

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 stan-

dard," 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 does out the money, the state's

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Med-mal filings fall in Massachusetts

By Julia Reischel

The number of medical-malpractice lawsuits filed in Massachusetts has been declining over the past several years, suggesting that attorneys who represent patients are exercising greater caution in the cases they accept, according to lawyers and insurers.

Statistics released by the state Administrative Office of the Trial Court show that 485 med-mal cases were filed in 2008, compared to 724 in 2003.

The state's biggest medical-malpractice insurer says that the decrease in filings is part of a nationwide trend that appears to have no single, obvious cause.

"There's really no one specific reason you can point to," said Michael R. Kubik, vice president of marketing at ProMutual Group, which insures health care providers.

Still, insurers, doctors and lawyers believe that two factors have played a role in reducing the number of med-mal cases filed in the

state: patient safety improvements and the rising cost of litigation.

"There has been a lot of attention and focus on [making] it safer to practice medicine," said Bruce S. Auerbach, immediate past president of the Massachusetts Medical Society. "We believe that there's a direct correlation between those activities and the reduction in suits that have been filed."

Auerbach added that MMS hears complaints from plaintiffs' lawyers about "the cost, both in actual dollars as well as in time that they must expend to develop a malpractice case." He speculated that the high cost of med-mal litigation is prompting attorneys to decline weaker cases that are "on the cusp."

Kubik said ProMutual, too, has observed that plaintiffs' lawyers in recent years have been "much more selective in terms of the types of case they're bringing to bear against insurers and doctors."

One of those lawyers is Robert M. Higgins, who practices at the

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Bruce S. Auerbach

Medical experts are facing complaints over their testimony

By Sylvia Hsieh

Physicians and medical experts who testify on behalf of patients in medical-malpractice cases say they are increasingly being singled out and accused of ethical violations of medical associations' rules.

In a growing trend, many medical associations are creating ethics complaint procedures that allow scrutiny of expert testimony by their members as false, deceptive or misleading.

The American Medical Association has taken the position that

expert testimony is the "practice of medicine," and some states have followed suit.

AMA spokeswoman Robert Mills said that the organization has also filed briefs in legal cases supporting medical societies' actions in disciplining member physicians for allegedly false testimony.

The medical societies say that the ethics procedures allow them to help maintain professional conduct standards and ensure unbiased expert testimony.

"The concept that medical as-

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In a med-mal case, 'who loses least?'

Rarely do I receive a call from a physician who wants to talk about his or her recent experience as a defendant in a medical malpractice case. We have printed only one such report, in Autumn 2007, "A doctor on trial: David Sugarbaker tells his story."

And who can blame a doctor who's finally finished with a trial for not reporting his or her story? Physicians who go to trial report feelings of self-doubt and anxiety, wanting

nothing more than to put the entire ordeal behind them as soon as possible.

That's why a recent series of blog posts entitled "The Trial of a WhiteCoat" caught my eye. Here is an excerpt:

"Medical malpractice is a game where neither side wins. On one side, patients suffer bad outcomes – some due to medical negligence, some not. On the other side, an accusation of medical malpractice cuts to the soul of any medical provider ... During the many years inherent to any malpractice litigation, both sides are forced to relive these bad moments over and over again. Both sides are forced to listen to other people question their actions and accuse them for being at fault. It isn't a matter of who wins in a lawsuit, it's a matter of who loses least."

This excerpt accompanies the genuine and complete expose that an emergency room physician dubbed "WhiteCoat" began writing in June on the WhiteCoat's Call Room blog at Emergency Physicians Monthly, <http://www.epmonthly.com/whitecoat/trial-of-a-whitecoat/>.

While it's clear that a med-mal trial doesn't make either side feel like a true winner – no matter what the legal result – this series encapsulates a rarely mentioned similarity between the patient and the doctor, the plaintiff and the defendant, whose uniquely private relationship has become a matter of public concern now that an injury is on the table.

Quite frankly, we need more doctors like WhiteCoat willing to share their stories.

Open discussion of such cases significantly helps doctors who will face lawsuits in the future.

Could we already be seeing progress in this regard? In this era of blogging, instant information and medical professionals being more transparent about medical errors, the number of medical malpractice lawsuits filed in the state and in the nation has been trending down over the past several years. See the story on page 1 and the data on page 7.

Here's hoping that's a trend that continues.

Reni Gertner, MPH

Editor's Note



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Why saying 'I'm sorry' helps to heal

Patients' attorneys shed light on the benefits of apology

By Jeffrey N. Catalano, Esq.
and Lisa G. Arrowood, Esq.

Mediation in a medical negligence lawsuit we handled last year started like any other, but took an unexpected twist.

The case involved the tragic death of a young girl, whom we will call Samantha, from an undiagnosed and untreated shunt malfunction in her brain.

At the start of the mediation, we, as the attorneys for her parents, made a presentation of the case and the evidence in support of our position.

There was no attempt to demonize the doctor, but just to explain in a professional manner the mistakes he made that led to her death. Samantha's mother then spoke about the hole in their life created by their daughter's death.

One of the most emotional moments was when she said that the dress she had purchased for her daughter to wear at her junior high school graduation that spring ended up being the dress in which she was buried.

One of the defendants, a pediatrician whom we will call Dr. Jones, appeared at the mediation out of respect for Samantha.

This case demonstrated that lawsuits can allow for what otherwise would not happen – reconciliation.

He listened intently to the presentations about the mistakes he had made and the devastation they caused Samantha and her family. He then asked to speak.

He said that he wanted the parents to know that he thought of Samantha all the time, and that he was sorry for what had happened. He made an honest evaluation of his mistakes and accepted responsibility for her death.

He expressed heartfelt sentiments of sorrow and conveyed that Samantha was more than just a patient to him. He missed her too. He stayed throughout the day-long mediation.

At the end when the case settled, he asked the parents if he could hug them, and they embraced.

None of us was sure how the parents would receive this. Would it deepen their anger? Would it add to the hurt? Would it

make them feel guilty for bringing the suit? Yet none of that happened.

At the moment, they appeared stunned. But a few days later, Samantha's mother wept from a sense of tremendous relief.

She had lived for years wondering if her daughter's death was somehow her fault. As parents like these know, when a child gets hurt or dies, the awful thoughts that can haunt them are, "Could I have done something more, something better, something different, to save her?"

Those thoughts vanished that day once Dr. Jones apologized. Dr. Jones did not save Samantha, but he did save her parents. Surely it also helped Dr. Jones heal, which he too deserved. The integrity and courage he displayed were inspiring.

Unfortunately, it almost never happens that a physician acknowledges his mistakes so forthrightly.

Instead, the usual instinct is to duck and dive. This only adds to the anguish felt by those who have suffered a loss.

Surely both sides to a lawsuit find the process very unpleasant and difficult. However, this case demonstrated that lawsuits can allow for what otherwise would not happen – reconciliation.

For this to happen, everyone must come to accept that medical mistakes do occur and that people do suffer from them.

But just as importantly, we should all realize that the physician's power to heal can be brought to bear even in the context of litigation.

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Listening In

The news beat of the medical profession



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Insurer develops program for 24-hour doctor access

Health insurer UnitedHealth Group says it is developing a service that will allow people to talk to a physician at any time on the phone or online through a collaboration with Boston-based American Well Corp.

The proposed service would be offered nationwide to the 60 million patients covered by UnitedHealth Group Inc.'s OptumHealth subsidiary.

UnitedHealth said it would combine Internet technology developed by each company: OptumHealth's eSync Platform sends a patient's health care information to doctors, and American Well's Online Care platform allows patients and doctors to talk in real time.

OptumHealth patients would have 24-hour access to local doctors through two-way video chat or secure online chat, on the phone or through the use of company websites.

Minnetonka, Minn.-based UnitedHealth is the nation's largest managed care company based on revenue. American Well was founded in 2006.

