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Inside MedLaw

Decision will result in protective reporting of child abuse

By Daniel J. Schulte, Esq.

The Supreme Court's failure to hear and overturn the Court of Appeal's decision in *Adrianna Lee v. Detroit Medical Center, et. al*. will lead to increased reporting of child abuse/neglect by physicians seeking to protect themselves from claims that they failed to report.

The filing of these protective claims will increase the investigative burden on the Michigan Department of Human Services (DHS). This will result in the loss of already scarce DHS resources being timely focused on meritorious claims of abuse. As these investigations are delayed, the risk that a child is left in an abusive situation increases.

The *Lee* case involves the terrible abuse and neglect of Rufus Young, Jr. He was 4 years old when murdered by his foster father, Roderick Hall, on April 6, 2003. DHS removed Young and his four siblings from their biological parents following complaints of child neglect over the course of a four-year period (involving substance abuse, lack of gas service at the home, sufficient beds for all the children, etc.).

In 2002 Young was taken by his foster mother to a pediatrician who noted he had eczema (an inflammation of the skin). During the

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No longer can a physician rely on medical judgment when assessing whether a mark on the skin is eczema or the result of physical abuse. The same is true when treating fractures, which could be the result of an innocent fall, brittle bone disease or an instance of abuse.

Missing or inaccurately listed entity names are epidemic

By Michael S. Hale, Esq.

In our weekly audit of many commercial insurance programs for all kinds of businesses insured through many agencies, we often find that many entity names are improperly listed on such policies, or not listed at all.

This is a problem that appears to be at epidemic proportions with the relative ease of the formation of limited liability companies, which now exceed corporations in number in Michigan, and with many joint ventures in the global economy.

This applies to many types of business insurance policies including property, general liability, workers compensation, umbrella, business automobile, directors and officers, employment practices and other policies.

Many insurance agents will not ask about all entity names and will rely upon what the company's main name is. This is a mistake that could lead to disaster.

One of the first things we look for in reviewing an insurance program for a business is how the named insureds are listed among the various policies. A "grid" analysis usually shows major gaps between names covered by various policies.

Many insurance agents do not think to add building owner names such as LLCs to business auto policies, leaving such entities with major assets fully uncovered. Some exposures in this area include an employee driving to a real estate closing or a parking lot accident where a janitor drives into a tenant leaving the building. Motor vehicle leases and titles should be examined to as-

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Watching the bottom line

How health care practices can control employee health insurance costs

By Suzanne D. Nolan, Esq., and Scott W. Malott

As health insurance premiums continue to spiral upward, small employers — including many health care practices — are looking for ways to control health insurance costs while still providing great health care benefits to their employees.

This year's Patient Protection and Affordable Care Act (PPACA) creates a special tax credit to help small practices offset the costs of providing such health insurance. Additionally, a Health Reimbursement Arrangement (HRA) can be easily used by a practice to reduce its overall health insurance costs.

Tax benefits to small practices

Section 1421 of PPACA amended the Internal Revenue Code to provide a tax credit to small businesses for health insurance costs. A small business that contributes at least half of the cost of individual health insurance coverage for its employees could qualify for

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When purchasing electronic health records: Buyer beware

Health Records

By Jeremy D. Bisdorf, Esq. and Amy K. Fehn, Esq.

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Recent legislation, including the stimulus bill and health care reform legislation have created strong incentives for physicians to purchase electronic health record (EHR) systems.

While the timing of such purchases is important to maximize incentives, physicians also must make informed decisions and proceed cautiously.

Beginning in 2011, physicians will be able to receive incentive payments from either the Medicare or Medicaid programs for demonstrating "meaningful use" of a "certified" EHR. The Medicare program is based on 75 percent of allowable Medicare charges and can include incentives of up to $44,000 over a five-year period.

Physicians who have not demonstrated meaningful use by 2015 will not only be ineligible to receive the incentive payments, but also will face reductions in Medicare payments as a penalty.

Medicaid incentives are generally available to physicians whose patient volume are comprised of at least 30 percent Medicaid patients and can result in incentives of up to $63,750 over six years.

In addition to the "carrot and stick" incentives and penalties, the use of EHRs will be essential for physicians wishing to take advantage of the many pilot and demonstration programs being implemented as a result of health care reform.

While physicians will generally see a decrease in Medicare fee-for-service payments over time, there also are opportunities to increase reimbursement through various programs, such as the shared savings program.

The shared savings program requires participation in an Accountable Care Organization (ACO), which, in general, is a group of health care providers across the health care spectrum sharing responsibility for a specified population. Participation in such programs will require physicians to be able to coordinate care and share outcomes and other data electronically.

Despite the many incentives to implement EHRs, physicians should exercise caution when choosing an EHR product and entering into contracts with vendors. Some of the considerations when choosing an EHR system should include:

Cost and financing

It is important to note that incentive payments will not be provided to physicians at the time of purchase. Rather, payments will be made retroactively and only if the government is satisfied that the physician meets the criteria for "meaningful use" of a "certified" EHR.

Physicians must, therefore, be prepared to finance the EHR system prior to receiving incentive payments. Physicians also face the risk that the government will determine that the physician failed to meet the criteria, especially for subsequent years, for which objectives have not yet been defined.

Initially, providers will receive payments through attestations, but CMS could demand return of the money if an audit shows that the physician did not actually meet the requirements.

Certification and meaningful use

In order to be eligible for incentive payments, physicians must demonstrate "meaningful use" of EHR technology that is "certified" by a certifying body approved by the Office of the National Coordinator (ONC) for Health Information Technology.

In August 2010, the ONC approved two certifying bodies and certified products are expected to be available in fall of 2010. To the extent that physicians purchase products that are not yet certified, they must be careful to obtain contractual assurances addressing the contingency of the vendor's inability to obtain certification.

Physicians should be aware that certifying bodies can certify complete EHRs or "modules" and must understand whether they are purchasing a complete system that is certified or merely a module that would need additional components to achieve meaningful use.

In addition to purchasing a certified EHR, physicians must actually use the system in a manner that meets the meaningful use objectives. Final rules on meaningful use were published on July 28, 2010, and include a "staged" implementation process, which increases objectives over time. The requirements for meeting stage one are set forth in the final rule, but stages two and three requirements will be set forth in future rulemaking.

User friendliness, ability to customize

Another obvious but important element of successful EHR adoption is the ability of physicians to actually use the system without impacting the normal flow of patient care.

All physicians in a practice should be involved in the selection process and participate in hands-on demonstrations. Additionally, the system should be customizable to include templates that allow specialty specific documentation. Vendor contracts should address training and other measures that will be taken to assist physicians with the transition to EHRs.

HIPAA compliance

An EHR system also must contain elements that are required for compliance with the Health Insurance Portability and Accountability Act (HIPAA) Privacy and Security Rules.

For example, the system should have appropriate user

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Fall RAC update

CGI Technologies and Solutions, Inc. (CGI), the RAC (Recovery Audit Contractor) for Region B, which includes Michigan, recently approved 18 issues for medical necessity reviews.

CGI was the first RAC to approve medical necessity reviews, but it was quickly followed by the RACs for Regions D and C, HealthDataInsights and Connolly Healthcare. Medical necessity reviews, like DRG (Diagnosis Related Group) validation, are complex reviews, which involve a review of the medical records related to the claim.

Practitioners should keep in mind that although medical necessity reviews are "new" in the sense that they were not previously approved, they may involve MS (Medicare Severity)-DRGs that were already listed as issues approved for review.

When reviewing CGI's approved issues list, the new medical necessity reviews may be difficult to notice, since several were added as edits to previously approved DRGs, rather than listed independently as new issues.

Under the health care reform legislation, CMS (Centers for Medicare and Medicaid Services) is required to expand the RAC program to Medicaid and Medicare Parts C and D by Dec. 31, 2010. Recently, CMS has indicated that it may be difficult to meet this deadline with regard to Medicaid, particularly in coordinating the RAC program with 50 different state programs. However, CMS has indicated that it is on track to expand coverage of the RAC program to Medicare Part D prescription drugs plans by the end of the year.

Provided by Wachler & Associates, P.C.
For more information, visit www.wachler.com.

MSC ends use of 'Fulton' in traditional med-mal claims

By Brian Frasier, Esq.

The "50 percentage point" differential that is used in a medical malpractice "lost opportunity" claim should not be used in analyzing a traditional medical malpractice claim, the Michigan Supreme Court held.

The differential analysis came from a 2002 Court of Appeals decision, *Fulton v. William Beaumont Hospital*, which the court overruled as to its use to treat traditional malpractice cases as "lost opportunity" cases.

"I think the most helpful thing that comes out of this case is that it clarifies that you don't do a *Fulton* analysis in a traditional standard medical malpractice case," said Ramona Howard of McKeen & Associates PC in Detroit. "The defendants have tried to force that strictly 50 percentage points issue into every causation argument in cases all across the board. It's created havoc, quite frankly."

The dispute in *O'Neal v. St John Hospital & Medical Center, et al.* (Lawyers Weekly No. 06-73761, 88 pages) focused on whether Raymond O'Neal's claim was a traditional medical malpractice claim or a loss of opportunity claim under MCL 600.2912a(2).

O'Neal claimed his doctors misdiagnosed his acute chest syndrome, a known complication of sickle cell anemia, as pneumonia and didn't give him an immediate blood transfusion. He suffered a stroke.

He filed a traditional medical malpractice claim using statistical evidence to allege the doctors' failure to give him a timely transfusion was a proximate cause of his stroke. He did not plead a loss of opportunity claim.

