

Social networking 101 for physicians

Managing the risks of Facebook, Twitter and other social media



By Eric T. Berkman

The usefulness of online social networking is undeniable and it's no surprise that physicians are embracing it.

But lawyers and other experts warn that these tools present a minefield of legal and professional hazards for medical professionals who don't take the utmost care in how, what and where they post.

"If you can't do something at a cocktail party without people staring and looking at you strangely, you shouldn't be able to do the same thing online," says Jim Tobin, president of Ignite Social Media, a Cary, N.C., social-media agency that is developing a social-networking program for the Massachusetts Medical Society and its members.

Physicians are using these tools to discuss medical news, pick other doctors' brains about clinical or practice-management issues, market their practices or just generally feel connected.

In June, MMS polled approximately 800 of its members and found that the usage of social media grew 50 percent in the last year, with usage by doctors aged 45 to 54 tripling.

Whether blogging, participating in open networks like Facebook and Twitter, or visiting physician-only networks

such as Sermo or iMedExchange, physicians can reduce their legal risk by doing the following:

- **Be mindful of patient confidentiality.**

Online networking presents a risk of a doctor compromising patient information and facing a compliance action under the Health Insurance Portability and Accountability Act (HIPAA) or a lawsuit.

Take, for example, a physician who shares a detailed anecdote about a patient on his or her personal Facebook page, or on Sermo.

The information a physician shares "needs to be generic enough that nobody can identify a patient in the course of reading a post," says David Harlow, a Newton lawyer and health care consultant who writes the blog HealthBlawg.

Though this sounds like common sense, the potential for carelessness is always present, says Kevin Pho, an internist in Nashua, N.H., whose 5-year-old blog, KevinMD.com, is one of the most popular health care blogs on the Internet, currently boasting more than 26,000 RSS subscribers.

"The easier it is to publish something, like a [Facebook] status update or a

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Credentialing file isn't protected by peer-review privilege

By David E. Frank

The Board of Registration in Medicine may be entitled to look at certain documents in a doctor's hospital credentialing file even though it hasn't begun formal disciplinary proceedings against the doctor.

That's the result of a new decision from the Massachusetts Supreme Judicial Court.

The Board is not entitled to see "core" peer-review documents, such as proceedings, reports and records, without filing a formal proceeding. However, it's entitled to subpoena "less central" documents, the court said.

These might include applications for reappointment to the hospital staff, in-

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Health care providers brace for Medicare audits

By Sylvia Hsieh

Health care providers are preparing for a national rollout of Medicare audits aimed at recovering money owed to the government due to incorrect billing by providers.

The Recovery Audit Contractor (RAC) program began in 2005 as a demonstration project in three states, and then expanded to more states – including Massachusetts – in 2007. It is scheduled for permanent rollout across the country in the coming year.

RACs are private companies hired by the Centers for Medicare & Medicaid Services to audit health care billing records and recover money that Medicare overpaid to providers.

Given the success of the demonstration program – Medicare recovered over \$1 billion in overpayments – many health care providers are seeking legal advice on RAC audits and compliance procedures, as well how to appeal RAC claims.

Preparing for a RAC audit should be part of an overall compliance program, according to Vincent L. DiCianni, an attorney who now runs Affiliated Monitors, Inc, a company with offices in Boston and Westborough, Mass., that advises physicians and other practitioners on compliance matters.

- **'Bounty hunters'**

The program began in California, Florida and New York in 2005, and then expanded



to Arizona, Massachusetts and South Carolina in 2007. It was authorized under the Medicare Prescription Drug Improvement and Modernization Act of 2003.

CMS has published the schedule for introduction of the RAC program in the rest of

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R_{FOR} EXCELLENCE
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Alfred DeMaria Jr., M.D., Barbara B. Anthony, Esq. and Alice Coombs, M.D. are among the winners at Oct. 29 breakfast

See inside for a complete list of honorees

Coping with a loved one's final chapter

When I was growing up, my maternal grandparents would drive from Washington, D.C., to see me in Philadelphia every Sunday.

And yesterday, my Bema (that's the name I gave my grandmother when I was two) started to receive hospice care.



She hasn't been herself for a long time, and yet there is no clear event that the epidemiology-educated person in me can pinpoint to describe why she is dying.

It has been slow and debilitating, and very tough to witness even though I don't see her every day.

I write and publish articles about legal issues involving patient care all the time. I have written about advanced directives, the latest rules on HIPAA and privacy concerns, and cases about the legal duties of hospice facilities.

But no amount of knowledge of the legal technicalities of the end-of-life process could have prepared me for how I feel today.

In prior columns, I have talked about the trials and tribulations

of being the patient looking for a primary care doctor, and what it was like to be a hospital patient giving birth to my son.

And now here I am, somehow suddenly, talking about what it's like to be a loved one, the family

Editor's Note

member of a patient, grappling with the reality of that family member's ultimate passage.

Once again, no matter how much I have written about the medical issues, there is no way to truly understand what it's like to live through them until you have actually been there. And that's a humbling thought for anyone who tries to provide

compassionate care, or who tries to write about that care.

I'm leaving town tomorrow to see my Bema for what, I imagine, will be the last time. Despite the intense sadness that brings, I take solace from one recent, meaningful memory of her.

I will never forget the joy my own two-year-old son Brett brought to her on our last visits, to the point that she would gather up the energy to sing. While Brett knows that Bema has been sick – and yet is unlikely to understand when she passes – I am comforted to know that his memory of her will always be their shared singing of "Patty Cake, Patty Cake, Baker's Man."

It closes the circle.

—Reni Gertner, MPH

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Section B

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By Carol Krohn, M.D., and Scott Summers, J.D.



Here's an essential guidebook – written by a doctor and a lawyer – that will answer all your questions about health care directives. You'll learn how to interpret directives in difficult cases, how to talk with patients about them, and how to understand the legal and ethical issues involved. You'll also get helpful advice on dealing with directives in special situations such as pregnancy, divorce, minors and foreign nationals, revocation of directives, legally inadequate directives, guardianships, organ donation, cryonics and much more. Includes a CD-Rom.

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Obama unveils medical malpractice reform plan

By Kimberly Atkins

WASHINGTON – President Barack Obama's plan to test state-level medical malpractice reform efforts with the help of federal grants is drawing praise from some lawmakers and medical organizations.

In his address to a joint session of Congress last month, Obama acknowledged the growing issue of tort reform in the health care debate, after the issue had been gaining steam in health care town hall meetings.

"Many in this chamber – particularly on the Republican side of the aisle – have long insisted that reforming our medical malpractice laws can help bring down the cost of health care," Obama said, as many lawmakers on the GOP side of the aisle broke out in thunderous applause.

"I don't believe malpractice reform is a silver bullet," Obama continued, "but I have talked to enough doctors to know that defensive medicine may be contributing to unnecessary costs. So I am proposing that we move forward on a range of ideas about how to put patient safety first and let doctors focus on practicing medicine."

Obama said the idea of state-level medical reform test programs was first floated by the Bush Administration.

"It's a good idea, and I am directing my Secretary of Health and Human Services to move forward on this initiative," Obama said.

The move drew immediate praise from the American Medical Association.

"We cannot ignore this problem if health system reform is going to address the growing cost of care," AMA President Dr. J. James Rohack said in a statement after the president's address.

But other groups, including the Center for Justice and Democracy in Washington, blasted the plan as "terrible public policy."

"Medical errors are at epidemic levels and this proposal will not only fail to fully compensate catastrophically injured patients, but will also undermine restraints the civil jus-

every year," Lipsen said. "That is a 10 percent increase since the [IOM] recommendations were made more than 10 years ago."

Lipsen also noted that malpractice reform measures have already been implemented in 48 states. Some measures – such as requiring med-mal complaints to be accompanied with a certificate of merit issued by a medical professional – have produced mixed results.

"In some states it's been done in a way that has brought case filings down, and that can be a good thing," Lipsen said. "In other states, the law has been written in such a way that courts have declared them unconstitutional for denying patients their right to a jury trial."

In past years, the American Bar Association has supported legislative efforts to provide grants for med-mal litigation alterna-



AP Photo/Jason Reed, pool

tives – such as alternative dispute resolution mechanisms like arbitration and mediation – so long as they are voluntary and initiated after a dispute has arisen.

Other measures, such as the establishment of health courts where the merits of malpractice claims are considered by health care panels, have faced strong opposition by the ABA and AAJ.

Other med-mal reform efforts discussed by lawmakers and other groups in the past include establishing an enterprise liability system that would shift the liability for medical malpractice from individual practitioners to hospitals and other larger providers, and no-fault plans that allow patients to be compensated without filing suit. **MMLR**

Questions or comments can be directed to the writer at: kimberly.atkins@lawyersusaonline.com

"I am proposing that we move forward on a range of ideas about how to put patient safety first and let doctors focus on practicing medicine."

– President Barack Obama

tice system currently imposes on dangerous misconduct," said Joanne Doroshov, executive director of the center. "Reducing legal accountability will lead to more errors and system costs."

Lawmakers have introduced bills seeking similar tests in recent years. Obama's plan would not be part of the health care reform bill or any other legislation – it will be implemented via an executive order, according to the White House.

Devil in the details

The exact form the state-level test programs will take remains unknown.

Linda Lipsen, senior vice president of public affairs at the American Association for Justice, the nation's largest trial lawyers' group in Washington, said while she is "heartened by the president's continued concern about patient safety," details of the plan would have to be spelled out before she can fairly assess its potential impact.

She said some malpractice reforms could lower costs and benefit patients, such as the creation of a mandatory reporting system for medical errors – a suggestion made by the Institute of Medicine in 1999.

"Researchers are saying [that] medical errors are increasing by about one percent



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Listening In

The news beat
of the medical profession

Study: primary care shortage continues

More family medicine practices in Massachusetts are no longer accepting new patients than two years ago, and wait times for primary care physicians are growing, according to a new survey conducted by the Massachusetts Medical Society.

According to the new MMS physician workforce study, 40 percent of family medicine physicians are no longer accepting new patients, up 10 percent from 2007. And the wait time for a new patient appointment has reached an average of 44 days, up from 36 in 2007.

The percentage of internists

no longer accepting new patients increased to 56 percent this year, up from 49 percent in 2007, with an average wait time for a new patient appointment dropping to 44 days from 50.