M.D. brings defamation suit against hospital

A former chief of Holyoke Medical Center's emergency room who raised concerns about patient safety has filed a defamation lawsuit against the hospital and three administrators.

Dr. Paul Gerstein claims in his lawsuit, filed in Suffolk Superior Court, that his medical reputation has been "shattered" and that he is making less money because of "false and defamatory statements" made by the defendants.

Gerstein prompted an investigation by the state Public Health Department in 2007 when he claimed that emergency room nurses were inexperienced and valued speed over quality of care.

Hospital not liable to third party

The Massachusetts Supreme Judicial Court has ruled that a police officer who was injured while responding to an emergency involving a patient discharged from Brockton Hospital cannot hold the hospital liable.

The officer alleged that the patient, who was hit by a car, should not have been released from the hospital without an escort after receiving sedating medication for a colonoscopy.

But the state's highest court disagreed, finding that the hospital owed no duty to the officer to control or detain the patient.

Chief Justice Margaret H. Marshall said that the officer's injury "was not 'caused' by the hospital because it falls outside the scope of foreseeable risk arising from any negligent conduct that would make the hospital's alleged misconduct tortious."

Town board objects to hospital expansion

The Framingham Board of Health has released a report challenging statements by the head of Newton-Wellesley Hospital regarding a proposed surgical center, according to the MetroWest Daily News.

The project in question would see Newton-Wellesley place four orthopedic operating rooms and four endoscopic procedure rooms in a former CompUSA store. While Newton-Wellesley says the project is meant to relieve pressure at its Newton campus and handle existing patients, MetroWest Medical Center believes the project will siphon higher-paying cases and jeopardize its operations.

"The contention that the facility chosen by [Newton-Wellesley] is the best location for its needs is not supported by the facts, and leads to contradictory and very troublesome statements by the president," the board wrote.

After holding two hearings, the Board of Health asked the state to examine whether the surgical center is warranted. While the \$17.5 million project appears to fall below the \$25 million threshold for review, town attorney Christopher J. Petrini believes the statute makes an exception for surgical centers.

Should the state fail to act, the board voted to file suit, the Daily News reported.

Hospitals: Obama likes Mass. health plan

With President Barack Obama adopting the same buzzwords as hospital advocates who support Massachusetts's landmark health insurance access program, those advocates are convinced that his vision for health care mirrors their own.

"President Barack Obama likes the Massachusetts health care reform model," the Massachusetts Hospital Association wrote in a report to its members, citing Obama's letter to Sens. Edward Kennedy, D-Mass., and Max Baucus, D-Conn., the two senators with jurisdiction over a potential national health care reform bill.

In his letter, Obama praises the concept of "shared responsibility" – cooperation between individuals, employers and government – to help finance such a plan. He also supports the idea of a "health insurance exchange," similar to the state Connector Authority, a clearinghouse of health plans given a seal of approval by a state-appointed board.

In his letter, Obama wrote that he is open to a mandate for individuals to purchase health insurance, which Mass. leaders have described as essential to the state's plan. In Massachusetts, 98 percent of residents have health insurance, the highest rate in the nation.



HIV-positive patients file suit against MGH

Four HIV-positive patients have sued Massachusetts General Hospital after a hospital billing manager left documents containing the patients' names and diagnoses on an MBTA train, according to Bay Windows.

The manager, who was riding on the Red Line, mistakenly left behind records bearing the names of 66 patients who received care at the MGH Infectious Disease Associates clinic.

The files contained the patients' Social Security numbers, the names of their doctors and their HIV status.

The patients' attorney, John Yasi of the Salem law firm Yasi and Yasi, has filed a motion to make the suit a class action representing all 66 patients, many of whom are also HIV-positive.

Physician sanctioning vastly underreported

Thousands of hospitals failed to report privilege sanctions against physicians, according to a recent report by Washington, D.C.-based Public Citizen.

Federal law requires hospitals to report a physician to the National Practitioner Data Bank whenever they revoke or restrict the physician's privileges for more than 30 days for an issue involving medical competency or conduct.

The U.S. Public Health Service estimated that 5,000 adverse actions per year are reportable, while the American Medical Association estimated 10,000 actions per year.

According to the report, though, since the Data Bank opened nearly two decades ago, it has received only 11,221 reports.

The report also revealed that 49 percent of U.S. hospitals have never submitted a clinical privilege sanction report on a physician.

According to the study, hospital reporting varies by state. For example, about 70 percent of the hospitals in Louisiana have never reported a physician, while only about 25 percent of the hospitals in Connecticut have never issued a report.

MMS outlines policies at delegates' meeting

The Massachusetts Medical Society adopted resolutions and policies on a range of important health topics at its annual House of Delegates meeting in May in Boston.

Among other things, the delegates approved:

- A mandate that physician performance measurements be evidence-based;
- Having the MMS representative on the state's Special Commission on Pay-

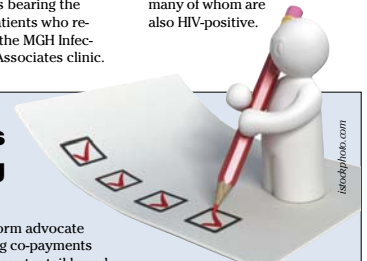
ment Reform advocate for making co-payments for services at retail-based clinics, such as Minute-Clinic, equal to or higher than those for a basic office visit;

- Supporting legislation to reduce secondary smoke exposure; and
- Proposing the state Legislature with scientific information regarding foods of low nutritional value to as-

sist lawmakers in enacting public policies.

Other resolutions considered by the delegates involved e-prescribing, electronic health records, nondiscrimination and organizational bylaws.

The complete list of resolutions is available at www.massmed.org/annual09.



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Doctors try to stop patients from rating them online

By Peter Vieth

An increasing number of physicians across the country are trying to control what patients say about them on physician rating websites by requiring patients to sign agreements stating that they won't make comments about them without their permission.

The rapidly growing Internet rating services offer a unique forum for people to talk – with no reservations and often no signature – about their experiences with individual doctors.

Although most reviews are positive, other online comments can be blunt and harsh.

For example, this comment was offered about a Massachusetts psychiatrist on the RateMDs website: "He has a glazed look and doesn't seem all there. His appointments consisted of me talking and him saying virtually nothing. They also last about three or four minutes."

On the same site, a family physician was blistered with this comment and accusation: "I can't believe this guy is still practicing. I got rid of him a few years ago after he prescribed the wrong medicine to one of my family members."

In response to such negative reviews, some medical offices are asking patients to sign agreements limiting their freedom to post reports about the doctors on the Internet. Free speech advocates, meanwhile, question whether doctors should condition medical treatment, even elective treatment, on an agreement to curb public comment.

A North Carolina-based organization that sells privacy agreement forms for doctors says the web-based criticism can be unfair.

The fact that a single anonymous comment can poison the reputation of a medical provider rankles former North Carolina neurosurgeon Jeffrey Segal. He started a business called Medical Justice six years ago to provide various legal protections to doctors. He has now added a "mutual privacy template" to his menu.

Under such an agreement, a patient agrees not to post about the doctor on the web without the doctor's permission. In turn, the doctor promises to provide a higher level of privacy than required by law, apparently by agreeing not to sell his patient list to marketing companies.

Shane Statler, a spokesman for Medical Justice, said that, in Segal's view, the medical rating sites "do more harm than good."

Statler explained that there is often no way to determine if posted comments actually come from a doctor's patient. He cited one instance where a competitor tried to blacken the reputation of a dentist by posting – falsely – that the dentist was a pedophile.

In addition, Statler said, a physician would be hamstrung by privacy laws if a patient decided to complain about a bad medical outcome. The physician would be barred from telling his side of the case to defend his practice.

"Doctors feel very isolated in their practice today," Statler said. "They feel they're targeted a lot, sometimes by frivolous litigation."

When a critical rating shows up on the Internet, he said, the privacy agreement provides recourse. The doctor can ask the rating site to take down the criticism by showing that all his patients had agreed to refrain from posting.