The defendants argued that, by using the statistical evidence, O'Neal was arguing a loss of opportunity claim, and the statistics did not show the 50 percentage point differential between his chances of having a stroke if the transfusion had been timely.

A Supreme Court majority held the *Fulton* standard only applies to "lost opportunity" cases, which O'Neal's claim was not. The decision overruled *Fulton* as it is applied to a traditional claim.

"*Fulton*'s analysis was erroneous because it misconstrued proximate causation as it applies to a traditional malpractice case," Justice Diane M. Hathaway wrote. "Under the *Fulton* subtraction formula it is mathematically impossible for there to be more than one proximate cause. …

"*Fulton* transformed the burden of proof in traditional malpractice cases from a proximate cause to the proximate cause because it allows for only one proximate cause in any case."

"I don't think this opinion clarifies the test determining what is a traditional malpractice case and what is a lost opportunity case, so I think we're left with the law that existed prior to this decision."
— Christina A. Ginter, Kitch Drutchas Wagner Valitutti & Sherbrook

While the plaintiff doesn't need to produce statistical evidence in a medical malpractice claim under this decision, the court allowed O'Neal to use statistics to show proximate cause because, Hath-

See "Fulton," page 16

‘Taken’ off-shore

Lawyers concerned over delays in settlement payments from Bermuda insurance carrier

By Carol Lundberg

When Berkley-based law firm Olsman, Mueller, Wallace & MacKenzie, PC reached the $195,000 settlement for their client, they thought they could chalk up another job well done. Soon their client would be paid, and so would the firm.

But that was in November.

Nine months later, attorneys Jules Olsman and Donna M. MacKenzie are still waiting to see the check, though they’ve been told several times that it’s on the way.

“We’ve been stiffed,” Olsman said. “But the bigger issue is the number of hospitals who might have doctors who are insured through this company. We have no idea how many there are, and this has the potential for real serious impact.”

In *Denise Allen v. Richard J. Worel*, Olsman and MacKenzie represented the estate

”There are doctors who paid for insurance, and thought they were insured, and then are running into these problems.”

— Attorney Marc E. Lipton, Lipton Law Center

of Mayla Malzhan, who died in 2006 after her physician, Dr. Richard J. Worel, placed a catheter to administer chemotherapy.

“He put it in the wrong place, and all the chemotherapy went to her heart and killed her,” MacKenzie said.

During case evaluation, Worel’s attorney said he had $200,000 in coverage from his carrier, Universal International Insurance Ltd., based in Bermuda. All parties agreed to the settlement.

But 28 days came and went, and MacKenzie said the payment, which was due in January, never came.

MacKenzie said she and the client are getting the runaround from Waterford-based attorney Nicholas A. Ianni, of Ianni & Associates PLLC, who represented the insurance carrier.

“He said we would have payment on April 8, and if we did not, we agreed to the entry of judgment against the doctor,” MacKenzie said.

But April 8 passed. Still no check had arrived.

As of April 14, a judgment in the amount of $199,500 was entered against Worel; the firm is pursuing collection against him.

The delay, according a May 5 letter from Ianni to Olsman, is due to a change in ownership of the carrier.

Ianni said in a phone interview with *Michigan Lawyers Weekly* that he is working with a group of investors who are acquiring Universal.

“The carrier is technically solvent,” Ianni said, but added that there have been some delays in working out the transaction because “one asset in the corporation is not liquid.”

In a May 5 letter to Olsman, Ianni wrote: “I have been working to secure payment of the monies owed to your client from the settlement … The payment from the company, New Millenium [sic] Ltd. [which is the new name of Universal] is in process, but as we discussed I have gone back to the carrier to secure further guarantees for payment in an effort to give the carrier time to resolve it’s [sic] issues and any further costs and inconvenience to any of the parties. …

“All payments owed pursuant to the New Millenium Ltd. judgment are to be guaranteed by Nicholas A. Ianni, Jr. In the event, the payments are not made by New Millenium Ltd. by May 28, 2010, a demand promissory note will take effect.”

MacKenzie has filed a complaint with the Office of Financial & Insurance Regulation, regarding New Millenium/Universal International Insurance Ltd., and Ianni & Associates.

‘Strange resistance’

Detroit lawyer Douglas Young of Wilson Young PLC has sought out information about Universal, but so far has not been able to find much, he said.

Young has a coverage counsel practice, and represents policyholders, but is not involved in any cases involving Universal.

The trouble with carriers licensed in Bermuda, he said, is that they are regulated by the Bermuda Monetary Authority.

“The BMA does not release to the public the annual reports of companies under its jurisdiction. This is not considered public information in Bermuda,” he said.

The only public information that can be found is at the BMA website, www.bma.com, where Universal International Insurance Ltd. is identified as a Class 3 licensed entity.

“There is a danger to policy holders in these off-shore carriers,” Young said. “Doctors and hospitals should be very concerned with why these claims haven’t been paid. In a legitimate insurance company they approve claims and pay them quickly. You don’t have this strange resistance.”

Still, he said, not every off-shore policy poses a reason for worry.

“There are a lot of professional liability captive policies in the Caymans, Bermuda, Barbados, and Turks and Caicos,” Young said. “In those, a group of doctors or other affinity group could band together and self-insure through an off-shore captive, believing that they’ll have a better claims experience than all doctors.”

There are plenty of captives that are well-managed and well-funded, Young said.

But it’s important that hospitals, which require proof of insurance from doctors, look into exactly who is insuring their physicians.

“Hospitals should provide better oversight because if a doctor can’t pay, the hospital will have to,” Young said. “If I were representing a hospital or a doctor, I would go through all my insureds to find out who’s insured by this carrier. Where there’s smoke, there’s fire.”

Further, he said, there is reason to look into physicians’ coverage by an off-shore carrier.

“The whole reason to have an off-shore captive would be to garner the profits,” Young said. “Doctors have no reason to purchase off-shore insurance, unless they could not get insurance because of a claims history from a U.S.-based carrier.”

Carriers’ ‘lax oversight’

In the meantime, lawyers need to be on alert, said Marc E. Lipton, of Lipton Law Center PC in Southfield.

He also is trying to collect payment for a client, who sued a physician insured by Universal.

“[Ianni] has kept on saying not to worry. It’s going to be resolved,” Lipton said. “He said that by Sept. 30, we’ll be paid.”

But Lipton is having his doubts.

“The one thing I do know is the doctors have paid their premiums, and that seems to be the real story, that there are doctors who paid for insurance, and thought they were insured, and then are running into these problems,” Lipton said.

Southfield-based lawyer Richard A. Lenter said he also worries about the physicians who are in that predicament.

He also has a $160,000 judgment against a doctor who was insured by Universal. The case settled last year, and when the payment didn’t arrive, in December he got the judgment against the doctor. So far, he’s only been able to collect $11,000, and the doctor is panicked, he said.

He believes there are many doctors in Michigan who are covered by the carrier, which “was just offering ridiculously low rates,” he said.

“We’re not fools. But in our business, we accept another attorney’s word as gold,” Olsman said. “When they say yes, there is insurance and they provide a certificate of insurance, we believe there is insurance. … But there is lax oversight of these off-shore carriers. And there is a lack of diligence on the part of the hospitals.”

If you would like to comment on this story, please contact Carol Lundberg at (248) 865-3105 or carol.lundberg@mi.lawyersweekly.com.

“He said we would have payment on April 8, and if we did not, we agreed to the entry of judgment against the doctor.”

— Attorney Donna M. MacKenzie, Olsman, Mueller, Wallace & MacKenzie, PC.

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Leadership for Physicians, Advocacy for Patients

Discipline

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DORDESKI

Many physicians go their whole careers without ever facing a credentialing, privileging, or licensing issue.

Those physicians are fortunate.

However, other physicians who are not so lucky often fail to appreciate the seriousness of their situation and take action too late in the proceedings, thereby jeopardizing their livelihoods.

Background

When physicians are granted medical staff privileges at a hospital, they are governed by the terms and conditions of both the hospital bylaws and medical staff bylaws.

The medical staff bylaws include provisions, in some form or another, for corrective disciplinary action to be taken against physicians for events broadly described as "disruptive conduct" or "posing a threat of harm to a patient or hospital operations." Such actions are generally initiated through an "investigation," which can result from a negative patient outcome or a statistically significant number of negative outcomes, or from a patient or peer complaint.

While hospital investigations of negative patient outcomes and complaints are necessary, unfortunately, there are times when such investigations are triggered by personal animosity, anti-competitive behavior, or economic motivations, under the guise of protecting "patient welfare and safety."

Most, if not all, bylaws also contain provisions allowing for the immediate or "summary" suspension of a physician before and pending an investigation. Many physicians erroneously believe that a summary suspension is only used in the most serious of cases, such as a physician reporting to work under the influence of drugs or alcohol. In reality, that's not the requirement of most bylaws or in practice.

Regardless of the underlying reasons for an investigation or other review, it is important that physicians act swiftly to assess the situation and obtain legal counsel. Often, physicians fail to respond promptly because they are not aware of the potential outcomes of hospital investigations and corrective disciplinary action, such as being reported to the State Licensing Board (SLB) and/or the National Practitioner Data Bank (NPDB).

These physicians are often left scrambling after their privileges have been suspended, revoked, or denied, and/or a report is made to the SLB or NPDB. Significantly, in Michigan, suspensions of more than 15 days are reportable to the SLB, thus, prompt action is critical once a suspension has been imposed.

Step 1 — Where am I?

It is crucial to immediately determine whether the disciplinary or credentialing proceedings initiated by a hospital qualify as an "investigation."