The survey also found shortages in seven of 18 specialty fields. In eight years, this was the first time that the study has found obstetricians and gynecologists in short supply.

These trends are putting a strain on the state's health care reform efforts, which have led to 440,000 individuals newly securing insurance.

Coakley names new health care chief

Thomas More O'Brien of Brighton, a former assistant attorney general, was promoted by Attorney General Martha Coakley to chief of her health care division.

Quentin Palfrey, the previous chief, left Coakley's office months ago to join the Obama administration in the Department of Commerce.

O'Brien joined the health care division when it was created by Coakley in 2007. As an assistant attorney general since 1993, he worked on health and insurance matters and was involved in public policy development.



Martha Coakley

AP Photo/Josh Reynolds

Doctors cut vaccines due to rising costs

A recent survey indicates that 5 percent of pediatricians and 11 percent of physicians overall are seriously considering no longer offering immunizations to patients, according to CNN.

The alarming numbers reflect the reality that doctors have to absorb any costs that insurance doesn't cover, because in most states, insurance contracts prohibit providers from charging patients the difference.

Most insurers pay providers the base cost of the vaccine. But the additional expenses – including refrigeration, electricity and insurance – make the actual cost to providers up to 28 percent more than the base cost.

The CDC maintains that vaccination rates for most child and adolescent vaccines are currently about 80 percent in the United States.

Boston among targets of Medicare fraud bust

Federal authorities arrested more than 30 suspects, including doctors, in July in a major Medicare fraud bust in Boston and three other cities.

More than 200 agents worked on the \$16 million bust that included 12 search warrants for health care businesses and homes across the Houston area, where the bulk of the arrests were made.

Authorities say those busi-

nesses were giving patients "arthritis kits," which were essentially expensive orthotics that included knee and shoulder braces and heating pads.

Patients told authorities that they were unnecessary and many never even received them. But health care clinic owners billed between \$3,000 and \$4,000 for each kit.

Another scam involved billing Medicare for thousands of dol-

lars worth of liquid food, such as Ensure, for patients who can't eat solid food. Authorities said clinic owners never distributed the food to patients. In some cases, clinic owners billed patients who were dead when they allegedly received the items.

The Medicare Fraud Strike Force has recovered \$371 million in false Medicare claims and charged 145 people across the country in just two months.

AMA changes position on health care

In stark contrast to its history of resistance to federal attempts at revamping the health care system, the American Medical Association is supporting proposals under President Barack Obama's plan, which promises to provide millions of dollars to help millions of patients pay their doctor bills, the Chicago Tribune reported.

Moreover, in a deal cut with Obama's congressional allies that has made it into one of the principal health care bills pending on Capitol Hill, the government will rescind scheduled cuts in Medicare payments to physicians, amounting to \$228 billion over the next 10 years.

Critics denounce the deal as a fiscally irresponsible effort to buy the medical community's support, while the AMA and leading Democrats defend it as necessary to safeguard the stability of the medical system. Whatever the merits of the deal, it stands as the most costly concession to any single interest group made so far.

AMA officials say their view on the need for government intervention has shifted as they have seen more patients struggling to get care, either because patients lacked insurance or because insurers interfered with care decisions.

\$1B

Dana-Farber raises \$1B

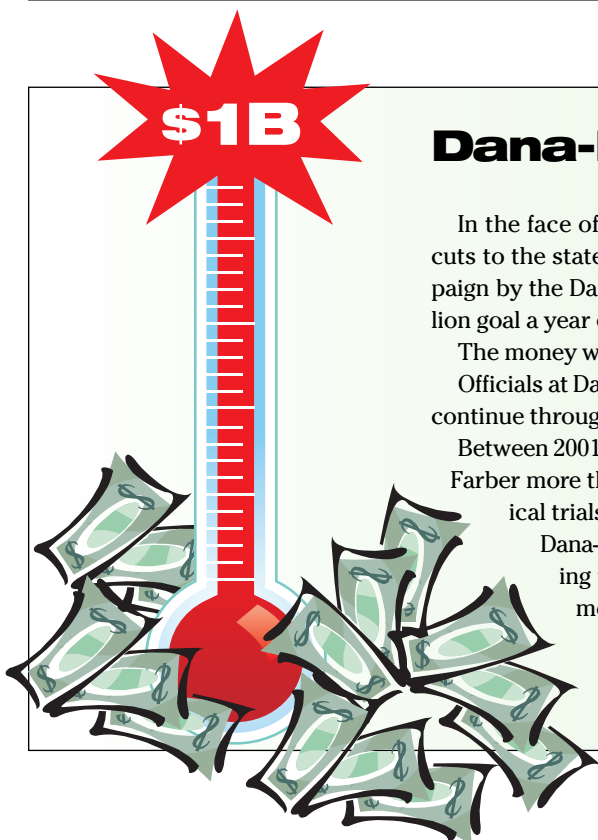
In the face of a stifling economy and unprecedented funding cuts to the state hospital system, an ambitious fundraising campaign by the Dana-Farber Cancer Institute has reached its \$1 billion goal a year early.

The money will be used for patient care and research.

Officials at Dana-Farber say the campaign launched in 2003 will continue through its original end date of Sept. 30, 2010.

Between 2001 and 2008, outpatient visits and infusions at Dana-Farber more than doubled to over 264,000. The number of clinical trials increased nearly 80 percent, to 735.

Dana-Farber has received more than 1.7 million gifts during the campaign, including 107 gifts of \$1 million or more, and 703 gifts of \$100,000 or more.



Health insurers sued for underpaying doctors

By Nora Lockwood Toohar

The American Medical Association and several state medical societies are seeking restitution for physicians and patients who were allegedly underpaid by health insurers for out-of-network medical charges.

Class actions against Aetna – brought by subscribers, the AMA and about 10 state medical societies – have been consolidated in U.S. District Court in New Jersey.

Similar actions have been filed against Cigna and WellPoint in federal courts in California and New Jersey.

The suits allege that the health insurers violated ERISA – the federal law that governs employee benefits – as well as racketeering and antitrust laws, by using deliberately skewed data to underpay physicians, which in turn jacked up policyholders' costs for out-of-network care.

The complex litigation centers on Ingenix, a Minnesota-based data-gathering subsidiary of UnitedHealth Group, that allegedly underestimated the “usual, customary and reasonable” (UCR) rate used by insurers to calculate payments to out-of-network physicians.

Aetna was a leading contributor to the Ingenix database, and allegedly lopped off high-charge data to skew the rates downward. The lawsuit says that Aetna and Ingenix “cooked the books,” and that the corruption of data invalidates its use by Aetna as the basis for determining the UCR rate for out-of-network payments.

Aetna denies the allegations.

“The Ingenix database is flawed; it’s not properly created, so you cannot rely on it to make a determination of usual, customary and reasonable rates,” said Brian Hufford, a partner with Pomerantz, Haudek, Grossman & Gross in New York, who is chair of the plaintiffs’ executive committee in the Aetna litigation.

Hufford said that because of the skewed data, physicians received reduced amounts from insurers, and then were forced to either pursue the remainder from patients or absorb the unpaid amount.

Edith Kallas, a partner at Whatley Drake & Kallas, a New York firm that also represents the AMA and state medical societies, said doctors are reluctant to sue, but “are being put in a terrible position by the conduct of these companies.”

‘Money is huge’

For subscribers, the average UCR reduction was \$50 to \$60 for an out-of-network medical service, and \$200 to \$300 per surgical claim.

“People have a lot more medical procedures than surgical, but the surgical procedures tend to be the overwhelming majority of the lost dollars,” said Barbara Quakenbos, a shareholder at Wilentz, Goldman & Spitzer, in New York, who is representing Aetna plan members.

“So the money is huge, and the companies’ liability is huge for having gotten literally millions of determinations wrong over time,” she said. An investigation by New York Attorney General Andrew Cuomo found that UnitedHealth had a conflict of interest in owning Ingenix. A report released by Cuomo in January found that health insurers who use Ingenix “systematically under-reimburse New Yorkers for doctors’ office visits.”

A report released in June by the Senate Commerce Committee determined that the use of Ingenix data was widespread in the insurance industry.

The committee said that 17 of 18 insurance companies it questioned reported that they used Ingenix data to pay claims for out-of-network services.

The committee also found that some insurance companies improperly “scrubbed” valid charges before submitting their data to Ingenix.

In one case, Aetna allegedly eliminated the highest 20 percent of medical charges before sending the data to Ingenix.

“It appears a lot of people were economically injured by these practices,” said Charles



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Bell, program director of Consumers Union, a nonprofit consumer group based in Yonkers, N.Y.

‘Never made sense’

Attorneys general and insurance regulators in several states, including Florida, are investigating health insurers’ use of the Ingenix database.

Richard Gulla, spokesman for the Massachusetts Medical Society, said MMS has not joined the Ingenix litigation, “and whether we will do so or not is still to be determined.”

In addition to health insurance products, Ingenix data was also widely used to calculate reimbursement in many other insurance products used to pay medical claims.

In a key Massachusetts case involving a dispute over the amounts an insurance com-

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MARCH 5, 10:40 AM

You respond to a request from The Center for Medicare Services for 100 of your patients’ charts.

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Verdicts & Settlements

Doctors allegedly overlooked signs of impending stroke

On March 3, 2003, the patient, a 56-year-old man with diabetes and hypertension, arrived at his primary care physician's office with a severe right-sided headache, dizziness, some weakness and tingling on his left side and problems picking up his left foot. He was seen by the family nurse practitioner.

The nurse practitioner recorded his symptoms as well as a family history of transient ischemic attacks, or "mini-strokes," that produce stroke-like symptoms but no lasting damage.

The nurse practitioner performed an EKG, noting that "there did not seem to be any neurological finding suggestive of a [transient ischemic attack]." She gave him prescriptions for aspirin and Atenolol, told him to make a follow-up appointment in one week.

She reviewed his case and the EKG with the physician on two occasions; however, the physician did not personally examine the plaintiff.

That night, the patient was admitted to the ER and received a work-up and treatment for an apparent stroke.