"It gives them a seat at the table," said Statler.



Rating sites catch on

Reviewing doctors online is a relatively new phenomenon, but apparently catching on quickly. The site Angie's List – which started by rating home contractors 14 years ago in Columbus, Ohio – began including health care reports only about a year ago. Founder Angie Hicks said her service now is receiving about 10,000 health care reports each month, about a quarter of all the reports they post.

"Consumers are looking for a trusted filter to help them make decisions," she said. Hicks said her website does not allow

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Medical experts are facing complaints over testimony

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sociations have some responsibility to enforce a code of ethics is gaining momentum. They don't want either side going off and testifying as rogues," said Russell Pelton, an attorney at McGuire Woods in Chicago who set up one of the first such committees for the American Association of Neurological Surgeons in 1983.

But the plaintiffs' medical experts say that they are being singled out because defense experts are rarely subjected to similar complaints, and the organizations bringing the complaints have a built-in bias against plaintiffs.

"There's been a big increase in these ethical complaints. These are not fair tribunals because they are held before a panel of self-interested parties, who are all interested in there being less med-mal litigation," charged John Vail, vice-president of the Center for Constitutional Litigation in Washington D.C., a plaintiffs' law firm.

"It's a hot issue," said Mark Whitmore, a partner at Bassford Remele in Minneapolis, who represents the American Academy of Ophthalmology.

In response, some medical experts are filing lawsuits against the associations and the complaining members for witness intimidation, defamation and interference with business contracts.

Chilling effect

Even the threat of an ethics complaint can have a chilling effect on medical experts' willingness to testify and an attorney's willingness to hire them.

"There is no doubt that it's had a chilling effect," said Dr. John H. Fullerton, an internal medicine and geriatrics physician in San



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Francisco who had a complaint brought against him by members of a medical society against whom he testified.

He testified as a medical expert for a Florida plaintiff who suffered a stroke and sued three doctors in 2003. Before he testified in a retrial against one of the doctors, Fullerton received a complaint from the Florida Medical Association, to which he belongs.

"The letter described me as a 'medical terrorist' and accused me of 'propagating theories about stroke that were not up to par' and 'testifying for financial gain.' My jaw dropped when I saw it," Fullerton said.

Fullerton has sued the doctors and medical society for libel and witness intimidation.

The doctors argued they could not be sued because of a federal law, the Health Care Quality Immunity Act, which protects those who participate in peer review proceedings from being sued. But a Florida appeals court ruled that the doctors could be sued because that law only protects peer review related to patient care, not peer review related to expert testimony, as was the case here.

Meanwhile, while he awaits a trial, Fullerton has been dropped from testifying in other cases.

"I definitely have been harmed as an expert. I'm viewed as tainted goods," said Fullerton.

Vail, who represents Fullerton in his case against the medical society, said that even the threat of an ethics complaint can make an expert think twice about testifying.

It can cost \$20,000-\$50,000 to defend an ethics complaint before a medical association, Vail noted.

Attorneys representing injured patients have also complained that it is harder to find medical experts.

"I have had experts say, 'Why bother? If I testify for a plaintiff, I have people at the medical societies going after my credentials,'" said Drew Britcher, a partner at Britcher, Leone & Roth in Glen Rock, N.J., who represents plaintiffs in med-mal cases.

Britcher recently found that an orthopedic surgeon he hired as an expert was subjected to ethics procedures over testimony in a prior unrelated case.

The American Academy of Orthopaedic Surgeons suspended his membership for a year after finding that his testimony against another member of the academy was "unfair and not impartial."

Rather than drop him from the case, Britcher successfully moved to have any reference to the earlier disciplinary activity barred from his case.

Defamation verdict

Some other medical experts have begun to fight back.

In a recent case, an ophthalmologist won a defamation suit against two doctors who brought an ethics complaint against him.

The ophthalmologist, Dr. Charles Yancey, originally testified for a plaintiff in a med-mal suit over injuries from Lasik surgery. The jury awarded the plaintiff \$3 million, but the court ordered a second trial on the issue of damages.

Meanwhile, the defense expert filed a complaint with the American Academy of Ophthalmology alleging that Yancey's testimony was false, deceptive and misleading.

The academy, in violation of its rules, faxed the complaint to Yancey so that he would receive it the day before he was scheduled to testify in a deposition for the second trial, according to Vail, who represents Yancey.

Yancey sued. The trial judge dismissed his claims against the academy, as well as claims of witness intimidation and unlawful interference with business relations, but allowed a defamation claim to go forward.

After a six-day trial, on Feb. 12, 2009, a jury awarded Yancey \$350,000, including \$200,000 for "future harm to his reputation, mental distress, humiliation and embarrassment."

Pelton said that medical associations should never bring an ethics complaint against a member over testimony in a pending case.

"In the associations I work with, we will not touch a complaint about a case that is still going on. We don't want to be criticized for intimidating a witness and it sure looks like that is what happened [in the Yancey case]," Pelton said. **MMLR**

Questions or comments should be directed to the writer at: sylwia.hsieh@lawyersweekly.com

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Medical-malpractice filings fall in Massachusetts

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Boston med-mal firm of Lubin & Meyer.

"I think it really does come down to the fact that [medical-malpractice cases] are very expensive and very high-risk to bring, and people just can't afford to do it," said Higgins.

Pamela S. Gilman, who defends health care providers as part of her practice at Taylor, Duane, Barton & Gilman in Boston, said the trend makes sense.

"The decrease in case filings is not surprising, given the current emphasis on improving patient communication and risk-management efforts," she said. "I also suspect that the decrease in filings is due to a hesitancy on behalf of smaller firms and solo practitioners to make the large investment in pursuing these types of cases."

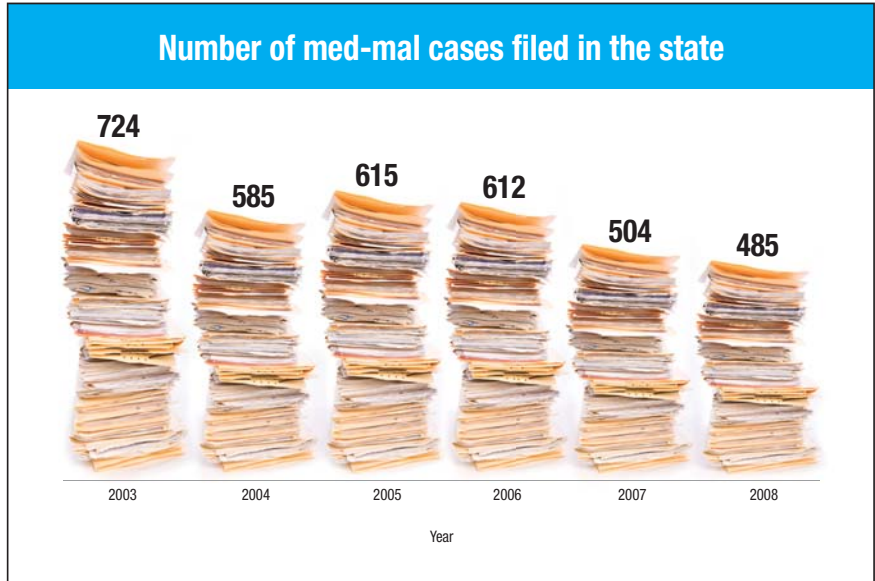
The result is that a few established, well-financed med-mal law firms are dominating the practice area more than ever before.

Charles P. Reidy of Boston, who defends doctors, said he is seeing fewer "fringe players" in the med-mal litigation field.

"It's very exceptional that you wind up seeing a law firm that doesn't regularly do it," said Reidy, who practices at Martin, Magnuson, McCarthy & Kenney.

As for the cases themselves, Reidy said it seems as if "more thought goes into them now. I don't see as many of the 'why-in-the-world-did-they-bring-this-case' cases." **MMLR**

Questions or comments should be directed to the writer at: julia.reisch@lacyersweekly.com



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Good Medicine

What doctors are talking about now



Q: Do the new state Department of Public Health requirements for hospitals and other facilities to undertake a “root cause analysis” as part of disclosing Serious Reportable Events compromise the confidentiality of physician peer review?