While seemingly innocuous, this distinction is important because both SLB and NPBD guidelines require physicians (including dentists) to be reported if they resign during an "investigation."

Many times, resignation seems like a reasonable alternative during the proceedings, and unwitting physicians resign (without challenging the substance of the charges against them) only to discover later that the resignation itself is reportable.

What constitutes an "investigation" and how these investigations are conducted are usually defined in some manner in the bylaws. However, some bylaws are poorly written, vague (intentionally or unintentionally) and fail to properly define an investigation, or how the investigation, review, and appeals process should be conducted.

Vague procedures for the investigation/review and appeal processes favor the hospital and can do a great disservice to the physician.

In situations where "investigations" are not clearly defined under the bylaws, the NPDB Handbook and case law provides guidance to determine if an "investigation" is present. Generally, an "investigation" must meet the following criteria: formal notice of the investigation must be given to the physician; an investigation must be carried out by a health care entity, not an individual.

Thus, just because a lone individual has raised concerns about a physician's quality of care, this does not mean an investigation is present. Generally during an "investigation," a physician's files are reviewed by an ad-hoc committee or submitted for outside, independent review.

A routine or general review of cases is not considered an investigation; generally, in cases where courts uphold NPDB reports arising from resignations during "investigations," the investigation is triggered by a specific complaint or incident.

The investigation must be related to issues directly pertaining to patient care, not documentation or administrative issues.

Step 2 — What are my rights?

Regardless of whether a physician is subject to a formal investigation or a more casual review, it is important that physicians know and understand their rights under the bylaws.

For example, do they have the right to be advised of the charges being made against them? Do they have the right to respond to the charges? Can they appear at review meetings or present expert testimony in defense of their actions? Do they have the right to bring legal counsel?

If these topics are not addressed in either the hospital or medical staff bylaws, clarification should be sought through appropriate channels (i.e., chief of the medical staff, hospital legal counsel, etc.), preferably in writing.

Step 3 — What should I do?

Some physicians think they should just wait for the Fair Hearing (if things get that far) before seeking legal advice. However, waiting can be a devastating mistake.

A Fair Hearing is conducted like a "mini-trial," often with lay and expert witnesses, and can be an exhausting and extremely expensive endeavor. Additionally, by the time a Fair Hearing arrives, due process rights may have already been waived, giving way to biased and one-sided conclusions regarding the physician's conduct.

Further, a physician may accidentally miss the deadline to request a Fair Hearing; fail to properly follow request procedures; unwittingly waive the right to a Fair Hearing; or not be entitled to a Fair Hearing on all of the adverse actions they would otherwise be entitled.

Waiting until a Fair Hearing can also mean that a physician has already faced a suspension or other restriction on his/her privileges, resulting in the loss of valuable income, a loss of good will, and a report to the NPDB or SLB.

Thrown away: Rite Aid settlement underscores the importance of personal information disposal

On July 27, 2010, it was reported that Rite Aid Corp. agreed to pay $1 million to the Department of Health and Human Services (HHS) to settle potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

The settlement follows a joint investigation by the HHS Office for Civil Rights (OCR) and the Federal Trade Commission (FTC).

An investigation of Rite Aid was initiated by OCR after pharmacies were videotaped disposing of prescriptions and labeled pill bottles containing individuals' PHI into open trash dumpsters that were accessible by the public. According to reports, this practice occurred in a variety of cities across the United States.

In the investigation, OCR and the FTC found that Rite Aid: failed to implement adequate policies and procedures to ensure the privacy of PHI during the disposal process; failed to adequately train employees on the proper disposal of PHI; failed to maintain a sanctions policy for members of its workforce who improperly disposed of patient information; and failed to assess compliance with its disposal policies and procedures.

In addition to paying the settlement amount, Rite Aid signed a consent order with the FTC to settle potential violations of the FTC Act. The retailer also agreed to take corrective action to improve its policies and procedures to safeguard the privacy of its customers.

These actions will include: revising and distributing their policies and procedures regarding the disposal of PHI; adequately training workforce members on these new requirements; conducting internal monitoring; sanctioning workers who do not follow the policies and procedures; and engaging a qualified, independent third-party assessor to conduct compliance reviews and render reports to HHS.

Document Disposal

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More information on proper disposal methods can be found in the frequently asked questions about the HIPAA Privacy and Security Rules requirements for disposal of PHI on the OCR website: www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/disposalfaqs.pdf

The HHS Resolution Agreement and Corrective Action Plan can be found at: www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/riteaidres.pdf

The Rite Aid case is the second reported joint investigation by OCR and the FTC. A similar case involving another drug store chain, CVS Caremark, was settled in February 2009.

Disposing of individual health information into a trash container without proper destruction methods could violate several requirements of the HIPAA Privacy Rule. The Rule requires health plans, health care clearinghouses and most health care providers (covered entities) to safeguard the privacy of patient information. This practice extends to protecting information during its disposal.

Although the HIPAA Privacy and Security Rules do not require a particular disposal method, covered entities are responsible for determining what policies and procedures are reasonable for their institution.

In making this determination, institutions should consider the form, type and amount of PHI to be disposed. Sensitive information, such as social security number, driver's license number, credit card number, or diagnosis and treatment information will warrant more care due to the risk of identity theft, discrimination, or other harm to the individual's reputation. PHI should be rendered unreadable, indecipherable, aand unable to be reconstructed before its disposal.

Examples of proper disposal methods include: shredding, burning, pulping, or otherwise pulverizing paper records containing PHI; maintaining labeled prescription bottles in an opaque bag in a secure storage area; clearing, purging, or destroying any electronic media containing PHI; and using a disposal vendor as a business associate to pick up and destroy PHI.

"We certainly felt that it was a breach of contract, because Blue Cross had promised that they would not put TheraMatrix at a competitive disadvantage. Meanwhile, they're telling Ford, 'Hey, don't do this.'"

— Sara K. MacWilliams, Young & Susser

Their (Blue) Cross to bear

After being kicked off provider network, physical therapy business fights back

By Douglas J. Levy

For years, Robert E. Whitton was used to seeing patients getting better at TheraMatrix Services, Inc., the Pontiac-based outpatient physical therapy company he founded in 1981.

But following a $4.5 million lawsuit against Blue Cross Blue Shield of Michigan, the CEO now is immersed in rehabilitating his business' image.

"Blue Cross dominates Michigan, and has 70 percent of its population insured," he said. "And when they're able to tell people, 'Here are our terms — take it or leave it,' everyone has to take it, including TheraMatrix. I don't think TheraMatrix can ever see justice from this."

It started in 2003, when Ford Motor Co. approached TheraMatrix — which, among its other services, provides on-site physical therapy for automakers — about an outpatient, physical-therapy network carve-out plan. The program was a way for Ford to save on the health insurance costs it had been playing to Blue Cross.

Blue Cross, in turn, agreed to act as third-party administrator for the program and process the claims. It's something that Blue Cross doesn't always agree to do, said Sara K. MacWilliams, who represented TheraMatrix in asserting breach of contract and tortious interference with economic and business relationships.

"Usually, when they're doing carve-outs, they put themselves in the vendor position and put someone else in the subcontractor position," she explained.

But in February 2005, Blue Cross abruptly dropped out of the carve-out plan, leaving TheraMatrix to find a substitute third-party administrator.

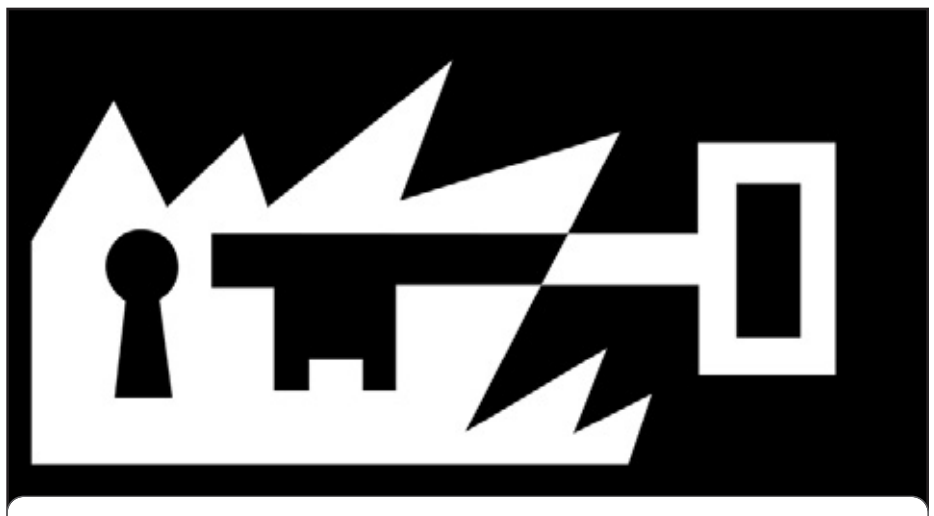
"Essentially, Blue Cross changed its mind," said MacWilliams, of Southfield-based Young & Susser. "They signed the contract, and the evidence, as far as we could tell, was that somebody at Blue Cross — we don't know exactly who — looked at the contract that the vice president had signed and said, 'We have an internal change in policy.'"

And, two months prior, before Ford signed the agreement, Whitton said Blue Cross was making threats to Ford, saying that if the automaker signed on with TheraMatrix, its hospital discounts would be impacted.

"We certainly felt that it was a breach of contract," MacWilliams said, "because

See "TheraMatrix," page 14

Proposed HIPAA regulations: What physician practices need to know



Regulation

By Abby Pendleton, Esq., Stephanie P. Ottenwess, Esq., and Jessica L. Gustafson, Esq.