The plaintiffs' experts confirmed that the defendants failed to recognize that the patient's symptoms were suggestive of a serious neurological event and failed to appreciate his risk factors. They concluded that if the plaintiff had been referred to the ER for an immediate stroke work-up and treatment, the progression of the stroke and his ensuing disabilities could have been prevented.

The plaintiffs also alleged that the physician failed to properly treat the plaintiff's chronic hypertension, diabetes and elevated cholesterol for many years preceding the stroke, and should have examined him personally.

The defendants asserted that prescribing aspirin and anti-hypertensive medication and sending the patient home met the standard of care. They also argued that earlier admission to the hospital would not have made a difference because his head CT scan at the hospital was normal and he suffered the stroke during admission.

The plaintiffs prepared a video demonstrating the patient's resulting physical and cognitive difficulties. The defendants were prepared to argue that the patient had recovered significantly from the stroke.

The case settled for \$750,000.

Type of action: Medical malpractice

Injuries alleged: Cognitive and physical disabilities

Date: May 2009

Submitted by: Lisa G. Arrowood and Jeffrey N. Catalano, Todd & Weld, Boston (for the patient)

Patient's shunt occlusion treated with analgesic

The patient was a 21-year-old single male who was born with spina bifida and hydrocephalus. He was partially paralyzed and used a wheelchair.

He was treated at an early age with a cerebro-spinal fluid shunt. He underwent a shunt revision in 1991 and a shunt conversion in 1992.

In July 2003, a CT scan revealed mild enlargement of the lateral and third ventricles. Telemetric shunt pressure was found to be abnormal.

In September 2005, the patient, then 16, fractured his leg while playing football. He had surgery, which included the insertion of a rod in his leg. Approximately 24 hours after the surgery, he developed compartment syndrome in the leg and underwent a fasciotomy procedure.

Over the next four days, the patient continued to have loss of sensation in his lower extremity, abnormal capillary refill times, increased pain, elevated temperature and abnormal appearance of the extremity. An arteriogram taken three days after the fasciotomies demonstrated reduced blood flow.

Despite his ongoing symptoms, the patient was treated and discharged from the hospital two days later.

Two days later, the patient returned to the hospital with a change in the appearance of his foot. He was re-admitted and underwent an emergency fasciotomy, which included extensions of previous fasciotomies.

Over the course of the next month, the patient underwent multiple debridement surgeries of his lower extremity, skin grafts and amputation of his forefoot.

To date, the patient has undergone approximately 25 surgeries including debridement procedures, skin grafts, amputation procedures and tendon transfer surgeries. Over the course of his treatment, he

He was referred to a neurosurgeon, who performed a shunt tap. Because the clinical findings were consistent with obstruction, the neurosurgeon admitted the patient for an endoscopic shunt revision in 2003. A new ventricular catheter was placed with no surgical complications.

The patient was admitted to the thoracic surgery floor over his family's objections. The chief resident neurosurgeon documented a stable exam and wrote that the patient was doing okay except for a frontal headache, for which medication was prescribed.

A nurse, who provided care over the next two days, also noted the administration of narcotics for headaches.

Later, when the covering neurosurgeon attempted a shunt tap, he noted a proximal occlusion. Emergency surgery was performed for shunt revision. When the wound was closed, the patient lapsed into a coma and was transported to the ICU. An MRI later confirmed that the patient had suffered a brainstem infarct. The patient remained in a coma for approximately two weeks, with a progressively worsening neurological status. On Aug. 9, 2004, life support was withdrawn and the patient died. No autopsy was performed.

The family sued the nurse and the neurosurgeon.

The defendants argued that the patient's post-operative symptoms were normal and that the pain he was experiencing was to be expected following a surgery of this type. They further alleged that early shunt revision would not have prevented the brainstem infarct.

The case settled for \$1.25 million.

Type of action: Medical malpractice

Injuries alleged: Valve occlusion/brain infarct after shunt replacement surgery

Teen's football injury results in partial leg amputation



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also has suffered infections requiring hospitalization and lengthy antibiotic treatment, and has undergone physical therapy.

Two experts, including a vascular surgeon, were expected to testify that the doctors were negligent in failing to recognize that the arteriogram performed during the initial admission was consistent with ongoing compartment syndrome.

An orthopedic surgeon also was prepared to testify that further amputation be-

low the knee likely would be necessary.

The case concluded with a \$2 million settlement.

Type of action: Medical malpractice

Injuries alleged: Amputation of forefoot, loss of muscle tissue and nerves of left lower extremity

Date: July 2, 2009

Submitted by: Patrick T. Jones, Donna R. Corcoran and Richard W. Paterniti, Cooley, Manion, Jones, Boston (for the patient)

Date: July 2009

Submitted by: Philip J. Crowe Jr. and Mike Harris, Crowe & Mulvey, Boston (for the patient)

Doctor mistakenly applies pure acid to patient's body

On Jan. 3, 2008, a 27-year-old female was scheduled for a loop electrosurgical excision procedure with cone biopsy.

Due to errors by the hospital pharmacist, circulating nurse and gynecologist, 100-percent acetic acid was applied to the vaginal area instead of the appropriate 5-percent solution. The pure acetic acid caused significant vaginal and rectal burns.

An investigation revealed that the pharmacy technician, circulating nurse and scrub

technician all failed to identify the undiluted acetic acid, and didn't pay attention to clear warnings on the bottle or notice its distinctive odor.

The patient was transferred to the burn unit of a major Boston hospital. An examination under anesthesia revealed second-degree burns to the vaginal and urethral surfaces.

The woman recovered from the burns but was left with scarring on her buttocks. In addition, her resulting Post Traumatic Stress Syndrome allegedly affected her longstanding relationship with her boyfriend.

The case resulted in a \$475,000 settlement.

Type of action: Medical malpractice

Injuries alleged: Chemical burn resulting in permanent scarring, emotional distress

Date: May 2009

Submitted by: Marc L. Breakstone, Boston (for the patient)

Verdict & Settlement Reports

Massachusetts Medical Law Report compiles the summaries of verdicts and settlements on this page from reports sent by attorneys to us or to Massachusetts Lawyers Weekly.

The report information is generally provided by one of the lawyers in the case, although occasional reports may be based on court records and news reports. We edit the material for style, grammar, length and, where appropriate, content. We are interested in printing verdicts won by both health care providers and plaintiffs, in addition to settlements.

If you have an item you would like to submit, please contact Matt Yas at matt.yas@lawyersweekly.com or 617-218-8152.

New HIPAA regs require notice of a 'data breach'

By Julia Reischel

Yet another set of data breach regulations has fallen on the shoulders of Massachusetts businesses that work with health information under the federal Health Insurance Portability and Accountability Act, known as HIPAA.

As part of the stimulus package passed by the Obama administration earlier this year, any company that comes in contact with so-called "protected health information" must comply with HIPAA's famously restrictive set of privacy rules.

The new regulation, which was issued by the Department of Health and Human Services in August and goes into effect Sept. 23, effectively extends HIPAA coverage to the "business associates" of hospitals and other health care providers.

"It could be an accountant; it could be an IT provider that does data aggregation; it could be really anyone that does services for the health care industry," said Ellen L. Janos, a partner in the

health law practice group at Mintz, Levin, Cohn, Ferris, Glovsky & Popeo in Boston.

The privacy rule requires these entities to implement a specific set of security protocols for health information and, in the case of an accidental breach, to determine whether it is necessary to notify the patient and the general public.

It is left up to the businesses themselves to decide whether notification is necessary, based on whether there seems to be a "significant risk of financial, reputational or other harm" to patients.

According to Jeffrey W. Mittleman of Holland & Knight in Boston, there are plenty of shades of gray involved in that decision.

"If just the fact that Jeff Mittleman received service in a hospital is breached, is that something really worthwhile to tell me about?" he asks. "But if the breach shows that I am having a tummy-tuck, or that I have something wrong with my prostate, that would likely be worth reporting."

David S. Szabo, a partner at Edwards, Angell, Palmer & Dodge in Boston, pointed out that the new regulation orders businesses to perform their own risk evaluations to determine whether someone has been harmed by a breach.

"What they've done here is created a requirement to do a kind of multi-fact analysis," he said.

As an added pressure, Mittleman noted, the exact definition of "harm" is murky and will likely vary from patient to patient.

"Some people are really sensitive about this kind of thing," he said.

To ease the transition, HHS will refrain from enforcing the rule until Feb. 10, 2010. After that, companies will be forced to live in a world in which the loss of a medical file or a laptop computer will require them to make a daunting set of decisions that could expose them to civil and criminal penalties.

An unintended side effect of the new rule might be a

rise in the price of health care, noted Szabo. "There absolutely are going to be some administrative costs," he said.

Further, the notification requirement will do little to tangibly help a patient once his or her private information has been released.

"If someone sent me a notice today that my protected health information had been breached, what am I going to do with it?" Mittleman asked. "Nothing. As an individual person, the only thing I'm probably going to do is get an upset stomach."

Szabo agreed.

"I don't know how you un-ring the bell," he said. **MMLR**

Questions or comments should be directed to the writer at: julia.reischel@lawyersweekly.com



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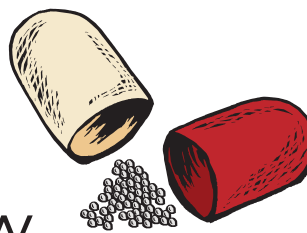
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Good Medicine



What doctors are talking about now

Q: Do physicians have a role in preventing a patient from driving a motor vehicle if his or her medical condition or treatment may impair driving ability?

"Yes. In Massachusetts, two recent decisions (one from the Supreme Judicial Court and another from the Superior Court) indicate that a doctor may be liable to third parties injured by their patients in automobile accidents when the doctor failed to warn the patient not to drive. One case involved the side effects of medication prescribed by the doctor; the other involved seizures associated with the patient's brain tumor. Both of these cases involved a failure by a doctor to warn his or her own patient not to drive. Outside that context, there is no indication that a doctor would be liable for auto accidents caused by patients."

— Lisa Arrowood, founding partner, Todd & Weld, Boston

"It is my understanding that the physician's role is limited to advising such patients not to drive because under current law, doctors could be liable for violation of patient confidentiality rules if they report such drivers to the Registry of Motor Vehicles or even share their concern with family members or other concerned parties without the patient's authorization. In my opinion, this should be remedied because it places physicians in an impossible position: Should a patient choose not to follow professional advice and have a serious accident, the doctor is, in effect, guilty of not having made the effort to have the patient's license suspended and is thus complicit."