“We firmly believe that any public reporting of SREs or their analysis should not be viewed as a voluntary relinquishment of a provider’s peer review safeguards and that protecting the integrity of the peer review process is essential for improving patient safety, our most important responsibility. There should be more explicit protections to ensure that peer review discussions are exempt from any public review.”

—**Timothy F. Gens, senior vice president, policy & regulation, general counsel, Massachusetts Hospital Association**

“While this new regulation does not directly jeopardize the confidentiality of individual physician peer review, there is a concern that erosion of protections for one type of peer review may weaken an entire system that is designed to promote quality care. . . . The new regulations require that the root cause analysis – which previously remained confidential – be provided to the payor and the patient as well as to DPH, which appears to create a conflict with existing peer review law.”

—**Pamela Heacock, associate general counsel, UMass Memorial Health Care Inc.**

“I think there is an irreconcilable tension between at least one section of the regulations and the confidentiality provided to a medical peer review committee under state law. Shortly after the peer review privilege was created, the Board of Registration in Medicine promulgated regulations to implement their newly created patient care assessment duties, some of which were challenged by a consortium of hospitals as violating the peer review statute. It may be that hospitals and or medical staffs will need to mount a similar challenge to these new DPH regulations.”

—**Paul R. Cirel, partner, Dwyer & Collora, Boston**

“As best I can tell, the Legislature did not intend to undercut the medical peer review privilege when it adopted [the new reporting requirements]. I anticipate that hospitals will complete the new reporting form by providing a short, non-privileged narrative. For those SREs that may also become the subject of a medical peer review proceedings, a hospital may do well to conduct two separate review processes. The first is not privileged and would focus on preventability and provide the basis of the hospital’s SRE report to DPH. The second would likely include a root cause analysis that remains privileged as part of the confidential medical peer review proceedings.”

—**Regina Rockefeller, partner, Nixon Peabody health services group, Boston**



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Reporting of serious reportable events may impact peer review

By Mario Motta, M.D.

For some time, state regulations on hospital licensure have required hospitals to report serious incidents that affect patient health and safety to the Department of Public Health (DPH).

In 2007, DPH revised its rules to require the identification and reporting of incidents that meet the National Quality Forum's (NQF) definitions of serious reportable events.

NQF is a national nonprofit group of health care organizations dedicated to improving health care quality measurement and reporting.

In 2002, it developed a list of 28 events it considers serious reportable events (SREs), grouped into the following six categories:

- Surgical, such as an instrument left in a patient,
- Product or device, such as contaminated drugs or a malfunctioning device,
- Patient protection, such as if an infant is discharged to the wrong person,
- Care management, such as a medication error,
- Environment, such as a fall in a health care facility, or
- Criminal event, such as an abduction or sexual assault of a patient.

"By creating a clear, unambiguous and standardized list," the agency wrote, "NQF aims to bring greater transparency to health care and an opportunity to learn from mistakes and take swift actions to improve patient safety."

"The errors are of concern to the public and health care providers and warrant careful investigation that should be targeted for mandatory public reporting," NQF said.

More than half the states, including Massachusetts, now require reporting of SREs, with many others considering such a system.

Doctor's Rx

Here in the Commonwealth, DPH, following a legislative mandate in last year's cost containment reforms, has added amendments to its

original requirements that compel a hospital to "make a preventability determination" following a documented review process for all SREs.

Hospitals must determine if the event was (1) preventable, (2) within the hospital's control and (3) unambiguously the result of a system failure based on the hospital's policies and procedures.

DPH states that the "revised amendments promote quality improvement and accountability through internal review and assessment and public reporting, and by prohibiting payment for SRE-related costs (i.e., payment for the original error and the costs of correcting the error)."

DPH also requires hospitals to include a "root cause analysis" as part of the preventability determination, which will be reported to DPH, third-party payers and the patient.

No one questions the necessity, professional importance or ethics of discovering the cause of an error. The patient deserves no less, and such findings invariably lead to improved patient safety efforts and systems.

But the new regulations do raise questions and concerns (putting aside the financial issue of SRE-related costs).

By requiring hospitals and physicians to conduct and report root cause analyses of SREs, DPH is essentially mandating a peer review process for such acts. Recognizing that peer review proceedings are protected under state law, will such actions change the nature of peer review? Will they improve the process or lead to reduced participation? Will hospitals have to change their by-laws on peer review to ensure protection of these new reports? And how will the new reporting affect facilities such as ambulatory surgery centers, where peer review is not an established part of the legal system?

Another concern is the confidentiality of the DPH reports. While peer review is protected, will

the DPH reports have the same safeguards?

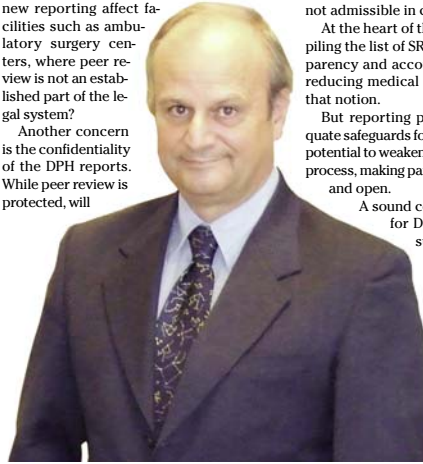
This is a new reporting process, untested in the courts. Will it be subject to disclosure by subpoenas or requests under the Freedom of Information Act? And will it lead to more medical malpractice cases?

Initial DPH responses to these questions indicate that the reports will not need to include patient-specific or provider-specific information. However, the identity of the parties in many cases will be well known and may be established by other means. The courts have found in prior cases that even if material is publicly disclosed, it is not admissible in court.

At the heart of the NQF's actions in compiling the list of SREs is the idea that transparency and accountability are critical to reducing medical errors. No one disputes that notion.

But reporting procedures without adequate safeguards for confidentiality have the potential to weaken the reporting and review process, making parties less likely to be frank and open.

A sound course of action would be for DPH to issue ironclad assurances that such reporting will not compromise peer review processes. Absent that, legislative action may be needed, just as it was to protect the peer review process.



Mario Motta, M.D. is president of the Massachusetts Medical Society.



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Verdicts & Settlements

Lahey agrees to \$844K overbilling settlement

The Lahey Clinic has agreed to pay nearly \$844,000 to settle allegations that it improperly billed the federal Medicare program from 2001 to 2005.

Federal prosecutors say that Lahey submitted claims to Medicare for multiple units of drug infusion therapy, chemotherapy and blood transfusion therapy services when only one should have been billed.

Authorities say that because of these billing practices, the hospital received more Medicare reimbursement than it was owed.

Lahey admitted no liability under the terms of the settlement.

Parents' genetic defect permanently impairs child

The patient, a woman of Chinese descent, became pregnant and was transferred to the care of an obstetrician/gynecologist. At approximately six weeks of pregnancy, the OB/GYN performed a CBC which showed clear signs of a probable Thalassemia trait carrier (low hemoglobin, high red blood cell count and low mean corpuscular volume). No further blood testing was performed nor was any recommendation made to have her husband, also of Chinese descent, tested for

Complications during spinal surgery lead to death

A 61-year-old female underwent spine surgery in 2005 to correct debilitating back pain, a result of scoliosis.

During the surgery, the patient suffered massive blood loss and life-threatening hemodynamic instability, which resulted in the transfusion by anesthesia of massive amounts of crystalloid and blood products.

When the patient was turned supine following the surgery, her abdomen was noted to be grossly edematous, and an emergent laparotomy was performed.

That surgery demonstrated large amounts of fluid in the abdomen and severe swelling of the bowel, leading to a diagnosis of abdominal compartment syndrome. The patient was stabilized in the ICU, but died several days later as a result of these complications.