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On July 14, 2010, the proposed rule amending the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy, Security and Enforcement Rules was published in the federal register (the Proposed Rule).

The purpose of the Proposed Rule is to implement many of the statutory amendments to HIPAA made by the Health Information Technology for Economic and Clinical Health Act (HITECH).

Additionally, the Proposed Rule eliminates ambiguities and improves the workability and effectiveness of existing HIPAA rules. Once finalized, physicians will have 180 days after the effective date of the final rule to come into compliance with most of the rule's provisions.

Agreements

Under the Proposed Rule, liability for HIPAA violations expands to business associates and their subcontractors. The Proposed Rule also expands the definition of "business associate" to include the following types of entities: entities that provide protected health information (PHI) data transmission services; people that offer personal health records on behalf of physicians; and any subcontractor that creates, receives, maintains, or transmits PHI on behalf of business associates.

The Proposed Rule also includes modifications to the requirements for business associate agreements. Business associates will be required to enter into agreements with their subcontractors.

Physicians need not enter into agreements with the subcontractors of their business associates; however, business associates must enter into business associate agreements with their subcontractors.

The Proposed Rule proposes the following modifications to existing requirements for business associate agreements: removes the requirement that physicians report to the Secretary when termination of a business associate agreement is not feasible; adds a requirement that a business associate must cure a subcontractor breach or terminate the contract if feasible, due to noncompliance by the subcontractor; requires that business associates comply with the HIPAA Security Rule; requires that business associates report breaches of unsecured PHI to physicians; requires that business associates ensure that any subcontractors that create or receive PHI agree to the same restrictions and conditions that apply to the business associate with respect to the information; and adds a requirement that business associates have direct liability under HIPAA.

Physicians need not enter into agreements with the subcontractors of their business associates; however, business associates must enter into business associate agreements with their subcontractors.

In an attempt to relieve some of the burden on physicians in complying with the revised business associate agreement provisions, a transition period is proposed to grandfather existing contracts for a specified period of time.

At this time, physicians should revisit their business associate relationships to ensure that they have agreements in place for all business associates. However, since the Proposed Rule has not yet been finalized, it may be too soon for physician practices to revise existing business associate agreements.

Notice of privacy practices

If provisions of the Proposed Rule are adopted without change, physicians will be required to make material modifications to their notice of privacy practices (Notice), triggering obligations to revise and distribute the "new" Notices.

Physicians will be required to revise their Notices consistent with new changes to the patient rights portion of HIPAA. Additionally, all physicians with Notice obligations will be required to revise and reissue their Notices.

This means that although handing out a Notice to a patient is typically a one-time obligation (i.e., continuing patients need not be offered a Notice at every visit), if the Notice provisions of the Proposed Rule are adopted, the practice would be required to provide all patients a new Notice.

Given that the Proposed Rule has not yet been finalized, physicians may wish to wait to revise their Notices to avoid duplication of efforts, lest the requirements change in the final rule.

Right to request restrictions

The Proposed Rule contains revisions to the patient rights provisions of HIPAA, specifically with respect to patients' rights to request restrictions to the use and disclosure of PHI.

Under the Proposed Rule, upon request from an individual, physicians must agree to restrict the disclosure of PHI to a health plan if: the disclosure is for the purposes of carrying out payment and is not otherwise required by law; and, the PHI pertains solely to a health care item or service for which the individual has paid the physician in full.

This modification would override the current provision that states that a physician is not required to agree to requests for restrictions. With respect to this proposal, a physician will be prohibited from requiring individuals who wish to restrict disclosures about only certain health care items or services (thus requiring payment in full for only those items or services) to pay out of pocket for all services.

Access to protected health information

The Proposed Rule expands physicians' obligations with respect to providing access to individuals to their PHI. Under the Proposed Rule, if the PHI requested is maintained electronically, the physician must provide the individual with access to the information in electronic form.

Marketing

Some of the biggest proposed changes to the HIPAA rules relate to the area of marketing. The Privacy Rule requires physicians to obtain a valid authorization from individuals before using or disclosing PHI to market a product or service to them.

The Proposed Rule contains three main exceptions to the definition of marketing, taking these activities out of the authorization requirement: certain health care operations communications, except where a physician receives financial remuneration in exchange for making the communication; communications regarding refill reminders or similar communications, provided that any financial remuneration received by the physician for making the communication is reasonably related to the physician's cost of making the communication; and treatment communications about health-related products or services by a health care provider to an individual.

Physicians are encouraged to review their existing marketing practices to determine whether authorizations will be required under the provisions of the Proposed Rule.

Physicians must manage new Stark law risks under the Health Care Reform Act

Compliance

By Adrienne Dresevic, Esq. and Carey F. Kalmowitz, Esq.

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There are a number of substantive provisions contained in President Obama's health care reform legislation (the Act) that effectively compel physicians and other health care providers/suppliers to take a proactive approach to compliance with the Federal Stark Law (Stark).

Failure to take such a proactive approach could trigger a high risk of False Claims Act liability. Given this background, health care providers should begin implementing steps to revisit their existing compliance programs to ensure that areas of potential risk under Stark are evaluated, incorporated, and factored into such programs.

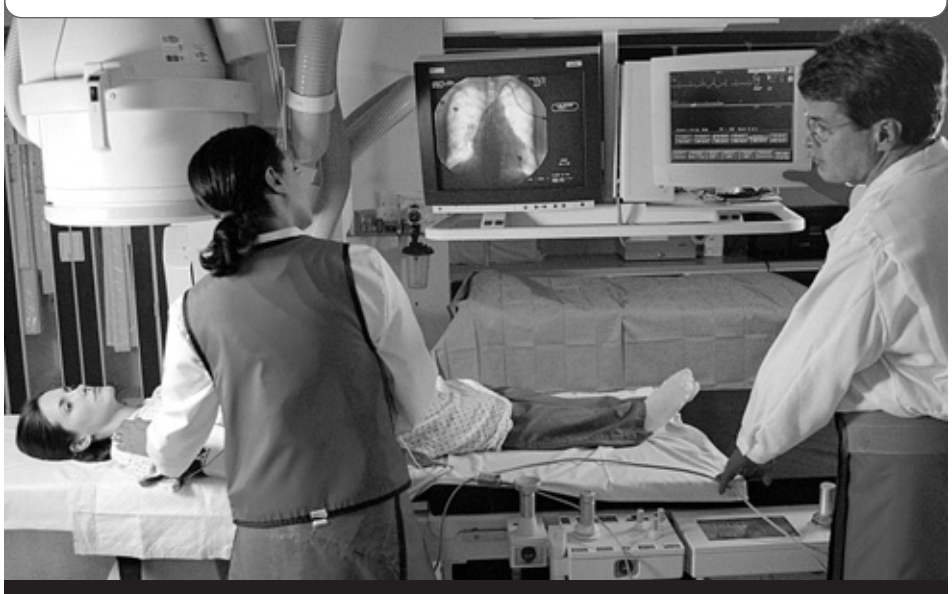
Medicare billing and payment prohibitions

Under Stark, unless an exception applies, a physician is prohibited from referring Medicare covered services to an entity for designated health services (DHS) (e.g., inpatient and outpatient hospital services physical therapy, DME, diagnostic imaging services, clinical lab services) if the physician (or his/her immediate family member) has a financial relationship with that entity.

If Stark is triggered and an exception is not met, the entity may not present or cause to be presented a Medicare claim for the DHS furnished pursuant to a prohibited referral. In addition to the Stark Medicare billing prohibition, CMS also takes the position that an entity receiving payment for a DHS that was performed pursuant to a prohibited referral must refund all collected amounts on a timely basis.

Violations and the refund dilemma

For years, it was commonplace for physicians and other industry stakeholders to creatively "fix" certain technical violations of Stark in order to avoid the draconian penalties that would otherwise apply to otherwise seemingly compliant physician financial relationships.



Some areas to evaluate under a Stark compliance plan may include contract management systems and contract review, accounts receivable and accounts payable records, tracking of nonmonetary compensation, and fair market value analysis.

For example, many typical Stark exceptions require a "signed writing" between the referring physician and the entity performing the DHS.

Thus, even if all of the other elements of an applicable Stark exception were met, if due to administrative oversight, the parties failed to obtain a signature at the commencement of the arrangement, the parties potentially could be subject to civil monetary penalties of $15,000 per claim, unless they found some means to correct that technical error.

In 2008, however, CMS confirmed that it interprets the "signed writing" requirement to mean that the signatures must be contemporaneous with the commencement date of the arrangement. Thus, parties were no longer able to "correct" Stark "signed writing" omissions simply by memorializing effective dates after the fact.

In light of CMS's position, an increasingly greater number of people in the industry have begun to take notice of these so-called technical Stark violations. During this same time, however, although the Office of Inspector General (OIG) Self-Disclosure Protocol had been a reasonably viable mechanism for resolving technical Stark violations, the OIG suddenly discontinued accepting Stark violations under its protocol, leaving physicians and other health care providers without this channel to redress the substantial dollar figures often attached to technical Stark violations.

In 2009, Obama signed the Fraud Enforcement and Recovery Act of 2009 (FERA), which amended the False Claims

See "Stark," page 18

Ten facts physicians should know about ACOs

Regulation

By Carey F. Kalmowitz, Esq., and Kathryn Hickner-Cruz, Esq.

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Medicare Accountable Care Organizations (ACOs) are a product of federal health care reform legislation.