— David Dodson, M.D., primary care physician at the Marino Center for Integrative Health, Wellesley

"Physicians have a duty to warn patients of potential impairment of driving ability arising from their treatment. The Supreme Judicial Court's ruling in *Coombs v. Florio* expanded the scope of a physician's potential legal exposure: Physicians may now be liable to victims of motor vehicle accidents caused by impaired patients. If one of the potential risks of a proposed treatment is impairment in the ability to drive, physicians must warn the patient not to drive while undergoing the treatment and must clearly document their discussion with the patient."

—David Gould, senior partner, Ficksman & Conley, Boston

"My responsibility is first and foremost to the patient sitting in front of me. Throughout my career, I have counseled patients on many issues impacting their health, and have addressed whether they should be driving. In fact, it is quite common for a patient who has had a recent surgery to be given a litany of instructions regarding when to resume usual activities, such as work, driving, exercise, etc. However, as a physician my responsibility ends in the office visit, with my words and documentation in the medical record. I have no ability to prevent my patient from doing anything once he or she walks out my office door."

—Patricia Sereno, M.D., family physician, Malden



Aging drivers and public safety: The physician's role

By Janet Jankowiak, M.D.

Following several widely reported incidents in which older drivers caused auto accidents, including one that resulted in the death of a 4-year-old, the elderly driver is increasingly seen as a major public safety concern.

Legislators, policymakers and safety advocates struggle with possible remedies. Many elderly people and their advocates balk at criticism, cite discrimination and cry "ageism." With our aging population and the motor vehicle as a longtime symbol and tool of our independence, the issue remains a public health concern.

Aging is but one of many factors that can impair a person's ability to drive. The greatest risk is alcohol, but drugs (including prescription medications), lack of sleep, psychiatric disturbances, diabetes, cardiovascular disease and disorders of the nervous system are among many others. Distractions such as cell phones, personal listening devices and heated conversations also interfere with safe driving.

A key concern in the debate about aging and impaired drivers is the role of physicians in preventing patients from driving, if the patient's condition or current treatment may impair the ability to operate a motor vehicle.

Federal Highway Administration data indicate that drivers 75 years and older have higher rates of fatal motor vehicle crashes per mile driven than any other age group except teenagers.

Collisions and traffic violations in the elderly population reflect errors of inattention, failure to yield, difficulty maneuvering and driving too slowly. Left turns are notoriously dangerous.

Physiological changes that come with aging eventually affect everyone's ability to drive. The rate of change in the physical and mental skills required for driving varies from person to person, but aging does take its toll on those critical components necessary for driving: vision, sensory motor abilities, reflexes and cognitive abilities such as divided attention and quick decision-making. Prescription drug use or chronic medical conditions, widely present in the elderly population, may increase impairment.

Doctor's Rx

Many physicians want the ability to reach out to the Registry of Motor Vehicles when patients present a danger on the highways.

Currently, no legal requirement exists for a physician or other interested party to report a possibly unfit driver to the Registry. If an interested party chooses to report such a driver, then the Registry will act on the information, provided it is reported in accordance with prescribed procedures.

This situation leaves physicians with questions about patient confidentiality under existing laws and with potential liability to patients for filing reports and to patients and others for not filing reports.

A bill before the legislature presents a reasonable solution. It would let physicians and other providers file written reports to the Registry about every patient 16 or older who has a cognitive or functional impairment that affects driving ability.

Determining impairment would not be based solely on a diagnosis, but in accordance with guidelines set by the Department of Public Health in consultation with the Registry and its

Medical Advisory Board, medical experts and experts on cognitive and functional impairments. These guidelines would define the conditions and impairments that tend to limit a driver's ability to operate a motor vehicle safely.

At present, a limited review process exists for patients with medical issues that pose potential dangers to their ability to drive.

Physicians have long supported voluntary reporting that protects them from civil liability and that affords help in dealing with patients who continue to drive while impaired. The proposed bill also would shield man-

dated reporters from civil liability arising from any situation in which a provider did not file a report with the Registry.

Our state medical society several years ago developed an educational program for physicians on how to identify problems of driving impairment and how to address the issue with patients.

The current policy "supports initiatives that improve driving safety, such as periodic re-testing of drivers in increased-risk categories, promotion of alternative modes of transportation, and improved patient education about driving responsibly."

Balance is in order. When conflict arises between a patient's right to privacy and a third party's need to know, resolution should be in favor of the patient's privacy and confidentiality.

Exceptions to patient privacy should be extremely narrow, as in infectious disease reporting or for patients in psychiatric treatment who make threats of serious harm to an identifiable third party.

The physician-patient relationship is a complex one in which the health of the individual patient must be the physician's highest priority. But physicians also know that impaired drivers pose a threat to public health, and we welcome the opportunity to balance the patient's right to confidentiality with public health and safety.



Janet L. Jankowiak, M.D., a geriatric neurologist at Radius Specialty Hospital in Boston, is a member of and advisor to the Committees on Geriatric Medicine and Communications of the Massachusetts Medical Society.

Massachusetts health care reform 'Part Two'

What providers should know about future managed care contracting

By Julia Feldman, Esq.

Health care reform "Part Two" is coming soon to Massachusetts, as a result of recent state initiatives focusing on payment reform.

On July 16, 2009, the state Special Commission on the Health Care Payment System unanimously endorsed recommendations intended to improve the quality of patient care by fundamentally changing the way health care is reimbursed.

The Special Commission was established to examine alternatives to the fee-for-service payment model. The details would need to be more fully fleshed out by legislation and likely regulation as well.

The Special Commission recommends that global payments completely replace fee-for-service reimbursement, over a five-year period.

Under a global payment system, a physician, physician group or other provider organization would be paid prospectively a set amount for all or most of the care that their

patients may require over a set time period, such as monthly or annually.

Global payments would be made to highly integrated accountable care organizations (ACOs), which would be comprised of primary and specialty care physicians, as well as hospitals and other institutional providers.

The recommendations apply to both public and private payers.

The Special Commission also proposes using agreements such as the Alternative Quality (AQ) Contract recently introduced by Blue Cross Blue Shield of Massachusetts as a payment model.

The AQ Contract is an innovative managed care agreement that may eventually be used as a model throughout the state if the recommendations are implemented.

For health care providers, these changes mean that a well-negotiated contract with payers will be even more critical. Providers will need to form alliances and negotiate collective agreements with managed care entities.

In this new, more highly managed world, all health care providers will need to negotiate the details of such agreements more carefully, focusing on the practical and financial ramifications.

Here is a look at what would change under the main recommendations from the Special Commission:

- Physicians would receive global payments for all or most of the care provided to patients.

- Consistent pay-for-performance (P4P) incentives would be applied across all payers. These programs would continue to focus on primary care physicians and hospitals, but might also include specialists.

- ACOs would be composed of hospitals, physicians and/or other providers. They would work as a team to manage both the provision and coordination of care for the full range of patient services.

Under the recommendations, the models for these organizations would be broad and could include incorporated or "virtual" organizations. For example, "a large physician organization that would contract with one or more hospitals and ancillary providers" would qualify.

- Global payments would be risk-adjusted, with providers responsible for performance risk, including cost performance and meeting access and quality standards.

- Tiering would be used to rank providers. Health plans may be required to classify physicians in their networks into performance tiers. National guidelines may be used for measuring and reporting physician performance.

The AQ Contract

The AQ Contract provides a model for global payment with quality-based performance incentives.

This new model of contract has recently been negotiated with several providers, including a physician group. It combines two forms of payment: a global payment per patient, and a second payment if the provider achieves certain nationally accepted measures of quality, effectiveness and patient care.

Under the AQ Contract, a physician would receive a fixed global payment per patient, adjusted for health status, as well as separate performance incentive payments for achieving certain quality measures.

The AQ Contract does not contain the larger yearly increases common in more standard managed care contracts, since it provides for the possibility of receiving fairly substantial performance incentive payments. The global payment amount is not reset annually; instead there is an inflationary increase. The AQ Contract term is generally five years.

Under the AQ contract, there would be many quality measures. Providers are at relatively low risk in the first two years and at greater risk in the subsequent years of the agreement, if they cannot meet the quality measures.

The determination as to whether a provider has achieved the quality measures would be made on a quarterly basis. Each measure would be evaluated individually. Providers would receive an add-on to their rate at the end of each year based upon the extent to which they have accomplished each quality measure, with a potential for in-

Continued on page 10



Feldman is of counsel at Krokidas & Bluestein LLP. She concentrates her practice in the areas of health care, non-profit, administrative, managed care and corporate law.



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Hernia patch litigation moves forward

By Nora Lockwood Tooher

The Kugel hernia mesh litigation – which alleges that breakage of the mesh causes patients infections and injuries – is moving forward with a series of settlements and a change in attorney for the defendant.

Five cases have settled, and plaintiffs' liaison counsel Donald Migliori said he expects additional settlements.

While the defendant is not admitting any liability, a change in defense counsel earlier this year has expedited efforts to resolve the litigation, according to Migliori, a partner at Motley Rice in Providence, R.I.

"There have been settlements. We expect them to continue," he said.

The mesh patches – made by Davol, a Cranston, R.I. medical device manufacturer – are used for hernia repair surgery.

The suits claim that the patch is defectively designed because it includes a plastic ring that can break off inside patients and cause the mesh to ball up or migrate, leading to perforation, infections and bowel injuries, including fistulization and peritonitis.

The product was recalled in three batches, from 2005 through 2007.

For the first two years of the litigation, Davol was represented by Hollingsworth in Washington, D.C. Earlier this year, the company hired Reed Smith, in New York, as defense counsel.

"Reed Smith has come in with a very different, much more practical approach," Migliori said. "They are focusing on the issues a lot more clearly. If these cases are going to resolve reasonably for both sides, this change in counsel will make a big difference."

Almost 1,000 suits have been filed in the



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federal multi-district litigation in U.S. District Court in Providence; 1,200 claims have been filed in state court in Providence.

The first test trial in the federal litigation was originally planned for this fall, but was moved back to March 2010 after the change in defense counsel.