The plaintiff alleged that the anesthesiologists over-infused the patient with crystalloid and under-transfused the patient with blood products, such as platelets and fresh frozen plasma, causing dilutional coagulopathy and resulting bleed and compartment syndrome.

The plaintiff also alleged that the standard of care required the anesthesiologists



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to terminate the procedure until the patient's bleeding was controlled. At a deposition, the attending neurosurgeon testified that had he been advised of the patient's hemodynamic instability or asked to terminate the procedure, he could have and would have done so at any time.

However, when the senior anesthesiolo-

gist was deposed, he claimed that he advised the neurosurgeon to halt the procedure, but that the surgeon failed to do so. As a result of this conflicting testimony, the neurosurgeon was added as a defendant in the case.

The doctors claimed that the patient was obese and had peripheral vascular disease and myocardial infarction with stent placement, thus requiring this extensive surgery to preserve her quality of life. As a result, the risk of complications was necessarily high, and included bleeding and death, the physicians contended.

They further alleged that coagulopathy is a known, unpredictable complication that is difficult to diagnose and treat. They also claimed that the patient's outcome would have likely been the same even if the surgery had been stopped.

The case settled for \$2 million.

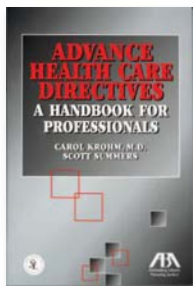
Type of action: Medical malpractice

Injuries alleged: Coagulopathy, abdominal compartment syndrome and death

Date: January 2009

Submitted by: Robert W. Casby and Benjamin R. Zimmermann, Sugarman & Sugarman, Boston (for the patient)

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

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Verdicts & Settlements

the Thalassemia trait. If both parents are carriers, the chances of a newborn suffering from full-blown Thalassemia are greatly increased.

The patient had also told the OB/GYN that her twin sister had a complete work-up for Thalassemia when she was pregnant and was found to be a carrier. The patient contended that the OB/GYN assured her that she had nothing to worry about and that there was no further need to evaluate her husband.

The patient's son was born on May 16, 2005, and shortly thereafter was diagnosed with Major Beta Thalassemia, a condition that will require blood transfusions throughout his life, as well as treatment with chelation agents. The boy has a significantly increased risk of shortened life span, growth impairment and deterioration of vital organs.

He presently undergoes a full blood transfusion every three to four weeks and undergoes daily chelation treatment.

The case settled for \$2.8 million.

Type of action: Medical malpractice
Injuries alleged: Need for lifetime blood transfusions and chelation treatment, developmental impairment
Date: April 2009
Submitted by: Max Borten and Sidney Gorovitz, Gorovitz & Borten, Waltham (for the patient)

Surgical team lacerates patient's sciatic nerve

In 2005, the patient, 64, experienced increasing pain and stiffness in his right hip. He was evaluated by an orthopedic surgeon who determined that he was a candidate for total hip arthroplasty.

On Sept. 13, the patient underwent a total right hip replacement at a VA hospital. When the patient awoke from surgery, he was numb from his hip to his foot and began to experience severe pain.

The operative report indicated that the patient's sciatic nerve had been lacerated. According to the report, the laceration was "probably caused by the electrocautery tool too close to the nerve."

An EMG and nerve conduction study revealed that the patient suffered sciatic nerve damage with severe right-sided sciatic neuropathy and severe axonal loss. The patient experienced decreased sensation and motor function with foot drop and was given a multipod boot and custom solid ankle AFO.

As a result of the surgery, the patient sometimes requires a cane to walk and has a compression dressing on his right foot up to his knee. He experiences persistent numbness and burning pain from his right knee to his toes.

The patient alleged that the VA hospital and its employees deviated from the applicable standard of care when they caused discrete and definite damage to his sciatic nerve as a result of the use of an electrocautery tool.

The patient also alleged that they failed to take necessary measures to identify and protect the sciatic nerve from this type of injury, such as palpating and/or visualizing the sci-

atic nerve during surgery, using appropriate retraction or a lap pad and/or using the short external rotator hip muscles.

The case settled for \$450,000.

Type of action: Medical malpractice
Injuries alleged: Sciatic nerve injury, foot drop
Date: Jan. 26, 2009
Submitted by: Jeffrey N. Catalan, Todd & Weld, 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.

Doctors try to stop patients from rating them online

Continued from page 5

anonymous postings, although the poster's identity is not publicly available. She also said service providers are allowed to respond. "And we show their response," she said.

Hicks said her service had not been asked by any doctor to remove a post based on a privacy agreement.

"I have heard of no activity in Massachusetts about any privacy agreements between physicians and patients related to postings on websites," said Rick Gulla, spokesperson for the Massachusetts Medical Society.

The use of patient privacy agreements has caught the attention of Paul Levy, an attorney at the Public Citizen Litigation Group in Washington.

Levy pointed to broad language used in one form – available online from a New Jersey medical practice – that appears to bar any publication of commentary about the

physicians, not just posting on the Internet. He said that the form, as written, might be read to forbid patients from making reports to state regulators or to a medical malpractice lawyer.

Rod Smolla, a First Amendment scholar and dean of the Washington and Lee University School of Law in Lexington, Va., worried that patients would sign the privacy forms without reading them, along with all the other forms doctors have their patients sign.

"Our public policy and our law should be highly skeptical of contracts that condition the public's access to the services of a critical profession on the signing of waivers gagging the public's constitutional right to be critical of a profession," Smolla commented in an e-mail.

Smolla said that equal access to the forum can cure the problem of posts that are criti-

cal of a physician.

"If a doctor's patient or a lawyer's client engages in an unfair criticism of the professional provider, other patients or clients are free to step in and offer counter-views," he said.

"I believe strong arguments of public policy, contract law, and constitutional law can be brought to bear against the enforcement of these waiver agreements," Smolla said. "Whether or not they are legally enforceable, they are not sound professional practice."

However, Robert M. O'Neil, director of the Thomas Jefferson Center for the Protection of Free Expression in Charlottesville, Va., said that the privacy agreements probably would stand up in court.

As long as a private doctor merely gets patients to agree not to post comments, he said, the practice may be short-sighted but doesn't raise a First Amendment issue.

"Only if some government agency or policy effectively induces patient silence would such an issue arise," O'Neil said.

John Whitehead, president of the Rutherford Institute, a civil liberties advocacy group in Charlottesville, Va., said he would be concerned if a doctor tried to impose a no-posting agreement as part of a publicly funded health care program.

"That would be a First Amendment violation," he said.

Medical Justice agrees that the forms are not appropriate for publicly funded health care.

MMLR

A version of this story originally appeared in Virginia Medical Law Report.

Questions or comments should be directed to the writer at: peter.zich@va.lawyersmedia.com

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Bills, Rules & Regs



From Beacon Hill

Bill protects doctors who apologize

Lawmakers are considering a bill that allows doctors to say "I'm sorry" without admitting they made a medical mistake.

Doctors have long expressed frustration that showing any compassion toward patients or their families – especially after a death following an operation or treatment – can be used against them in a medical malpractice lawsuit.

The bill, sponsored by Sen. Robert D. O'Leary, D-Barnstable, would make the expression of "benevolence, regret, sympathy, commiseration, condolence, compassion, mistake [or] error" inadmissible as evidence in such a lawsuit.

The bill is pending before the Joint Committee on Health Care Financing.

Council approves law on restaurant labeling

A month after passing regulations calling for checking the body mass index of all school children in Massachusetts, the state Public Health Council has approved rules that require major chain restaurants to provide customers with calorie information regarding items on their menus.

The Department of Public Health estimates that 50 restaurants with 5,000 locations in Massachusetts will need to comply with the new requirements, which mandate that calorie content details be made available either on a menu board or on the restaurant's menus.

The rules will take effect in November 2010 in order to give local health departments and restaurants time to prepare.

The rules mirror laws already in place in California and New York.

