plans to remain actively engaged in working with the Investing in Tobacco Free Youth coalition in an effort to make changes in the Ohio law in order to fund tobacco prevention and cessation programs in our community and across the state.



Elayne Biddlestone, EVP/CEO met with Senator John Eklund to discuss AMCNO legislative initiatives.

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