However, the case settled two months ago for a confidential amount, along with three other federal suits, Migliori said.

One state claim has also settled.

Bowel injuries

The mesh patches made by Davol, a division of C.R. Bard in Murray Hill, N.J., are used for hernia repair surgery.

The legal claims are divided into "ring break" cases and "non ring-break" cases.

The plaintiffs claim that the ring either breaks and pierces the bowel wall or causes

the patch to ball up or flip over so the sticky side adheres to the bowel or other organs.

Injuries include ruptures or blockage of the bowel, infection and in some cases death, the suits allege.

The suits also allege that the company failed to instruct doctors on how to fold the patch to minimize breakage of the oval-shaped ring, which is welded together at the ends.

Davol now uses a bio-absorbable ring instead of a plastic one.

Litigation 'moving forward'

Despite the settlements, discovery continues.

As of July 23, Davol had produced about 5 million pages of documents, according to court records.

"The litigation is still moving forward," Migliori said. "We are in the middle of our liability discovery."

Plaintiffs' attorneys are currently taking depositions from marketing directors, production managers, quality assurance and research and development personnel. Plaintiffs have indicated that they intend to take about 33 witness depositions related to liability.

Discovery is slated to be completed by mid-December.

Under an order issued this summer by Chief Judge Mary M. Lisi, the first of a new batch of four test trials in the federal litigation will begin in March.

The first state court case to go to trial is set for June 2010. **MMLR**

Questions or comments can be directed to the writer at: nora.tooher@lawyersusaonline.com



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Health care reform 'Part Two'

Continued from page 9
creasing the total payment by up to 10 percent of the fixed rate.

Tips for negotiating agreements

Here are some important provisions that providers should negotiate in their managed care agreements going forward:

- Quality measures, and the method for evaluating whether each measure has been achieved, should be based on standards set by a third party. For example, the Healthcare Effectiveness Data and Information Set (HEDIS) is a tool used by most of the nation's health plans to measure provider performance. Quality measures may be proposed by the provider, and then negotiated with the payer.

- Explicit upper and lower limits of financial risk for failing to reach each quality goal should be instituted for each quality measure.

- A slow phase-in of the quality measures over the contract term during the first year(s) of the contract should be included.

- Any changes to quality measures (or other contract terms) should be by mutual written agreement. A payer should not have the ability to eliminate and replace quality measures in its sole discretion.

- Provisions that limit potential losses should be included to protect against excess risk and catastrophic loss.

- A global payment model for primary care providers is advisable, with a separate model for specialists. A "carve out" for certain service categories, such as behavioral health, should be included in the contract, meaning that those services might be paid on a fee-for-service basis, and not subject to the global fixed rate.

- The ability to enter into global fixed rate (sub-capitated) service contracts with specialty providers, service vendors and/or community hospitals should be included for services the provider does not provide directly or through its affiliated integrated system.

- A risk "floor" – which is a minimum level beneath which the provider is protected from loss or liability – should be included.

- The contract should revert to a straight "rate lift" contract (a low or non-risk-based contract with annual rate increases) in the event that quality measures are not met, or if there are losses on the global rate.

Providers need to educate and prepare themselves for a completely new type of managed care environment. Fortunately, some strong contract models already exist, so all will not be new territory in this brave new world of managed care. Following these tips will go a long way toward protecting providers facing a new reimbursement model.

For the full text on the Special Commission's report and Recommendations, please see: http://www.mass.gov/Eeohhs2/docs/dhcfp/pc/Final_Report/Final_Report.pdf. **MMLR**

Mistrial declared in first Fosamax trial

By Nora Lockwood Tooher

A federal judge in New York declared a mistrial Friday in the first trial in the Fosamax federal multi-district litigation.

The decision sends both parties back to square one, uncertain about the value – if any – of the cases.

While a mistrial is a disappointment to both sides, it is a more severe blow to the plaintiffs' lawyers, said J. David Prince, a professor at William Mitchell College of Law in St. Paul, Minn. who specializes in product liability law.

"All other things being equal, a mistrial is bound to make the plaintiffs think harder about how much more to invest and whether to try the next bellwether case. If they can't convince this jury that there should be liability, it will make them more thoughtful about whether they have a convincing case," Prince said.

Plaintiffs' lawyer Timothy O'Brien, a partner at Levin, Papantonio, Thomas, Mitchell, Echsner & Proctor in Pensacola, Fla., requested Wednesday that a mistrial be declared after jurors told the judge they were unable to reach a verdict and one juror said she had been threatened by another juror.

Judge John Keenan, who is overseeing the MDL in U.S. District Court in Manhattan, asked the jury forewoman early Friday afternoon whether jurors had made any progress. "Absolutely not," the forewoman replied, according to attorneys for both sides.

Keenan ordered a one-day cooling off period Wednesday after a female juror complained that she had been threatened by another juror who threw a chair at her.

The case of Shirley Boles, 71, of Fort Walton Beach, Fla., was the first of three "bell-



AP Photo/Brian Branch-Price, file

wether" cases scheduled for trial in the MDL to show the strength of each side's case and set a basis for settlements.

Boles took Fosamax from 1997 to 2006 and developed severe jaw disease in 2003.

Jury deliberations in her case began Sept. 2, following a three-week trial.

Merck defense lawyer Paul Strain said seven of the eight jurors signed a note indicating they agreed there was no proof Fosamax caused Boles's injury.

O'Brien said he expects Boles's case to be retried in the spring, after the next bellwether trials in the Fosamax MDL in January

and April. A trial in state court in Alabama is set for later this year.

Jaw death blamed on drug

More than 900 lawsuits have been filed against Merck & Co., claiming that the company's osteoporosis drug Fosamax causes osteonecrosis of the jaw (ONJ). Federal suits have been consolidated in the MDL in New York.

Fosamax belongs to a class of drugs called bisphosphonates, and is used by millions of women across the country to treat osteoporosis.

According to the complaints, Merck put Fosamax on the market in 1995 without warning users of the potential risk of ONJ.

Also called "dead jaw syndrome," a debilitating condition that causes the jaw to deteriorate, ONJ causes infections or sores on the jawbone and teeth to fall out.

The suits further allege that New Jersey-based Merck ignored Food and Drug Administration requests to place a warning about the risk of this condition on its packaging.

Before the mistrial was declared, Howard Erichson, a professor at Fordham University Law School and co-author of the Mass Tort Litigation Blog, predicted that a mistrial would be a disappointment to both sides because it offers "very little information to either side."

"Judges schedule bellwether trials to help the parties get information about the strength of the cases so that the parties can reach a broad settlement of the claims. No judge wants to try 1,000 separate plaintiffs' claims in a mass tort litigation," he said.

Often, however, neither side wants to settle until they "have a clear picture of how jurors are going to react to the evidence," he explained.

"When a MDL judge, like Judge Kennan, schedules bellwether trials, all eyes are on that first trial," Erichson said.

Another hurdle for plaintiffs in the remaining Fosamax litigation may be the issue of causation, according to Prince.

"There just isn't much evidence one way or the other as to whether exposure to bisphosphonates can cause jawbone deterioration," he said.

MMLR

Questions or comments can be directed to the writer at: nora.tooher@lawyersusaonline.com

Health insurers sued for underpaying doctors

Continued from page 5

company paid for chiropractic services, a Massachusetts appeals court ruled that Ingenix data lacked the "requisite indicia of reliability to be admissible" in Massachusetts courts. (*Davekos v. Liberty Mutual*, 2008 Mass.App. Div. 32, 2009 WL 241613 (Mass. App. Div.))

The court said that evidence showed that Ingenix did not verify the accuracy or completeness of the data it used to develop its database products.

Francis A. Gaimari, an attorney at Fireman & Associates in Needham, who represented chiropractor Michael Davekos, said he has been fighting over the issue of out-of-network payments since the mid-1990s.

"I'm saying to myself, 'Doesn't there have to be some sort of proof of the scientific reliability of this database before it comes into evidence?'" said Gaimari, who specializes in representing medical providers in statutory claims against insurance carriers.

"Over the years, this stuff just never made sense," he added. "You would see fee reviews done for different doctors on the same day or same week in the same location, and there

would be different amounts for reimbursement of the same service."

In January, the AMA announced that it had reached a tentative settlement in a lawsuit it filed along with the Medical Society of the State of New York, the Missouri State Medical Association, and several other state medical societies against UnitedHealth.

Under the agreement, UnitedHealth pledged to pay \$350 million to settle claims that it underpaid reimbursements to patients and providers for out-of-network medical services.

The insurer also agreed to shut down Ingenix and to pay \$50 million toward establishing an independent nationwide database.

Hufford said he is hopeful the settlement in the UnitedHealth case can be finalized this fall, and that the independent database will be established under the auspices of the New York Attorney General. MMLR

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Bills, Rules & Regs



From Beacon Hill

Pandemic response bill passes Senate

The state senate has unanimously passed a pandemic flu preparation bill that had languished in the Legislature before the recent swine flu outbreak.

The "Pandemic Response Bill," S. 2028, now awaits approval in the House. Both branches have taken it up in past years, but have not been able to agree on the details.

The bill would, among other things, allow authorities to forcefully quarantine citizens in the event of a health emergency, protect health care providers from liability for vaccinating patients, authorize forceful entry into private dwellings and destruction of private property, and impose fines for non-compliance.

If citizens refuse to comply with isolation or quarantine orders in the event of a health emergency, they could be imprisoned for up to 30 days and fined \$1,000 per day that the violation continues.

Coakley proposes regulation against health discount plans

Attorney General Martha Coakley has proposed a regulation aimed at requiring detailed disclosure from "medical discount plans" seeking to lure consumers with promises of special deals on health services.

Discount plans do not meet minimum coverage standards as required by state law and are not considered health insurers, according to Coakley.

"Under a medical discount plan, the member receives a discount, but is obligated to make all payments for services provided," she said.

The regulation would require discount plans to disclose exactly how they work and whether they are limited to certain services or products from certain providers. They also would have to make clear that they do not represent insurance plans.

The regulations also require the release of lists of health care providers that offer additional discounts for members of such plans.

Bill aims to restrict teen tan booth use

Calling tanning booths "cancer-dispensing machines," Sen. James Timilty, D-Walpole, urged the state Committee on Public Health to approve legislation that would prohibit state residents under 16 from using tan-

ning booths and residents under 18 from working at tanning salons.