Lawmakers propose regs for Alzheimer's special care units

A pair of bills pending before the Joint Committee on Elder Affairs would force the state Department of Public Health to issue regulations governing specialized Alzheimer's units in nursing homes.

The local chapter of the national Alzheimer's Association has expressed frustration with the DPH for failing to advance guidelines and standards of care for the units.

James Wessler, president and CEO of the Massachusetts and New Hampshire chapter of the association, said, "Many of [the units] are good, but there are too many outliers."

One-third of the state's 425 nursing homes have special care units. Wessler's group has been pushing the DPH to set regulations for the units for four years, he said.

According to the association, Massachusetts has 120,000 residents with Alzheimer's.

However, DPH spokeswoman Jennifer Manley contended that the regulations and the specialized units themselves are not needed because such a large proportion of nursing home residents have some form of dementia, including Alzheimer's. In its most recent review, the DPH found that more than 60 percent of all nursing home patients had some form of dementia, Manley said.

The chairs of the committee, Rep. Alice Wolf, D-Cambridge, and Sen. Patricia Jehlen, D-Somerville, both expressed interest in moving quickly on a bill. A similar bill passed the Senate last year, but died in the House at the end of the session.

Patrick in favor of road test for elderly

Gov. Deval L. Patrick announced his support for legislation that would require drivers 85 and older to pass a road test and eye test every five years to have their licenses renewed, *The Boston Globe* reported.

Two high-profile accidents in June involving elderly drivers and multiple injuries intensified the pressure on lawmakers to monitor elderly drivers more closely, renewing the heated debate over whether seniors should have to prove their continued fitness to drive.

At New England Rehabilitation Hospital in Woburn, therapists work with patients to prepare them for a return to the road, using simulators to hone their reflexes, depth perception, and other skills in a two-hour program.

Sherry Rodrigues and Keith Poulin, two of the therapists, said that they support more frequent testing of older drivers, who often find it hard to accept that their abilities are declining.

But others doubt that the registry could handle administering more road tests.

DPH stops routine H1N1 virus testing

On June 12, the Hinton State Laboratory Institute ceased performing diagnostic testing for H1N1 influenza, except in rare circumstances.

Testing will be performed only in cases where confirmatory results will significantly impact the clinical management of a patient, or where there is a clear public health benefit. Such specimens should be submitted only after the approval of a state Department of Public Health epidemiologist.

As swine-origin influenza A H1N1 infections became increasingly widespread, laboratory confirmation of the novel H1N1 influenza is becoming less critical to decisions regarding antiviral treatment, chemoprophylaxis and disease control measures.

In addition, as the number of seasonal influenza A infections has declined, the identification of influenza A by rapid tests and other methods has become more useful as an indicator of the presence of H1N1 influenza.

Specimens from influenza sentinel sites will continue to be tested at HSLI. This will provide a representative sample for disease surveillance, and will allow for identification of significant mutations in the viral genetic structure over time.

The World Health Organization declared a global H1N1 influenza pandemic on June 11, the first pandemic in 41 years.



From Capitol Hill

Medical groups urge replacement of SGR

Dozens of medical organizations, including the American Medical Association and the Medical Group Management Association, are calling on federal lawmakers to repeal Medicare's sustainable growth-rate formula and enact other payment reforms.

In joint recommendations sent to Congress, the Obama administration and the Medicare Payment Advisory Commission, some 60 organizations asked that the SGR be eliminated and replaced with a system that reflects increases in physicians' and other health professionals' practice costs, according to *Modern Physician*.

The SGR is based on the health of the economy and has been threatening cuts to physician payments for at least six years. Physicians in 2010 face a 21 percent cut to their Medicare payments unless Congress intervenes.

If Congress doesn't repeal the SGR this year, the groups recommended that Congress and the White House adopt a transitional approach that links payments to the Medicare Economic Index for five years.

Similar recommendations to the House Ways and Means and Energy and Commerce Committees were released by the American Academy of Family Physicians, the American College of Physicians and the American Osteopathic Association.

Specifically, these groups called on Congress to direct HHS to make Medicare payments for primary care "competitive in the market with other specialties within five years," *Modern Physician* reported.

HHS issues guidance on electronic health data

The U.S. Department of Health and Human Services issued guidance in May on how to protect electronic health care data.

The American Recovery and Reinvestment Act of 2009 required the agency to issue guidance for entities covered by HIPAA and their business associates. (Other entities will receive guidance from the Federal Trade Commission.)

The guidance identifies two methods, encryption and destruction, by which to render protected health information "unreadable, unreadable, or indecipherable to unauthorized individuals."

Several states have recently passed similar laws. But the HHS guidelines are more specific and instruct covered entities to use processes of encryption tested and approved by the National Institute of Standards and Technology.

The agency emphasizes that the guidance is "not intended to instruct covered entities and business associates on how to prevent" a data breach, however.

And while covered entities are not required to follow the guidance, those that do will be protected by a safe harbor in the case of a data breach, and would not be forced to provide notification of the breach under HIPAA.

Identity theft rule delayed to Aug. 1

The Federal Trade Commission has delayed enforcement of the "red flag" rule that requires certain businesses – including physicians' practices – to implement identity-theft policies to Aug. 1.

The rule has slipped under the radar because many affected businesses are still unaware that they are likely to fall under the rule's broad definition of "creditor."

The three-month extension will give businesses more time to comply and make use of a model policy from the agency, said Betsy Broder, Assistant Director of the FTC's Division of Privacy and Identity Protection.

"We realize a lot of companies are not in compliance, and we want to work with them to get them where they need to be by providing the resources and time," said Broder.

She said that the model policy will allow entities at low risk of identity theft to "fill in the blanks" on the template in order to comply with the rule.

Experts warn that many businesses are still unprepared.

"Quite frankly, a lot of businesses are still just now realizing it applies to them because of the expansive definition of creditor. Retailers, health care providers and even law firms have been caught off-guard," said Misty Speake of Atlanta, an associate involved with King & Spaulding LLP's privacy initiative.

The American Medical Association argued that physicians should not be covered by the rule because they are already covered by HIPAA, but the FTC rejected that argument.

The FTC has created a website where it has published a how-to guidance on the rule.

This is the second time enforcement has been delayed in order to give businesses more time to comply. The original deadline was November 2008.

Obama requests details on health care savings

President Barack Obama has instructed the health care industry to provide specific details on its pledge to slow rising costs and help to save the nation \$2 trillion over 10 years.

Crunching Medicare statistics, researchers concluded that as much as 30 cents of each U.S. health care dollar might be paying for tests and procedures that are of little or no value to patients.

Insurers, doctors, hospitals, drug makers, medical device manufacturers and a leading health care union took the savings pledge at the White House in May.

They said they were ready to do their part to slow projected increases in costs by an average of 1.5 percentage points per year for 10 years.

Insurers are working on how to reduce the administrative costs of filing claims. Instead of having a different claims system for every insurer, a more efficient system might allow physicians to use a single Internet portal to handle transactions with all insurers.

Physicians are working on how to avoid situations where different physicians prescribe contraindicated medications.

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Office compliance 101: A guide

By Amy Johnson Conner

In the midst of taking care of patients every day, doctors across Massachusetts are struggling to comply with an overwhelming number of constantly changing state and federal regulations.

Medical professionals “don’t have the time to think, let alone deal with the 30 different [regulations] on the state and federal level,” said Michael Manere, vice president of sales at Total Compliance Solutions in Wellesley.

Physicians must follow federal regulations under the Health Insurance Portability and Accountability Act, known as HIPAA; The Occupational Safety and Health Administration, or OSHA; The Centers for Disease Control, known as the CDC; and Medicare and Medicaid, among others.

There are also a host of other federal and state regulations covering:

- Billing and coding;
- Recordkeeping;
- Insurance fraud;
- Patient boundary violations;
- Informed consent;
- Licenses to practice medicine; and
- Delegation of care.