By now, most health care providers have at least a basic understanding of the recent and broad sweeping federal health care reform legislation commonly known as the Patient Protection and Affordable Care Act (PPACA), which was enacted March 23, 2010.

One aspect of federal health care reform eliciting significant interest among health care providers is PPACA's Medicare Shared Savings Program, under which ACOs that meet certain quality performance standards will be eligible to receive Medicare shared savings payments.

PPACA requires the Secretary of the U.S. Department of Health and Human Services to establish the Medicare Shared Savings Program no later than Jan. 1, 2012.

ACOs will be eligible for financial incentives (enhanced reimbursement) based upon the quality and efficiency of care provided to their patients.

Under the Medicare Shared Savings Program, physicians and other professionals manage and coordinate the care of Medicare fee-for-service beneficiaries in a multi-disciplinary manner through ACOs.

ACOs that meet certain quality performance criteria, will be eligible to participate in the resulting Medicare savings.

It is important to note that the payments through the Medicare Shared Savings Program are enhancements to the otherwise available Medicare reimbursement. The ACO physicians and other professionals will continue to receive payment under part A and part B of the Medicare fee-for-service program in the same manner as they would otherwise. ACOs will not be penalized if quality benchmarks are not attained.

ACOs will not be permitted to directly choose the patients for which they are accountable.

PPACA provides that each ACO will be assigned at least 5,000 Medicare fee-for-service beneficiaries based upon those beneficiaries' utilization of primary care physicians. ACOs will be prohibited from taking steps to avoid patients that are likely to negatively impact the ACO's receipt of shared savings.

Primary care physicians will play an integral role in each ACO.

PPACA promotes the adoption of patient-centered "medical homes" to achieve improved quality of care through coordination of care. Because assignment of patients to an ACO is based upon the primary care physicians participating in the ACO, it is anticipated that, as a practical matter, primary care physicians will be required to have a relationship with only one ACO and will have substantial influence within the their respective ACOs.

In contrast, specialists will probably have more flexibility to belong to additional ACOs.

Those ACOs that retain patients and refer patients within their ACO network will have the greatest opportunity for success.

Although ACOs will be responsible for the care of their assigned beneficiaries, Medicare beneficiaries will be able to choose their health care providers even if such providers do not participate in the ACO to which the Medicare beneficiaries are assigned. Thus, ACOs are accountable for achieving quality of care goals without having the ability to necessarily control whether those goals are achieved.

There will certainly be an incentive for ACO physicians to refer patients to other physicians within their own ACO.

ACOs must satisfy numerous eligibility requirements in order to participate in the Medicare Shared Savings Program.

Each ACO will need to satisfy numerous requirements, including, without limitation: being willing to be accountable for the quality, cost and overall care of Medicare beneficiaries; contractually committing to participate in the Medicare Shared Savings Program for at least three years; maintaining a management structure that includes clinical and administrative systems; and adopting processes to promote evidence-based medicine and patient engagement, report on quality and cost measures, and coordinate care.

Health care providers have substantial flexibility when structuring their ACOs.

PPACA provides that numerous types of organizations can become ACOs. The various types of models can be conceptualized as highly integrated models (e.g., hospital employment and group practices), models with limited integration (e.g., joint venture, physician organization (PO) and physician hospital organization (PHO) models), and contractual models (e.g., management services and service line models).

The ability to efficiently and effectively share information will be key to the success of any ACO.

As a condition of receiving Medicare shared savings payments, ACOs will need to submit information to the Secretary that is necessary to determine the quality of care furnished by the ACO.

Each ACO will need to have the information technology and other electronic health record (EHR) infrastructure in place to maintain, share, retrieve and report meaningful and usable data.

ACOs will serve as a catalyst for further integration among health care providers.

In order to achieve the clinical and administrative coordination and sharing of information that will be necessary to the success of ACOs, physicians, hospitals and other professionals will need to integrate but within the constraints of applicable law.

Significant bodies of federal and state law impose numerous barriers to integration among health care providers, including the federal Anti-Kickback, Stark and Civil Monetary Penalty laws, federal tax exempt laws and federal and state privacy laws, federal anti-trust laws, and the state corporate practice of medicine doctrines.

The health care community is preparing for future participation in the Medicare Shared Savings Program through ACOs.

As of today, there are many uncertainties surrounding the requirements that ACOs will need to satisfy in order to receive payments under the Medicare Shared Savings Program. CMS' Notice of Proposed Rulemaking regarding this program is expected to be published during fall 2010.

Notwithstanding this current state of affairs, many providers are wisely looking beyond the basic contours of the proposed Medicare Shared Savings Program and developing strategies to prepare for its future implications.

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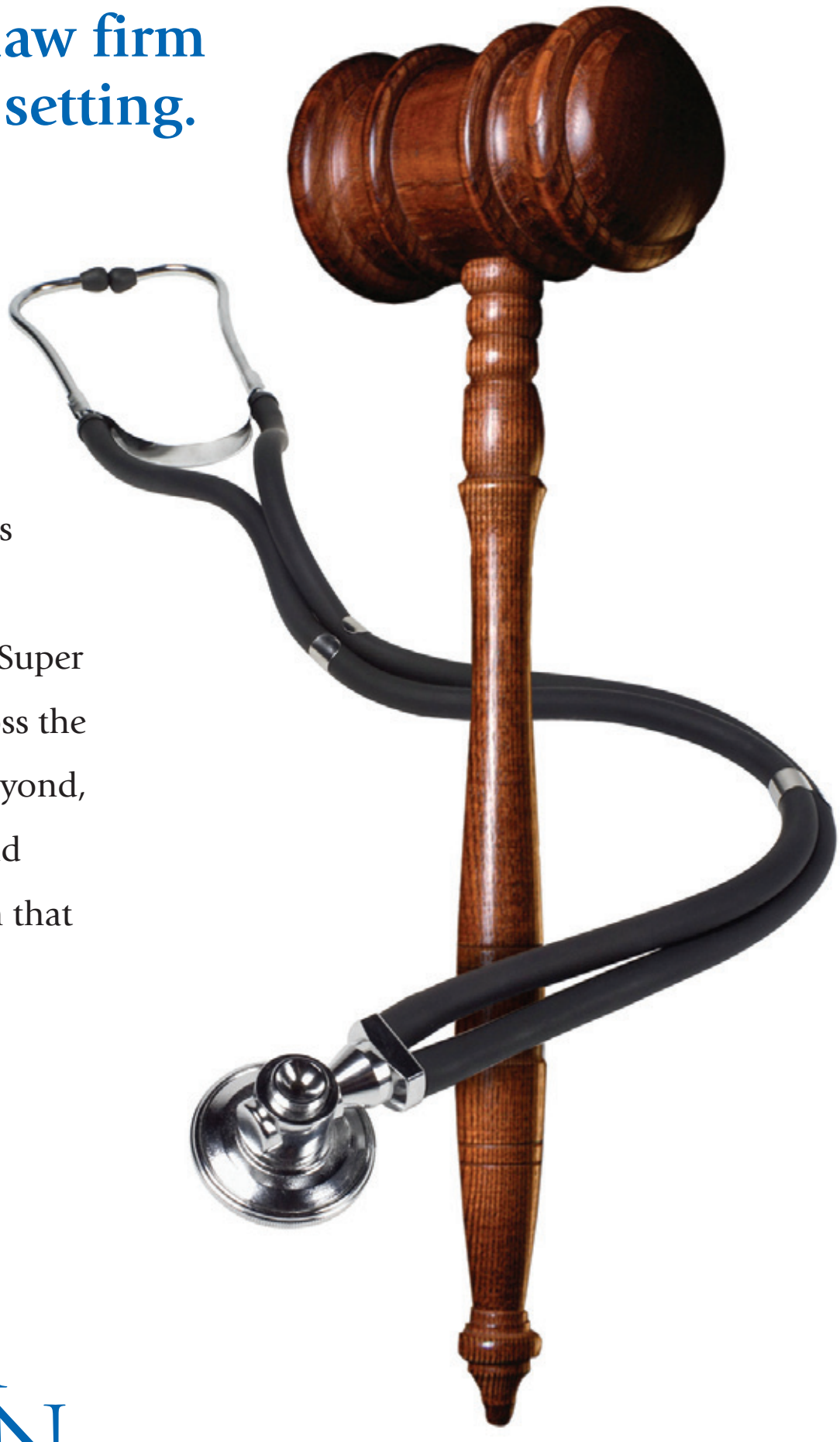

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Pending Legislation

MICHIGAN MEDICAL LEGISLATION REPORT

Following is a list of bills pending in the Michigan Legislature related to health care and health care professionals. Detailed information and analysis on this and other pending legislation can be found at www.michiganlegislature.org.

HOUSE BILLS

HB 6260 – Prohibiting research on a live or aborted embryo, fetus, or neonate after elective abortions and require consent after spontaneous and nonelective abortions

"A person shall not use a live human embryo, fetus, or neonate for nontherapeutic research if, in the best judgment of the person conducting the research, based upon the available knowledge or information at the approximate time of the research, the research substantially jeopardizes the life or health of the embryo, fetus, or neonate. Nontherapeutic research shall not in any case be performed on an embryo or fetus known by the person conducting the research to be the subject of a planned abortion being performed for any purpose other than to protect the life of the mother.

"For purposes of subsection (1) the embryo or fetus is conclusively presumed not to be the subject of a planned abortion if the mother signed a written statement at the time of the research, that she was not planning an abortion.

"A health professional or other individual shall not knowingly perform research utilizing organs, tissues, or cells taken from a dead embryo or fetus if the death of the embryo or fetus was the result of an elective abortion.