Timilty was flanked by professional dermatologists who cited research that regular use of a tanning booth can increase a person's likelihood of melanoma by 75 percent.

"The FDA has ruled that tanning rays are carcinogenic agents," said Martin Cohn, associate director of the Massachusetts Academy of Dermatology. The effect of 20 minutes of tanning, he said, equals five hours of natural sunlight.

The bill would require that 16- and 17-year-olds who use tanning booths receive parental consent, after parents are provided copies of literature describing the risks of artificial tanning.

Doctors slam midwife, naturopath legislation

Massachusetts legislators are considering bills that would establish separate boards of registries for midwives and naturopaths and that would allow certified nurse anesthetists to prescribe certain medications, according to *The Boston Herald*.

But the Massachusetts Medical Society opposes all three measures, saying they aren't good medicine.

The so-called "midwives bills" seek to establish a board of registration for lay and nurse midwives.

Supporters say the move will create statewide practicing standards for midwifery. But MMS says that the measures don't ensure adequate oversight of midwives and don't provide enough patient protection.

Other bills currently pending in the House and Senate would require that all naturopathic practitioners in Massachusetts be held to certain standards of education and training.

Supporters of these measures say that extending prescribing rights to certified nurse anesthetists will streamline onerous medical procedures, while critics contend that it will disrupt the current prescribing system.

Physician assistants seek reimbursement

Physician assistants argued this summer before the state Legislature's Financial Services Committee that the care they provide should be reimbursed by insurers.

They contended that such a change would increase patient access to care and prevent unnecessary and costly emergency room visits.

Physician assistants said they often provide care to low-income patients, and noted that care provided by nurse practitioners, nurse midwives and nurse anesthetists is reimbursed.

"This does not increase the cost of health care," said Robert McQuaid, a physician assistant in private practice.

The assistants spoke on behalf of a bill, H. 948, sponsored by committee co-chair Rep. Peter Koutoujian, D-Waltham, and Senate Minority Leader Frederick Berry, that would allow physician assistants' care to qualify for reimbursement.



From Capitol Hill

Nonprofits excluded from health reform

Nonprofit organizations say they are upset that Congress and the Obama administration have not addressed their rising health care costs in the various proposals being floated on Capitol Hill, according to *The New York Times*.

The main bill in the House would award a tax credit to small businesses that provide their employees with health insurance – but nonprofits do not pay income taxes and thus would not benefit from it.

Some nonprofit groups have called for a subsidy along the lines of the Earned Income Tax Credit, in which money would be returned to organizations that demonstrate they have paid for an employee's health care.

Physicians billing for services by unqualified staff

The Department of Health and Human Services inspector general's office is concerned that physicians are billing Medicare for services provided by individuals who lacked the training, experience or license to complete them, according to *Modern Physician*.

A new report looks at a sample of 2007 Medicare claims in which more than 24 hours of services were billed for a single day to look for services not personally performed by the billing physician.

Medicare covers but does not explicitly track these services, which are considered "incident to" the physician's direct care.

The review found that 21 percent of such services in the sample were performed by someone either without – or without proof of – the appropriate credentials to do so, representing \$12.6 million in paid claims.

The inspector general's staff concluded that the Centers for Medicare and Medicaid Services should require a code modifier identifying the services physicians hand off to others.

CMS called that option "operationally difficult" because of the way these codes are typically shared among physicians and staff.

In about half the cases, the person who provided the care lacked the necessary certification or license. In the remaining cases, the staff member either lacked required training or the physicians failed to document his or her qualifications.

The rules governing Medicare allow physicians to bill for services performed by any

staff member, licensed or not. CMS wants the agency to change that policy, *Modern Physician* reported.

U.S. allocates \$1.2B for electronic records

The U.S. government announced grants of almost \$1.2 billion to help hospitals and health care providers establish and use electronic health records, according to Reuters.

The grants include \$598 million to set up approximately 70 health information technology centers to help health care institutions acquire EHR systems and \$564 million to develop a nationwide system of health information networks, Vice President Joe Biden's office said in a statement.

National Coordinator for Health IT David Blumenthal said these funds will likely be granted in three cycles over the course of 2010.

The grants will be funded by the American Recovery and Reinvestment Act of 2009.

Senator seeks to stop medical ghostwriting

A senator who helps oversee public funding for medical research is putting pressure on a federal agency to crack down on medical ghostwriting, according to the *New York Times*.

Senator Charles E. Grassley, R-Iowa, who has led a long-running investigation of conflicts of interest in medicine, has urged the National Institutes of Health to take disciplinary action against individuals who engage in the controversial practice.

A growing body of evidence suggests that doctors at some of the nation's top medical schools have been attaching their names and lending their reputations to scientific papers that were drafted by ghostwriters working for drug companies – articles that were carefully written to help the manufacturers sell more products.

Experts in medical ethics condemn this practice as a breach of the public trust.

FTC moves 'red flags' rule deadline to November 1

The Federal Trade Commission will wait until Nov. 1 to enforce a provision of the "red flags" rule requiring physicians and hospitals to adopt written plans for tracking and responding to indicators of identity theft in their billing operations.

The rule had been set to go into effect on Aug. 1. This is the third time the FTC has changed the date, and the agency is again promising additional resources and guidance to help businesses understand if the rules apply to them.

The requirement initially was supposed to be enforced beginning in November 2008, but the agency offered a reprieve in response to confusion about the rule, which stems from the Fair and Accurate Credit Transactions Act of 2003.

In the FTC's view, hospitals and physicians are "creditors" for purposes of the rule because they accept deferred payment for their services.

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Course Fees

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Course Information

Intended Audience

This course is intended for physicians and allied health professionals.

Course Objectives

- Provide physicians and other health care providers with an understanding of barriers to electronic health record (EHR) adoption.
- Discuss federal and state plans for providing incentives to physicians who implement EHR systems.
- Learn about legal considerations before selecting an electronic health record (EHR) system.
- Highlight examples of successful electronic health record (EHR) implementations.

Course Credit

The Massachusetts Medical Society designates *Electronic Health Records Surge Despite Barriers* for a maximum of 1 *AMA PRA Category 1 Credit*[™]. Physicians should only claim credit commensurate with the extent of their participation in the activity.

This program meets the criteria of the Massachusetts Board of Registration in Medicine for risk management study.

Participants will receive a confidential report of their examination score. You must receive a score of 70% or better to receive *AMA PRA Category 1 Credit*[™]. A confirmation of credit will be issued at the end of the course to those who successfully complete the examination.

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Electronic health records surge despite barriers

By Kimberly Ashton

Although Massachusetts has a head start on the national effort to digitize medical records, much work remains to be done before the state can meet President Barack Obama's goal of having all health documents computerized by 2015.

The path ahead isn't straightforward, and physicians must pay attention to the potential legal risks involved in using electronic health records (EHRs). A number of technological and financial hurdles stand between the government mandates and getting the nation's medical system wired.

According to Kristina Barry, a spokeswoman for the state Office of Health and Human Services, 90 percent of private medical practices in Massachusetts are still not using EHRs. It can take years to select a vendor and set up electronic records in a typical medical office.

To meet deadlines and be eligible for incentives, physicians should start preparing now for the complete transition to electronic records, said James Bush, director of practice services at Massachusetts eHealth Collaborative.

"In order to qualify for incentives, providers really need to act now," Bush said.

Incentive payments for physicians who implement EHR systems are scheduled to begin in 2011 for doctors who have EHRs that meet a "health information standard" and a "meaningful use standard," neither of which has been defined yet, Bush said.

The Centers for Medicare and Medicaid Services (CMS) will be leading the formal rulemaking process to define "meaningful use standard" under the new law, according to discussions at a federal HIT Policy Committee in mid-June.

Failure to switch to EHRs won't just result in missing out on funding. As of 2015, adoption of EHRs will be required for physicians to gain hospital licensure. And 2012 is the deadline for computerized physician order entry systems, Bush said.

The federal American Recovery and Reinvestment Act, passed Feb. 17, allocated nearly \$20 billion for health information technology across the country.

"We estimate approximately \$500 million over five years in [federal funding] will be given to Massachusetts," said Barry.

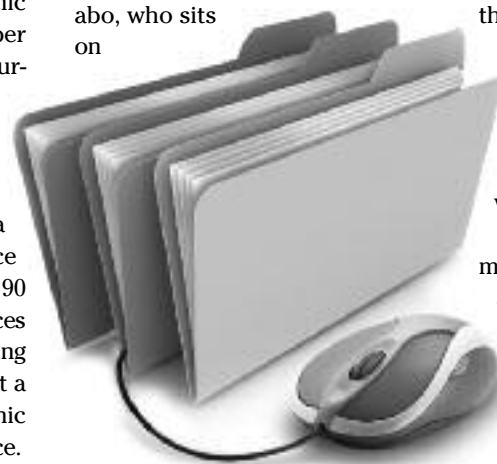
States are required to match \$1 for every \$10 provided in federal EHR implementation grants in 2011, \$1 for every \$7 in 2012, and \$1 for every \$3 in federal grants in 2013 and beyond.

In order to make sure the state has funds allocated to match the expected federal funds, the state Legislature in August allotted \$25

million per year over the next seven years for adoption of health information technology. The amount was later cut to \$15 million, with funding allocated only for one year.

Before the state doles out the money, the state's nine-member Health Information Technology Council – which was appointed by Gov. Deval Patrick – must first decide how it will be distributed.

Attorney David Szabo, who sits on



the council and is a partner at Nutter, McClennen & Fish in Boston, said the council will have control over allocating the state funds, but it's still unclear what role it might play in doling out the federal money.

The council is now in the process of gathering feedback from health care providers, software engineers and other interested parties, and there is no date set to distribute the funds, according to Szabo.

A costly endeavor

Although most large providers, such as Beth Israel Deaconess Medical Center, have already implemented EHRs, many small medical offices have found it cost-prohibitive.

Dale Magee, former president of the Massachusetts Medical Society, estimated that only 10 percent of small practices use EHRs.

Barry agreed with this figure, and said that two-thirds of hospitals need additional resources to have fully integrated electronic records in place.