While HIPAA and other privacy concerns are of paramount importance, experts said many physician offices don’t focus enough on the many other high-risk regulatory areas, especially those that affect billing.

The sure-fire way to stay out of hot water is to overcome the fear of regulatory compliance and dedicate yourself and your staff to following the rules. That means you must learn the regulations, follow

them and train your staff to do so as well.

While relatively expensive, third-party companies can provide compliance plans, but if a small office can dedicate roughly 15 hours each month of one employee’s time, it’s possible to do it in-house. (See “Can you do it yourself?” on this page.)

Documentation and coding

Compliance experts agree that the biggest risk area is coding and billing for Medicare, Medicaid and insurance reimbursements.

Sometimes physicians don’t comply with these rules because the codes for procedures are confusing and time-consuming to figure out and document. Some physicians have a tendency to under-bill when they aren’t certain about their documentation of a more expensive procedure.

A physician might say, “I’m just going to under-code; then I don’t have to worry about whether I’ve documented it correctly or not. I’ll just bill the lower code,” explained Tray Dunaway, a surgeon and compliance guru based in South Carolina.

The problem with under-billing – which is also considered fraud because you’re billing for a service you didn’t perform – is the physician isn’t reimbursed at the proper level for the services provided.

Another problem, Dunaway said, is that physicians sometimes resent surveillance.

They might think, “Why should I have to prove I did anything? Can’t you just take my word for it?” For the vast majority of physicians you can, but there are people out there who have abused that,” said Dunaway, who has developed a

coding system for physicians.

However, he maintains that it’s easier to be in compliance than out of compliance, and that once physicians understand the rules precisely, coding correctly can take less time than coding incorrectly. Plus, chances are the right code is a higher-paying one.

Physicians can hire a third party to develop a plan for billing and coding tailored to their practice and to train their staff on how to use it.

“A training session shows the staff the doctor cares and recognizes there might be a problem and lets the world know they’re fixing the problem. That transparency is good,” said Vincent DiCianni, owner of Affiliated Monitors in Boston, a company that specializes in compliance programs. “It helps boost morale and also increases people’s awareness.”

Delegating care

Delegating care to various health care workers is another area where offices get into trouble because they aren’t following the regulations related to what functions a nurse practitioner or physician’s assistant are allowed to perform.

First and foremost, physicians must ensure that all members of their staff are credentialed and allowed to provide care in Massachusetts. They must also perform background checks on all staff members, compliance experts said.

It’s important to know if a caregiver was under supervision in another state or asked to leave a practice because their records were bad or their judgment was at issue, DiCianni noted.

Then, physician offices must be

Continued on page 14

Can you do it yourself?

The way to stay out of hot water is to learn the regulations and assign an employee the task of keeping the practice in compliance.

In a small office, it will likely take about 15 hours per month to research and develop a protocol, maintain the protocol and train employees, said Michael Manere, vice president of sales at Total Compliance Solutions in Wellesley. However, he compares compliance to doing your own taxes. You can do it yourself, but do you really want to?

“You don’t have your employees do your taxes; what makes you think they’re going to [create the right] HIPAA program?” Manere said.

The costs to hire a third party to provide a compliance program vary by the size of the practice and services provided.

While Manere’s operation charges \$1,400 for the research and development of a site-specific program, Vincent DiCianni’s Affiliated Monitors in Boston charges roughly \$6,000 for a package that includes conducting an audit for a small practice, drafting a compliance manual and training the staff. Lyn Henderson, vice president of

medical staff and regulatory affairs at the Needham campus of Beth Israel Deaconess Hospital and a private compliance consultant, said she might charge \$24,000 for a complete compliance package for a 10-doctor group, which includes her ongoing consultation.

Of course, for these prices, different services are included.

While they are obviously biased, third-party companies note that these charges pale in comparison to the fines an insurer or Medicare might levy on a practice that’s noncompliant.

“It’s better to be proactive,” DiCianni said. “It’s better to recognize that maybe it’s time to have somebody else come in and look at what you’re doing. We all have blinders on when we’re dealing with ourselves.”

If bringing in a third party won’t work, he suggests doctors attend coding seminars to stay in touch with regular practices. It’s not uncommon for a practice to develop its own shorthand that isn’t the same as standard coding.

While it’s okay to do that, it’s also important to document what your own codes mean, keep your key with the records and distrib-

ute it to your entire staff, he said.

Recordkeeping classes also teach an approach to charting, and then a physician’s practice can conduct a random audit to evaluate proper implementation, DiCianni noted.

Probably the most important aspect of regulatory compliance is ensuring that members of your staff are adequately trained.

Manere said he often walks into offices where office staff members have been following the various regulations to the best of their ability, but the physicians have never written a policy and never officially trained their employees on compliance.

Compliance doesn’t happen overnight, and physicians don’t have to tackle everything at once, said Anne Huben-Kearney, a clinical manager in the risk management department at ProMutual Group in Boston.

She suggests starting with setting up systems to bring high-risk areas such as Medicare, Medicaid and insurance billing into compliance first, and then moving on to other areas.

— Amy Johnson Conner

Office compliance 101: A guide

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sure they know the scope of services each caregiver is allowed to provide.

" Oftentimes the nurse practitioner or physician's assistant is providing services he is not credentialed to provide," said Lyn Henderson, vice president of medical staff and regulatory affairs at the Needham campus of Beth Israel Deaconess Hospital and a private compliance consultant. "A lot of times these people aren't credentialed for the insurance company, so you're billing incorrectly because you didn't realize they needed to sign up."

Patient follow-up

Other problems arise with tracking patient care.

HMOs and Medicare are often concerned about whether high-risk or sick patients are receiving follow-up care and tests, and that they are receiving this follow-up in a timely manner, said Anne Huben-

Kearney, a clinical manager in the risk management department at ProMutual Group in Boston.

If physicians sign off on a patient's diagnostic or lab work without looking at it carefully, or if the staff automatically files those results without showing them to the physician, the physician may never know of an abnormal result that requires follow-up.

Huben-Kearney suggests that offices have a policy that no test results are filed unless the physician has dated them and signed off on them.

Documentation of telephone calls with patients is also becoming a bigger problem. Offices need to set up systems for delivering messages to a physician when a patient calls to ensure that calls are returned in a timely manner.

Members of a physician's office staff need to know the "magic words" that signify serious illnesses, such as chest pain, the worst headache a patient has ever had and other phrases that signal a life-threatening situation where the

physician must be notified immediately.

"The second part is documenting those calls," Huben-Kearney said. "It's a good practice to have telephone pads, but the best practice is to make sure it's in the chart."

Companies like ProMutual help doctors develop and implement more detailed procedures to follow up with their at-risk patients, she said.

Other concerns

Other compliance issues to pay attention to include:

• Legibility of the record.

"It has to be something that everybody can read. Handwriting, abbreviated symbols and the hieroglyphics we all use [aren't sufficient.] Make sure you're documenting appropriately and legibly, and make it a permanent part of the record," Huben-Kearney said.

Records travel with the patient and they're useless if they can't be read by the next physician.

• Informed consent.

"[N]ot being able to present informed consent – that a patient was fully aware and making a rational, personal decision to consent to a particular procedure" – can get offices into trouble, DiCianni said.

When physicians give an "English form to a Spanish-speaking person, are you really getting informed consent? That can be crucial, particularly with surgeons and practices dealing with certain kinds of treatments."

• Boundary violations.

"Improper touching or not explaining you're going to be touching or when a doctor starts revealing his or her personal life, that crosses a line of professional conduct," DiCianni said.

While it's rare for a physician to be sent to jail for noncompliance, there are financial and reputation-related consequences.

"Medicare not only wants the money back for the incorrect billing, but they can [calculate]

that you've been doing this for, say, the last seven years and they can fine you back," Henderson said. One of her clients once faced a fine of \$1 million calculated this way.

Another typical consequence is the loss or suspension of a physician's license to practice. That can happen even if the regulatory violation is a staff person's fault. The fact that staff members practice under the physician's license underscores the importance of properly training them.