"A health professional or other individual shall not knowingly perform research utilizing organs, tissues, or cells taken from a dead embryo, fetus, or neonate, the death of which was the result of a spontaneous or nonelective abortion, unless the consent of the mother has first been obtained. Consent is not required in the case of a routine pathological study.

"For purposes of this section, consent is conclusively presumed to have been granted by a written statement, signed by the mother that she consents to the use of her dead embryo, fetus, or neonate for research.

"Written consent constitutes lawful authorization for the transfer of the dead embryo, fetus, or neonate to a medical research facility.

"Research being performed upon a dead embryo, fetus, or neonate shall be conducted in accordance with the same standards applicable to research conducted pursuant to part 101."

Sponsored by: James Marleau (R)
Referred to Committee on Health Policy

HB 6299 – Prohibit eligibility for individuals who have been convicted of any felony to be a primary caregiver for patient's medical use of marihuana

"As used in this act … '[p]rimary caregiver' means a person who is at least 21 years old, who has agreed to assist with a patient's medical use of marihuana and, beginning on the effective date of the amendatory act that added this phrase, who has never been convicted of any felony."

Sponsored by: Marty Knollenberg (R)
Referred to Committee on Health Policy

HB 6304 – Require department of community health to create electronic medical records system for state medical facilities and make available to other facilities

"On or before the expiration of one year after the effective date of this section, the department shall create, administer, and maintain a secure, paperless, electronic medical records system for use in state medical facilities. In creating, administering, and maintaining the secure, paperless, electronic medical records system under this section, the department shall do all of the following:

"(a) Utilize open-source software initially created by the United States department of veterans affairs, unless a more efficient and cost-effective software is available for this purpose, as determined by the department.

"(b) Consult with the health information technology commission; the department of human services; the department of technology, management, and budget; the department of corrections; and any other public or private entity, organization, association, or person the department considers appropriate.

"The secure, paperless, electronic medical records system created under this section shall be designed initially for clinical purposes and may include billing functions. If not included in the initial design under this section, the department shall include billing functions in the secure, paperless, electronic medical records system on or before the expiration of two years after the effective date of this section.

"Upon creation of the system, but no later than one year after the effective date of this section, the department shall notify all state medical facilities that the secure, paperless, electronic medical records system has been created and is available for use. Upon notification by the department under this section, a state medical facility shall utilize the secure, paperless, electronic medical records system.

"On or before the expiration of six months after the notification is made under subsection (3), the department shall make the secure, paperless, electronic medical records system created under this section available for use by a health facility or agency in this state or a health professional or group of health professionals in this state."

Sponsored by: Jeff Mayes (D)
Referred to Committee on Health Policy

HB 6326 – Require health facilities and certain health professionals to submit health care claims to insurance carriers electronically unless hardship exemption is granted by department

"Beginning July 1, 2011, a health care provider that submits a health care claim to a carrier for covered health care services, either directly or through a clearinghouse, billing service, or any other vendor that contracts with a health care provider to deliver health care claims to a carrier on the provider's behalf, shall submit health care claims in electronic data format to the carrier. Upon request, the director may exempt a health care provider from the requirements of this section only if the provider demonstrates hardship in complying with the requirements due to the geographic location of the provider.

"A violation of this section by a health professional is considered a violation of article 15 and that health professional is subject to administrative action under sections 16221(h) and 16226."

Sponsored by: Bert Johnson (D)
Referred to Committee on Health Policy

HB 6387 – Require accreditation for nursing education programs for licensure and specialty certification by national nursing accreditation body

"The board of nursing may issue a specialty certification to a registered professional nurse who has advanced training beyond that required for initial licensure and who has demonstrated competency through examination or other evaluative processes and who practices in one of the following health

See "Pending Legislation," page 12

Legislative Committee Members

COMMITTEE ON HEALTH POLICY

House

- Marc R. Corriveau (D) Committee Chair, 20th District
- Kate Segal (D) Majority Vice-Chair, 62nd District
- Barb Byrum (D) 67th District
- Marie Donigan (D) 26th District
- Martin J. Griffin (D) 64th District
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- Bert Johnson (D) 5th District
- Lesia Liss (D) 28th District
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- Roy Schmidt (D) 76th District
- Dian Slavens (D) 21st District
- Mary Valentine (D) 91st District
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Senate

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- Andy Neumann (D) 106th District
- Gino Polidori (D) 15th District
- Kate Segal (D) 62nd District
- Joel Sheltrown (D) 103rd District
- Jimmy Womack (D) 7th District
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- John J. Walsh (R) 19th District

Contact information for state senators can be found at http://senate.michigan.gov. Contact information for state house representatives can be found at http://house.michigan.gov.

The mind-body exception?

Immunity statute is same for physical, mental illnesses

Court of Appeals

By Carol Lundberg

If it wasn't already clear, the Michigan Court of Appeals made it so: the "medical care or treatment" exception to governmental immunity includes care for mental illness, as well as physical illness.

"This is a really important opinion," said Judge Milton L. Mack Jr., chief judge of Wayne County Probate Court, of the opinion in *McLean v. McElhaney, et al*. (Lawyers Weekly No. 07-73898, 8 pages). "I've been arguing for a long time that it's a mistake to treat mental illness differently than physical illness. Science and the medical community are way ahead of the law, the government, and policy makers."

Plaintiffs Donald and Christine McLean, representatives of the estate of their daughter Karen McLean, filed suit after Karen died. She was 30 years old.

Defendants included Hiawatha Behavioral Health (HBH), a community mental health services agency; Maureen Phenix (who died in May 2007), a clinical social worker and employee of HBH; and Samuel W. Harma, the CEO of HBH.

For 12 years, according to the opinion, Karen McLean had suffered from a major depressive disorder, bipolar illness, borderline personality disorder, anorexia nervosa, bulimia and hypoglycemia. She also had been an alcoholic for five years, and had "an extensive psychiatric history that included several suicide attempts.

Plaintiffs asserted that their daughter died "from cardiopulmonary arrest secondary to seizures brought on by her withdrawal from alcohol" after she "unsuccessfully attempt[ed] detoxification without assistance or intervention by health care professionals."

They alleged ordinary negligence, gross negligence, intentional misconduct and civil conspiracy. They also said that the defendants were not immune because they had provided medical care under MCL 691.1407(4).

The defendants moved for summary disposition under MCR 2.116(c) (7) and (8), arguing that they were entitled to governmental immunity because they did not "provide plaintiffs' decedent with 'medical care or treatment' under the 'medical care or treatment' exception."

Defendants also argued that Phenix and Harma were not grossly negligent; instead, they said, it was Karen McLean's own conduct that caused her death.

The trial court concluded that the exception applied and the plaintiff's claims were not barred by governmental immunity.

The case required the Court of Appeals to construe the medical care or treatment exception to governmental immunity, MCL 691.1407(4).

The Court of Appeals opined that immunity from tort liability "extends to all governmental agencies … when the governmental agencies are engaged in the exercise or discharge of a governmental function."

Exceptions, said the court, are to be narrowly construed.

"The plain language of the exception uses the broad phrase, 'medical care or treatment' and does not contain any language restricting or limiting the exception to medical care or treatment for physical illness or disease alone," according the opinion. "If the Legislature had intended to exclude care or treatment for mental illness or disease from the exception, it could have done so by specifically limiting medical care or treatment to care and treatment for physical disease or illness …"

It's not much of a stretch or sea change for the Court to determine there is no distinction between providing mental health care and treating physical illness, said Robert B. Sickels of Sommers Schwartz, PC in Southfield.

"The opinion just reaffirms that medical care includes mental health care," he said. "The defendants were relying on language of the statute; no case in the past had differentiated mental health care. The court reached a sensible conclusion that there is no distinction."

The Court noted that in order for the exception to apply, Karen McLean must have been a patient.

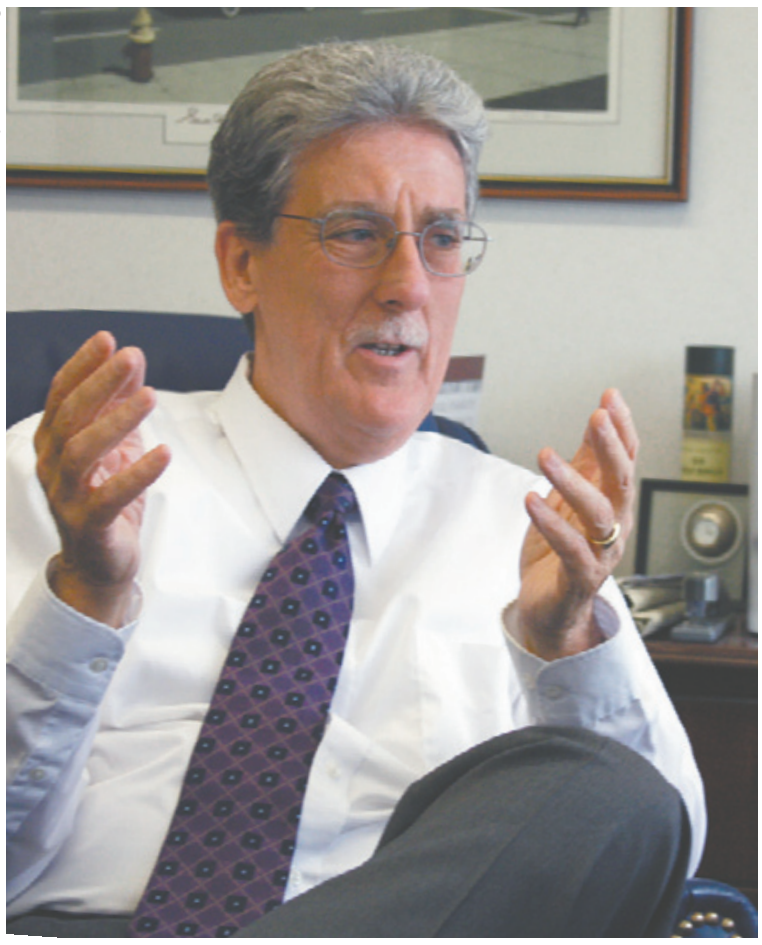
If the trial court determines that she was a "recipient," in the mental health code MCL 330.1700, it wouldn't preclude her from also being a patient, according to the court.