"Financial barriers are viewed as having the largest effect on the decisions to implement [electronic records]. The [health] council will be working to alleviate these barriers," Barry said.

EHR software runs well over \$10,000 per doctor, and support can easily cost 15 to 20 percent of that each year, said Magee, whose office has been using EHRs since 2002. Even if a physician's office has the capital to invest in such software, there is no guarantee that the program won't be obsolete in a few years, requiring a large, new investment to update it.

On the flip side, politicians often cite cost savings as one of the main reasons to transition from paper to computer.

But Magee is doubtful.

"I think you do better care [with EHRs], but you're not going to save money," Magee said.

Szabo agrees that EHRs won't produce an immediate savings. "In the short term it might not make the practice more profitable. It might require [doctors] to change business practices, [resulting in] a period of reduced productivity," he said.

Others, including Obama, claim that electronic records will reduce the cost of health care.

Legal, practical concerns

Doctors should pay attention to the details of the contracts they enter into with EHR software providers, Szabo said.

For one thing, they should determine to what extent the company selling the software will aid in implementing it, he said. Also, they should enter into some sort of agreement concerning IT support.

Physicians must also make sure their EHR systems comply with state and federal privacy rules, Szabo said.

Magee said his records are protected by a firewall and a series of passwords, a system that makes it impossible for outside persons to view the records but also allows him access to them when he is away from his office.

Many of the privacy concerns are based on "fear more than reality," Magee said. "There is far more harm done in medicine today by health care providers lacking information than by patients' privacy being violated."

Barry said that the council is looking into whether additional statutory protections will be necessary to protect patient privacy.

Another concern is that the many programs on the market are not interoperable – which means they don't allow one office's electronic records system to communicate and connect seamlessly with other offices' and hospitals' systems. And there has yet to emerge one dominant software player.

"The technology is where word processors were in the mid-1980s," Magee said in terms of compatibility. "The industry absolutely needs some interoperability standards to be stronger than they are at present."

He noted that he even finds it difficult to share information with other doctors who are using the same program, and that the IT support for the electronic records platforms tends to be inadequate.

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Questions or comments should be directed to the editor at: reni.gertner@mamedicalaw.com

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The Physician's Corner

Preparing for electronic health records (EHRs)

By Henry Tulgan, M.D. FACP

Part of President Barack Obama's proposed \$634 billion reserve fund to overhaul the American health care system includes implementation of electronic health records by 2015.

The plan also includes incentives for physicians whose EHR systems are in place by 2011.

While EHRs have existed for a full generation, adoption of them has been limited to date. In 2005, the National Center for Healthcare Statistics (NHSC) estimated that less than 10 percent of private practices use a "complete" electronic records system, though institutional practice usage is higher.

EHRs are intended to increase physician and institutional efficiencies in the long run, reduce costs and promote standardization of care.

In addition to individual electronic medical records, EHRs also include such things as Computerized Physician Order Entry (CPOE), e-prescribing, laboratory results, radiology and cardiology images. They may also contain insurance, billing and other demographic information. They are computer accessible over networks.

What are some of the potential advantages of EHRs?

First, EHRs allow for the elimination of physical space and records, which leads to a huge savings, along with minimizing paper copies and faxes. The reduction in handwritten notes as a result of e-prescribing is also likely to reduce medical errors.

Second, readily available EHRs are likely to reduce repetitive laboratory and imaging studies and minimize unnecessary hospitalizations.

Expanding the use of electronic records will also improve quality, clinical trials research, and communicable disease tracking, in addition to billing security.

Are there potential barriers to implementation?

• Cost

One obvious barrier is that EHR software costs more than \$10,000 per doctor to install, and support may cost \$1,500 to \$2,000 annually on top of that. It's still unclear how

the government will pay for these costs, estimated to be well over \$100 billion across the country. The federal American Recovery and Reinvestment Act of 2009 allocated \$20 billion toward this effort. These funds will go to the states, which will provide additional matching funds.

• Finding a system provider

Another concern is that there are hundreds of systems commercially available, some of which may not survive competition.

• Interoperability

Interoperability – the means for systems to communicate with each other – is yet another concern. However, this concern may be alleviated by the development of common IT standards, as well as new network and mobile technology solutions.

To address these concerns, the Office of the National Coordinator for Health IT funded initiatives to create a certification process to harmonize standards for EHR products and interoperability.

The Certification Commission for Healthcare Information Technology, established in 2006 by the U.S. Department of Health and Human Services, recommended minimum criteria for the certification of ambulatory EHR systems.

Qualifying EHR systems are listed on the Commission's website at <http://www.cchit.org/products/Ambulatory>.

• Converting paper records

Converting paper records to electronic ones can be difficult. Conversion can be done in a number of ways, including manual data entry, scanning or electronic conversion. Many practices choose a blended approach for converting their paper medical charts to an EMR system.

• Retaining records

Another concern will be how long and where EHRs should be retained. This issue will have to be resolved by federal and state law changes.

• Privacy and security

To protect privacy and ensure security of electronic records systems as required

by the Health Insurance Portability and Accountability Act (HIPAA) and state law, secure passwords and other protections will need to be developed for all users.

• Record review by patients

If records are maintained in a central repository, who will be responsible when a patient requests to review his or her records? If a physician employed by a health system leaves, who will be the responsible custodian?

Successful EHR models

Until a decade ago, the VA health care system was in deplorable condition. But implementation of an EHR, the Veteran's Health Information Systems and Technology Architecture (VistA), has linked all its 155 hospitals and 800 Outpatient Clinics and, despite a recent computer glitch, has revolutionized care. The success of this system has led to expanding the program to The Indian Health Service and The Department of Defense.

Also, in 2006, the United Kingdom National Health Service began to introduce EHRs and expects to cover 60 million people by 2010. Several Canadian provinces are also utilizing EHRs.

While this will be a difficult program at the start, the benefits of EHRs will clearly outweigh the startup costs and limit the spiraling cost of health care in the United States. Physicians need to be ready for this major change.

Risk management strategies

- Pay close attention to the details of the contract with your EHR software provider to determine if it is also providing the installation services.
- Insure that your EHR system complies with state and federal privacy rules.
- Confirm that your EHR system is interoperable and can communicate and connect with other provider offices and hospital systems.

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Please answer the following questions. A score of at least 70% is required to receive *1 AMA PRA Category 1 Credit*™. Deadline for completing the exam is October 5, 2010. Please make a copy for your records.

1. It is projected that electronic health records (EHR) will contain costs by significantly reducing duplication of laboratory and imaging testing.
 - ? a. True
 - ? b. False
2. Electronic health records (EHRs) will contribute to
 - ? a. quality improvement.
 - ? b. clinical trials research.
 - ? c. communicable disease tracking.
 - ? d. all of the above.
3. Successful implementation of EHRs has taken place in
 - ? a. VA hospitals.
 - ? b. Indian Health Service.
 - ? c. Department of Defense.
 - ? d. all of the above.
4. It is estimated that 50% of private medical practices in Massachusetts are still not using EHRs.
 - ? a. True
 - ? b. False

Please complete the evaluation portion of this activity. Your feedback is important in developing future educational programs. Please send additional comments to continuingeducation@mms.org.

Did this activity meet the stated objectives?
? Yes ? No

How do you rank the effectiveness of this activity as it pertains to your practice?
? High
? Average
? Low

Will you make any changes in your practice as a result of participating in this CME activity?
? Yes ? No

If yes, please explain.

How do you rank the quality of this education program?
? High
? Average
? Low

Did you perceive any evidence of bias for or against any commercial products?
? Yes
? No

What are your topics of interest for future CME activities?

Health care providers brace for Medicare audits

Continued from page 1

the country. "Health care systems are really struggling with preparing for this because they know it's just a nightmare. During the demonstration program, it was very broad in that RACs were given all the data and told to go out and find errors," said Steve Lokensgard, a health care lawyer and special counsel to Faegre & Benson in Minneapolis, who previously worked as chief compliance officer to Allina Hospitals and Clinics.

RACs work on a contingency fee basis, receiving between 9 and 12.5 percent of overpayments they discover, so there is a big incentive to find billing errors.

Massachusetts is among the states with higher fees – 12.45 percent.

"They're bounty hunters on behalf of the Medicare program," said Jessica L. Gustafson, a partner at The Health Law Partners in Southfield, Mich., who co-chairs the firm's Medicare and RAC practice group.

She noted that of the misbilling identified by RACs during the demonstration phase, 96 percent was for overpayments and only 4 percent was for underpayments by Medicare.

Two types of audits

There are two types of audits: automated audits and complex audits.

The automated audit is based on data mining and automated analysis and usually involves clear errors, such as if a provider billed for duplicate procedures performed on the same patient on the same day.

Automated review began in Massachusetts in August.

A complex audit requires an auditor to request medical records and typically involves areas susceptible to error based on the auditor's knowledge of the industry, said Lokensgard.

Complex reviews for coding errors are scheduled to begin in Massachusetts in October and November.

Reviews of records focused on whether the care that was billed was medically necessary are scheduled to begin in 2010.

"Once they get to the medical necessity reviews, I believe this is when individual providers will start to encounter the program in significant numbers," said Phyllis Flora, a health care attorney at Dwyer & Collora in Boston.

A medical necessity review may be triggered if Medicare suspects certain tests, billing codes or other services are being abused. This suspicion could be based on a higher use of those services in one area compared to the rest of the country, or on a rise in billing for certain codes.

In the past, Medicare has run reviews that focus on the medical necessity of power-chairs and ambulance services, Flora said.

She also said that durable medical equipment providers are specifically mentioned in the national rollout schedule and should be especially vigilant now in reviewing their record-keeping practices.

Gustafson predicts that Medicaid will step up audits under a parallel program similar to RAC called "Medicaid Integrity Contractors" (although MICs are not paid on a contingent basis).

Andrew Wachler of Wachler & Associates in Royal Oak, Mich., said he has already seen an increase in audits by private third-party payors, such as Blue Cross Blue Shield of Michigan.

Getting prepared

While large hospital systems appear ready for the permanent program, smaller physicians' offices that have more limited resources are less prepared.

"Our advice to clients of any size is you have to really pay attention to your compliance efforts. Now is the time to get your house in order," said Abby Pendleton, also a partner at The Health Law Partners in Southfield, Mich., who co-chairs the firm's Medicare and RAC Practice Group with Gustafson.