Physicians also want to avoid negative attention in the press related to noncompliance.

"I tell my clients not to worry about the fine," Manera said. "It's your name in the paper, and the litigation that's going to follow if you didn't follow federal or state law."

Questions or comments should be directed to the editor at: revl.gertner@mmedalliance.com

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The Physician's Corner

Some considerations related to office compliance

By **Henry Tulgan, M.D., FACP**

When physicians open the doors of their offices for business every day, the vast majority don't think about the substantial number of state and federal regulations that apply to them.

Some regulations are common to all lines of business, such as the federal OSHA (Occupational Safety and Health Administration) rules.

Many more are specific to our profession; these include the federal ones promulgated under HIPAA (Health Insurance Portability and Accountability Act) and by the CDC (Centers for Disease Control and Prevention) and CMS (Centers for Medicare and Medicaid Services).

However, the regulations for billing, coding, recordkeeping and insurance fraud may not immediately come to mind.

Nor may we realize that we may need to obtain informed consent and document translator services when they are required in certain circumstances.

As practices increasingly employ more nurse practitioners, physician assistants and others, it is mandatory to know just what functions they are licensed to perform. A complete background check on all employees, particularly when initiating employment, will ensure that no previous legal violations have occurred.

Also, patient care issues may include the necessity to document incoming telephone calls and timely returns of those calls, keep records legible, and document physician review of all ordered lab or other diagnostic studies.

In addition, boundary violations, such as improperly touching a patient, must be addressed and avoided.

The consequences for failing to comply with rules and regulations can be serious. Improper coding and billing may not only carry financial penalties but may even lead a physician to lose his or her license.

There are a number of proprietary companies available to assist physician practices in developing compliance plans, and skilled attorneys and accountants may also serve as advisors.

Physicians are already familiar with policy and procedure manuals in hospitals and developing them for our offices. It is essential to periodically review these manuals with members of our staff and update them as new regulations are passed. After all, it's a form of "preventive medicine."

Risk management strategies

• Start with setting up systems to bring high-risk areas into compliance – such as Medicare, Medicaid and insurance billing – before expanding to other areas.

• Have systems in place and provide staff training for compliance in the following areas:

- Accurate billing and coding
- Delegating care to staff members
- Following up with patients

- Documenting phone calls
- Keeping readable records

Document informed consent, making sure that a patient was fully aware and making a decision to consent to a procedure. The informed consent must show that it was presented in the patient's language. (For example, an English form should not be presented to a Spanish-speaking person.)

- Be aware of boundary violations such as improper touching or revealing your personal life.

Centers for Disease Control (CDC)
www.cdc.gov/

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www.hhs.gov/ocr/hipaa/

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Henry Tulgan, M.D., FACP is a clinical professor of medicine at the University of Massachusetts Medical School, a consultant to the MMS Committee on Sponsored Programs, which he formerly chaired, and Director of Medical Education at Wing Memorial Hospital in Palmer, Mass.

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- | | |
|---|--|
| <p>1. Medical offices are exempt from a number of federal and state rules and regulations.
 ? a. True
 ? b. False</p> | <p>3. Fiscal penalties may be levied for improper insurance billings.
 ? a. True
 ? b. False</p> |
| <p>2. Physicians are not responsible for the areas of practice handled by nurse practitioners or physicians' assistants they employ.
 ? a. True
 ? b. False</p> | <p>4. Violations of rules and regulations may be punishable by loss of license to practice.
 ? a. True
 ? b. False</p> |

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 quality of this education program?
 ? High
 ? Average
 ? Low

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 ? High
 ? Average
 ? Low

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

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

What are your topics of interest for future CME activities?

If yes, please explain.

Electronic health records surge despite barriers

Continued from page 1

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. **MMLR**



HIPAA changes included in stimulus law

By Correy E. Stephenson

In addition to allocating substantial funds for the implementation of electronic health records, the American Recovery and Reinvestment Act of 2009 also included changes to the Health Insurance Portability and Accountability Act (HIPAA).

The changes, which affect HIPAA's privacy and security requirements, came as something of a surprise because President Barack Obama didn't indicate they were part of his health care policy plans, said Rachel Cutler Shim, a partner at Reed Smith in Philadelphia who is an expert on health and welfare plan compliance.

As a result, covered entities must "update their policies and procedures and retrain employees," she said.

The biggest change involves new requirements for providing notification of a data breach.

The various provisions have different effective dates, with some already in effect and others not going into effect until 2010.

In addition, Shim noted, some provisions – even if they have a specific effective date – still require regulations from the Department of Health and Human Services.

Here is a look at some of the major changes:

• Increased notification requirements

Covered entities are now required to notify affected individuals when a privacy breach occurs. (Previously, an entity only needed to try to limit the negative effects of a breach).

If the breach affects more than 500 people, the covered entity must also report the incident to HHS and the media, noted Joseph Lazzarotti of White Plains, N.Y., a partner at Jackson Lewis, who coordinates the firm's HIPAA and workplace privacy practice.

Notification must be given no later than 60 days after discovery of the

breach, and if the breach includes 10 or more individuals with insufficient contact information the covered entity must make a conspicuous posting on its website or provide notice in print and broadcast media.

Importantly, Shim noted, the notification requirement applies only to "unsecured" information, which is defined as protected health information that is not secured by an accredited "technology standard."

HHS issued a proposed guidance on this issue in May. (See the article on page 12.)

• Business associates now covered

The changes expand who is covered by HIPAA to include "business associates" of covered entities.

Previously, a business associate – such as a third-party administrator who helped an employer administer its health plan – was covered by HIPAA only through a contractual agreement with a covered entity, Shim explained.

But now, business associates are directly subject to the security regulations and privacy requirements of HIPAA, said Edward I. Leeds, counsel at Ballard Spahr Andrews & Ingersoll in Philadelphia, who focuses his practice on health and welfare benefit plans.

This change "will have a big impact because business associates [already] had obligations through contractual agreements with covered entities but now must comply with the statutory requirements" as well, he explained.

• Mandatory audits by HHS

Before, HHS was permitted to perform audits on entities covered by HIPAA to make sure they were following the rules.

But the Act includes a provision requiring HHS to perform audits, which could increase the amount of enforcement actions, Shim said.

• Expansion of patients' rights

There are several changes that increase patients' rights under HIPAA, Shim said.

For example, "individuals are now able to go to a doctor, pay 100 percent for their procedure and then notify the doctor that they want to limit the disclosure of their information and say it cannot be provided to their health insurer," she explained.

An employee might choose to keep information such as drug counseling private in this way, Shim said.

In addition, patients also have greater rights to get an accounting of how their protected health information is being used.

• Greater fines and penalties

Covered entities that violate HIPAA are now subject to a \$1,000 per violation penalty (up from \$100 per violation), and the maximum annual penalty has increased to \$100,000 from \$25,000. Both civil and criminal penalties now apply to business associates as well.

• 'Minimum necessary' rule tightened

Previously, the "minimum necessary" rule instructed covered entities that if they were using or disclosing protected information for any reason, the use or disclosure should be kept to the minimum amount necessary to accomplish the intended purpose.

Entities had a good deal of discretion in this area, Leeds said, but the "standard has now been tightened."

Under the new Act, the disclosure and use of protected information must be restricted to a "limited data set" that has the patients' identifying information removed "to the extent practicable." This is another area where HHS is scheduled to issue further guidance.

Questions or comments can be directed to the writer at: correy.stephenson@lawyersusaonline.com

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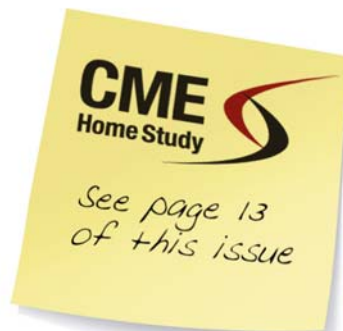
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