Plaintiffs contend that their daughter was under the defendants' care from January 1996 until Dec. 13 2000, when "treatment services were effectively discontinued although not formally terminated until January 4, 2001."

After Jan. 4, Karen McLean called HBH's crisis intervention workers more than 50 times. She was seeking, according to the opinion, "emergency counseling for her deepening depression, feelings of

See "Mind-body," page 17

LW photo by Carol Lundberg



Judge Milton Mack said *McLean v. McElhaney, et al.*, which recognizes mental illness, is a really important decision.

Decision in a nutshell

The Case: *McLean v. McElhaney, et al.*

The Facts: Karen McLean had been treated for depression, bipolar disorder, alcoholism and other mental and physical illnesses, by Hiawatha Behavior Health, a community mental health services. In late December 2000, HBH discontinued treatment services, though McLean called the agency's crisis intervention line repeatedly. She died on Feb. 14, 2001. Her parents said she died from cardiopulmonary arrest and seizures, which were the result of alcohol detoxification. They claimed that HBH, its CEO and one of its clinical social workers were grossly negligent. The defendants claimed that MCR 2.116 (c)(7) and (8) entitled them to governmental immunity.

The Decision: Affirmed in part, reversed in part and remanded; immunity statute is same for physical, mental illnesses.

From the Decision: "If the Legislature had intended to exclude care or treatment for mental illness or disease from the [governmental immunity] exception, it could have done so by specifically limiting medical care or treatment to care and treatment for physical disease or illness …"

Pending Legislation

Continued from 10

professions in the advanced practice nursing specialty fields: field of nurse midwifery, nurse anesthetist, clinical nurse specialist, or nurse practitioner. Beginning one year after the certification of administrative rules, the advanced training required under this section for the advanced practice nursing specialty fields of nurse midwifery, nurse anesthetist, clinical nurse specialist, and nurse practitioner shall be from a nursing education program that is accredited by the council on accreditation of nurse anesthesia educational programs, the accreditation commission for midwifery education of the American college of nurse-midwives, the national league for nursing accrediting commission, the commission on collegiate nursing education, or other national nursing accreditation body approved by the board for that advanced practice nursing specialty field.

"An institution seeking to conduct a nursing education program to prepare individuals for licensing shall be accredited by the national league for nursing accrediting commission, the commission on collegiate nursing education, or other national nursing accreditation body approved by the board. For purposes of this section, a nursing education program that is approved by the board on the effective date of the amendatory act that added this sentence meets the requirements of this section as long as that program becomes accredited on or before Dec. 31, 2015. The board shall continue the review process for any nursing education program that has been granted initial approval under this section and, if approved, that program meets the requirements of this section as long as that program becomes accredited on or before Dec. 31, 2015."

Sponsored by: Barb Byrum (D)
Referred to Committee on Health Policy

HB 6394 — Prohibit formation of medicinal marihuana clubs or operation of medical marihuana bars

"A person shall not organize or operate a marihuana club.

"A person shall not operate a marihuana bar or knowingly allow land or a structure on land owned by or in the possession of the person to be used as a marihuana bar.

"A person who violates this section is guilty of a misdemeanor punishable by imprisonment for not more than 90 days or a fine of not more than $500, or both.

"As used in this section:

"(a) 'Marihuana bar' means, subject to subdivision (c), land or a structure on land where an individual is allowed to use marihuana under the Michigan medical marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430, if the use of marihuana on the property is conditioned on the payment of a fee.

"(b) 'Marihuana club' means, subject to subdivision (c), an association of individuals with membership restricted to those who pay money or any other thing of value to become members, the purpose of which is to allow more than one individual to use marihuana under the Michigan medical marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430, at the same time in the same private place.

"(c) 'Marihuana bar' and 'marihuana club' do not include any of the following:

"(i) Property used as a hospice licensed under part 214 of the public health code, 1978 PA 368, MCL 333.21401 to 333.21420.

"(ii) Property used as a nursing home or skilled nursing facility licensed under part 217 of the public health code, 1978 PA 368, MCL 333.21701 to 333.21799e.

"(iii) Property where marihuana is legally dispensed under the Michigan medical marihuana act, 2008 IL 1, MCL 333.26421 to 333.26430.

"(d) 'Payment of a fee' means the payment of money or any other thing of value. Payment of a fee includes the purchase of goods or services, including goods or services that are not incidental to the use of marihuana, and the payment of money or any other thing of value to belong to an association of individuals."

Sponsored by: Rick Jones (R)
Referred to Committee on Health Policy

HB 6408 — Use of acupuncturist title by certain registrants and expand to include individuals certified by certain associations

"Except as otherwise provided under subsection (2), after rules are promulgated under section 16145, an individual shall not use the words, titles, or letters 'acupuncturist,' 'certified acupuncturist,' or 'registered acupuncturist,' or a combination thereof, with or without qualifying words or phrases, unless he or she is registered under this part.

"Neither of the following is subject to the provisions of this part:

"(a) A physician who is licensed under part 170 or 175.

"(b) An individual who is certified by the national acupuncture detoxification association or the American Manual Medicine Association."

Sponsored by: Gary McDowell (D)
Referred to Committee on Health Policy

SENATE BILLS

SB 0858 — Amend 1961 PA 236, to limit liability for emergency treatment rendered in a hospital

"A licensed health care professional or a licensed health facility or agency is not liable in an action based on medical malpractice arising out of the provision of emergency medical care in an emergency department or obstetrical unit located in and operated by a hospital, or in a surgical operating room, cardiac catheterization laboratory, or radiology department immediately following the evaluation or treatment of the patient in an emergency department, unless the plaintiff proves by clear and convincing evidence that the licensed health care professional's actions constituted gross negligence.

"In an action described in subsection (1), the court shall instruct the jury to consider, in addition to all other relevant matters, all of the following:

"(a) Whether the person providing care had the patient's full medical history, including knowledge of pre-existing medical conditions, allergies, and medications.

"(b) Whether there was a preexisting licensed health care professional-patient relationship.

"(c) The circumstances that constituted the emergency.

"(d) The circumstances surrounding the delivery of the emergency medical care."

Sponsored by: Roger Kahn (R)
Referred to the Committee on Judiciary

SB 1303 — Michigan business tax; definition of purchases from other firms; include cost of vaccines and certain pharmaceuticals administered by physicians

"'Purchases from other firms' [now includes]:

"For tax years that begin after December 31, 2009, for a taxpayer licensed under part 170 of the public health code, 1978 PA 368, MCL 333.17001 to 333.17084, or under part 175 of the public health code, 1978 PA 368, MCL 333.17501 to 333.17556, payments for the purchase of vaccines and any other pharmaceutical drugs that are administered by the taxpayer in the ordinary course of his or her business."

Sponsored by: Randy Richardville (R)
Referred to Committee on Finance

BILLS PASSED

SB 1315 — Modify accreditation requirement for institutions that offer doctoral degrees in psychology; to recognize nationally accredited institutions

Sponsored by Gilda Jacobs (D)
Passed in House (104-2), Senate (37-0), approved by governor

Are health care institutions government contractors?

Regulations

By Adil A. Daudi, Esq.

Adil Daudi is an attorney with Smith Haughey Rice & Roegge in Ann Arbor. He represents physician groups, hospitals and health care providers of all types in general health, transactional and regulatory matters, with an emphasis on medical staff matters, reimbursement, and regulation of hospital-physician relationships. He can be reached at (734) 913-6907 or adaudi@shrr.com.

In the May 20, 2010, Federal Register, the Department of Labor (DOL) published a rule that references a new notice that must be included in any contracts or subcontracts with the federal government, and must be posted at the worksite of federal contractors or subcontractors.

The notice is similar to the postings currently required informing employees of their rights under state and federal anti-discrimination and FMLA.

The new rule involves informing employees about their rights under the National Labor Relations Act. It is considered a "victory" by labor unions because it contains very specific language about what employees (and employers) can and cannot legally do in the workplace.

It also is much longer than the typical notices found in employee posters.

This is an issue of particular concern for health care institutions, because the Office of Federal Contract Compliance Programs (OFCCP), which monitors labor laws and regulations governing government contractors, has taken an expansive view of the types of entities that may qualify as a government contractor or subcontractor.

While the OFCCP has affirmed its position that it does not have jurisdiction over health care institutions based solely on the institutions' provider agreements for reimbursement services covered under the Medicare and Medicaid programs, it has extended its jurisdiction to other areas involving health care institutions.