Within a 45-day period, a limit of 10 records can be requested of a solo practitioner, 20 records for a partnership and 30 records for a group practice, said Flora.

Health care providers are preparing for RAC audits by improving record-keeping and documentation and training employees.

Based on the demo phase, one area of focus will be in-patient hospital stays.

The vast majority of overpayments found by RACs in the demonstration phase – 85 percent – involved in-patient hospital stays, such as short stays or in-patient rehabilitation following surgery, said Gustafson.

Given these statistics, providers are reviewing their utilization review processes and whether physicians are admitting patients to the right area of the hospital, Wachler said.

"When providers take a close look at the records, maybe a patient met the criteria for an in-patient stay, but the documentation could be improved so that defending claims is easier," said Pendleton.

In preparation for the RAC program, Andrea Kloubec, senior director of compliance at Park Nicollet in St. Louis, Minn., has established a RAC committee and met with medical practitioners, such as in cardiology.

"If you look at one-day stays for congestive heart failure, should this have been in-patient or observation? If we found it should have

been out-patient, we set up protocols for [determining] whether it met in-patient or out-patient criteria," said Kloubec, who said there is software to help with these criteria.

Because her organization is a hospital, clinic, hospice, homecare and durable medical equipment provider, she also created five RAC response teams and completed a demonstration of a RAC request. She then tracked how long it took the teams to respond and what the outcomes were.

"We've timed every person in all stages of doing the RAC response" in order to find which areas could use improvement, said Kloubec.

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Questions or comments can be directed to the writer at: sylvia.hsieh@lawyersusaonline.com

More appeals expected

As the RAC program expands across the country, health care providers are expected to appeal more "denials" – the term for a RAC claim for overpayment to a provider.

Although only a small percentage of denials were appealed during the demo phase, this is likely to change.

"In the permanent program, health care providers are going to be more interested in appealing and fighting these denials," said Steve Lokensgard, a health care lawyer and special counsel to Faegre & Benson in Minneapolis, who previously worked as chief compliance officer to Allina Hospitals and Clinics.

The appeals process has five levels, including a hearing before an administrative law judge and a fifth stage before a U.S. District Court.

It's important for providers to hire an attorney early on, as soon as they get a request for records, said Phyllis Flora, a health care attorney at Dwyer & Collora in Boston.

Jessica L. Gustafson, a partner at The Health Law Partners in Southfield, Mich.,

agreed.

She noted that hiring a lawyer before the hearing stage helps create a record for presenting and preserving evidence for the next level.

Attorneys who have represented health care providers in RAC appeals said they have had a high success rate.

"These appeals are winnable," said Gustafson, who co-chairs her firm's Medicare and RAC practice group.

Abby Pendleton, who co-chairs The Health Law Partners' Medicare and RAC Practice Group with Gustafson, said appeals can be made on two grounds.

Some appeals are based on the substantive merits of a claim – such as by presenting a physician's testimony as to why a patient was treated as an in-patient rather than as an out-patient.

Others are based on legal grounds – such as whether records are beyond the time frame of allowable requests or whether the standards for determining in-patient care were clear.

–Sylvia Hsieh

Credentialing file isn't protected by peer-review privilege

Continued from page 1

insurance information (including malpractice claims), licensing information, controlled substances certifications, and professional references and evaluations.

In this case the Board was investigating a doctor for allegedly omitting a criminal charge on his license renewal application and practicing while impaired by alcohol or drugs. When it subpoenaed the information in the credentialing file from Hallmark Health Corporation, Hallmark refused to comply on the grounds that the documents were protected by the peer-review privilege.

But according to the court, only "core" peer-review documents, such as proceedings, reports and records, can be withheld from the Board prior to a formal proceeding. Other documents must be produced if they are "less central" to peer review.

The court sent the case back to a trial judge

to decide which specific documents in the file were "core" and which were "less central."

'There will be a lot of fights'

Some lawyers and doctors are concerned that the court's ruling will create a great deal of uncertainty about what documents are privileged.

"Anytime there are inroads being made into privileged materials, there is always the fear of a slippery slope," said William S. Eggeling of Ropes & Gray in Boston. "If the lawyer says the line is gray, which they really have to say at this point, then the question of how to guide [a medical provider client] becomes much harder because it's not perfectly clear what can and can't be done."

"I think there will be a lot of fights in the next few months as a result of this decision over whether a particular document is covered," added Dean

P. Nicastro of Pierce & Mandell in Boston, who co-authored an amicus brief in support of Hallmark.

Nicastro said that the burden will be on hospitals to make sure documents are generated by a properly structured medical peer-review committee process in order to protect them.



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But Max Borten, a medical-malpractice plaintiffs' lawyer and a physician, praised the ruling and said he believes it will curb medical providers who have been "trying to expand peer review to things the statute never intended to be covered."

According to Borten, who practices at Gorovitz & Borten in Waltham, "the SJC is going to look very carefully at the statute and not buy wholesale arguments that peer review protects every document ever created and ever given to a hospital."

Borten contended that concerns that the decision will erode the genuine peer-review privilege are "baloney." He notes that the decision only applies to the Board, and will not affect public or plaintiffs' attorneys' access to documents.

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Questions or comments should be directed to the writer at: david.frank@lawyersweekly.com

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Social networking 101 for physicians: Managing the risks

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[tweet], the easier it is to slip up and give identifying information," says Pho, who has more than 500 Facebook fans and 14,000 followers on Twitter, a "microblogging" site where users can post 140 character "tweets" on issues of interest.

Daniel Palestrant, the Cambridge-based founder and CEO of Sermo, says the same is true for doctors posting on his site.

"Though Sermo is a secure site and we make every effort to keep information in the community, there may be situations where information is cut and pasted out or someone is motivated to pull information out of the community in one way or another," says Palestrant, himself a physician.

Confidentiality issues may also arise when doctors allow patients to post on their websites or Facebook pages. A patient might be too open in a "wall" post and later realize he's made his own information public. He might then blame – and perhaps sue – the doctor.

"Once a patient posts, [he or she has] essentially consented that it be public, but most [patients] won't view it that way," says Harlow.

There's no guarantee such a case would hold up in court. But to be safe, Harlow advises doctors to block patient access to their personal Facebook pages, and provide clear warnings on any public sites against posting medical information.

- **Remember that your patients are not your 'friends.'**

A physician who gets too close to his patients puts himself at risk.

That's why Cambridge internist Phoebe Cushman refuses to accept Facebook "friend" requests from current or former patients.

"I just hit 'ignore.' ... I think it's very important to have boundaries in the physician-patient relationship," says Cushman, who also maintains the strictest privacy settings on her account.

That's a good approach, says Harlow, suggesting that doctors set up a separate page representing their practice and enabling patients to become "fans."

"This is a way of connecting and allowing folks to follow your updates without blurring that personal/professional line," he says.

- **Monitor your web presence regularly.**

Harlow points out that the pervasiveness of social networking has resulted in some people transmitting all their communication through Facebook and Twitter and expecting others to be there to receive their messages.

Doctors who enable such communication without properly monitoring their sites run the risk of missing urgent messages or a patient's medical history details and possibly facing a malpractice action for failing to respond, he says.

ment in how you communicate with people, perhaps you could be charged with at least looking at it on a reasonably regular basis and being aware of information sent that way," he says.

Palestrant reiterates Sermo's extensive physician verification process, adding that when a user clicks on another member's profile, he or she can see the member's specialty, the history of his activity on the site, and his rating by fellow users.

Nonetheless, Palestrant adds, physicians should of course solicit information from multiple sources, such as journals, peers, or non-physician colleagues such as nurses and physician's assistants.

- **Be aware that you're never truly anonymous on the web.**

In 2007, a Boston-area pediatrician, known as "Dr. Flea," blogged about his ongoing medical defense, sharing candid musings on defense strategy, the jury, opposing counsel and the plaintiff's case.

He thought everything was safely cloaked in anonymity until his cross-examination at trial, when plaintiff's counsel – who had been following the blog and noting similarities – outed him to the jury. The case settled the next day.

Szabo says this is a cautionary tale that anything posted on the web can be traced back, with severe consequences.

"When you start throwing in little details, if you have any connection to someone, it may not be too tough for that person to figure out who you are," he says.

Pho adds that anything you write on Twitter or your blog is indexed by Google and kept permanently.

"So never write anything disparaging about your hospital, patients or other doctors, because it can be found," he says.

Further, Szabo warns that Internet service providers, websites and social-networking companies are under no obligation to resist subpoenas in a civil lawsuit. Accordingly, they might decide to produce information like an IP address or e-mail address that could identify the name of a person who posted offending content.

Finally, says Tobin, the existence of vehicles like Facebook and Twitter does not change existing copyright, slander and libel laws.

"We're under the same restrictions we've always been under," he says. "The only difference is that saying something is much easier. You can send a tweet or a Facebook status update in seconds. So you need to pause and think before you hit that 'update' button." **MMLR**

Questions or comments should be directed to the editor at: reni.gertner@mamedicallaw.com

Social networking tips



- **Be mindful of patient confidentiality.**
- **Remember that your patients are not your 'friends.'**
- **Monitor your web presence regularly.**
- **Take advice from online doctors' forums with a grain of salt.**
- **Be aware that you're never truly anonymous on the web.**

While social media is obviously not a reliable means of clinical communication with a doctor, it's hard to tell where a jury's sympathies might lie.

"There are now more than 300 million Facebook accounts," says Harlow. "Do you run the risk of going to trial and facing a jury full of people who rely on Facebook as their primary means of communication? They might say someone should have been monitoring the account."

David S. Szabo, a partner at Edwards, Angell, Palmer & Dodge in Boston, agrees.

"If you start using [social media] as a means of regular communication or an ele-

- **Take advice from online doctors' forums with a grain of salt.**

Physician-only discussion boards like Sermo have become a valuable replacement for the traditional "curbside consult" with colleagues about complex cases.

But Harlow warns that free advice is "worth what you pay for it" and thus "should be taken with a grain of salt." After all, relying on advice outside the standard of care could constitute malpractice.

Also, since all users post under pseudonyms, "you have to be confident that whoever's replying [to your inquiry] is who they say they are," says Pho.

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