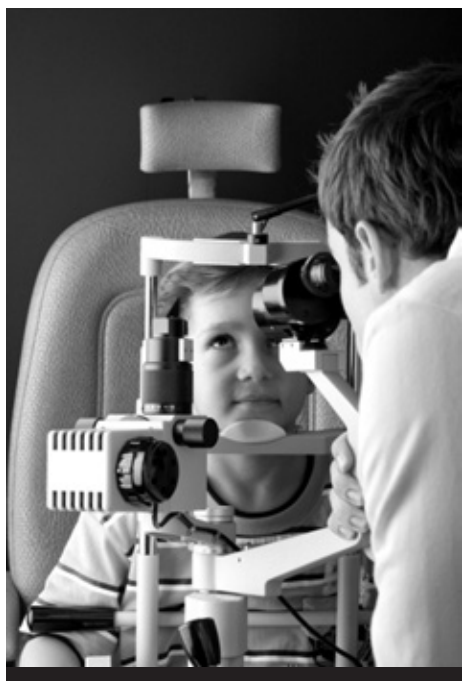
Specifically, according to the OFCCP, its jurisdiction extends to health care institutions that: (1) provide medical care to federal employee members of an HMO based on the HMO's contract with the government; and (2) contract with health benefit plans that act as regional administrators for the TRICARE program.

Pursuant to the federal regulations applied by the OFCCP, the terms "government contract" and "subcontract" make a distinction between "personal" versus "non-personal services." See 29 CFR 471.1.

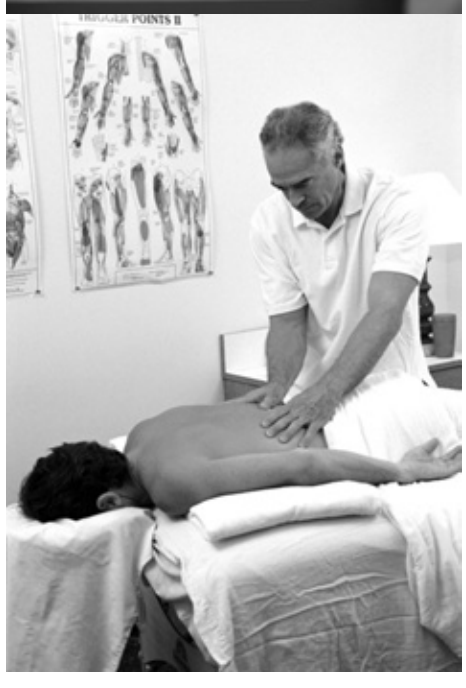
One of the positions advanced by health care institutions to dispute the OFCCP's jurisdictional claim is to argue that their participation in HMO-style arrangements and contracts with regional administrators for the TRICARE program are for "personal services," specifically medical services.

See "Contractor," page 15

More data: New rule represents expansion of collection and dissemination of information



Licensed practitioners subject to Section 1921 reporting requirements include chiropractors, podiatrists, pharmacists, physician assistants, optometrists, nurses, physical therapists and social workers.



Licensing

By Andrew B. Wachler, Esq. and Jesse Adam Markos, Esq.

WACHLER

MARKOS

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Jesse Adam Markos is an associate at Wachler & Associates, P.C., where he practices in all areas of health care law with a specific concentration in license defense, staff privileging matters, and Medicare and other third-party payor audit defense. He also provides assistance to clients with transactional, corporate, and regulatory compliance matters. Contact him at (248) 544-0888 or jmarkos@wachler.com.

The Department of Health and Human Services Final Rule implementing Section 1921 of the Social Security Act represents a sweeping expansion of the information collected and disseminated through the National Practitioner Data Bank (NPDB).

Among other changes, Section 1921 expanded the current adverse licensure action reporting requirements for state licensing authorities.

These new reporting requirements are intended to help the health care community make sound employment, credentialing, and licensing decisions. The resulting increase in the volume and scope of reporting will have significant professional and economic ramifications for many physicians, dentists, and health care practitioners.

The NPDB was established by the Health Care Quality Improvement Act (HCQIA) of 1986 as an alert system designed to collect and disseminate information and assist states in protecting the public from unfit physicians, dentists, and other health care practitioners.

A report to the NPDB can have significant professional and economic ramifications. State licensing authorities, hospitals and other health care entities, and professional societies query the NPDB when investigating qualifications. A response that contains an adverse action can result in denial of credentialing, loss or limitation of hospital privileges, loss or limitation of licensure, exclusion from participation in health plans, and increases in premiums or exclusion from professional liability insurance.

On March 1, 2010, the NPDB was expanded by the implementation of Section 1921. Previously, state licensing authorities were only required to report adverse actions taken against physicians and dentists related to their professional conduct or professional competence. These adverse actions included a revocation, suspension, reprimand, probation, surrender, or censure.

State licensing authorities also reported adverse actions to the Healthcare Integrity and Protection Data Bank (HIPDB).

The HIPDB was created by the Health Insurance Portability and Accountability Act of 1996 to combat fraud and abuse in health insurance and health care delivery.

The HIPDB includes adverse licensure actions taken against health care practitioners other than physicians and dentists, as well as licensure actions taken against physicians and dentists that are not related to professional competence or professional conduct. However, a report to the HIPDB had limited professional and economic ramifications because the HIPDB was only accessible by federal and state agencies and health plans.

The implementation of Section 1921 expanded the current NPDB adverse licensure action reporting requirements for state licensing authorities in two ways.

First, state licensing authorities must report adverse actions taken against all health care practitioners, not just physicians and dentists, as well as those actions taken against health care entities.

As a result, private-sector hospitals and health care organizations, which previously did not have access to licensure actions taken against all health care practitioners through the HIPDB, now have access through Section 1921.

Licensed practitioners that are subject to Section 1921 reporting requirements by the state licensing authorities include, but are not limited to, chiropractors, podiatrists, pharmacists, physician assistants, optometrists, nurses, physical therapists and social workers.

Second, state licensing authorities must report any adverse actions, including revocation or suspension of a license, reprimand, censure, or probation resulting from a formal proceeding. Under Section 1921 the NPDB is no longer limited to reports of actions judged by the licensing authority to be based on the quality of the health care services provided.

State licensing authorities also must report any publicly available negative action or finding that results from a formal proceeding.

The definition of "negative action or finding" excludes administrative fines or citations, and corrective action plans unless they are connected to health care delivery or taken with another reportable action. An example of an administrative fine unrelated to health care delivery would be a fine for failing to notify a licensing authority of an address change in a timely manner.

After implementation of Section 1921, the reporting requirements for state licensing authorities to the NPDB and the HIPDB are similar with the exception of a few key differences.

For example, adverse actions do not have to be final to be reportable to the NPDB while the HIPDB only collects final adverse actions. Also, publicly available negative actions or findings reportable to the NPDB include administrative fines or citations related to health care delivery or taken with another reportable action while they are reportable to the HIPDB only if they are both related to health care delivery and taken with another reportable action. Otherwise, the reporting of adverse actions by state licensing authorities is nearly identical for both data banks.

After implementation of Section 1921, actions reportable by a state licensing authority may include the following: a revocation, suspension, limitation, restriction, censure, reprimand, probation; voluntary surrender of a license (except for relinquishment for personal reasons such as retirement or change to inactive status); denial of an initial application or renewal; and withdrawal of an application

Other actions include a monetary penalty that is a formal disciplinary action imposed by the board; modification to a previously reported action, including reinstatement; summary suspensions; publicly available administrative fines or citations related to health care delivery or taken with another reportable action.

The Final Rule implementing Section 1921 also requires state licensing authorities to retroactively report actions that meet the Section 1921 reporting criteria dating back to Jan. 1, 1992. To ease the resulting administrative burden, the Department of Health and Human Services provides state licensing authorities the option of submitting HIPDB legacy reports. Pursuant to these reports, all adverse licensure actions reported to the HIPDB dating back to Aug. 21, 1996 are placed in the NPDB under Section 1921.

Physicians, dentists, and health care practitioners facing an investigation or administrative action by the State of Michigan or with a previous action made retroactively reportable by implementation of Section 1921 must become familiar with the expanded adverse licensure action reporting requirements and the professional and economic ramifications of a report to the NPDB.

'Meaningful use' regulations ease burdens on providers

Following receipt of more than 2,000 comments from concerned providers and health care professionals, the Centers for Medicare and Medicaid Services (CMS) and the Health and Human Services Office of the National Coordinator for Health Information Technology have revised the standards for providers to make "meaningful use" of health information technology.

The comments, received between Jan. 13–March 15, 2010, illustrated providers' and health care professionals' concerns that the criteria for meaningful use were set too high and the regulations needed more flexibility to enable eligible professionals and hospitals to meet the required objectives and measures.

Starting in 2015, providers that do not make meaningful use of certified electronic health records (EHR) will receive progressively reduced payment adjustments to their Medicare and/or Medicaid reimbursement. Conversely, providers may be eligible to receive incentive payments to help recoup a portion of their costs if they can demonstrate meaningful use of certified EHR technology.

Under the final rule, which was published July 28, 2010, CMS abandoned its original "all-or-nothing" approach to offering incentives for the adoption of EHR. Health care providers now have various ways of reporting objectives to demonstrate meaningful use of EHR.

Additionally, some objectives that were deemed too difficult to achieve by the original 2011 deadline will be delayed a year. The final rule enables eligible professionals and hospitals that demonstrate meaningful use of information technology, as contemplated by the regulation, to tap into some $27.3 billion in financial incentives.

Health technology

By Maro E. Bush, Esq.

Maro E. Bush is an associate with Frank, Haron, Weiner and Navarro PLC, where she focuses her practice on federal False Claims Act/qui tam litigation and health care law, including representation of individual physicians, health care professionals and other health care entities in a variety of areas relating to health law and regulations. Contact her at (248) 952-0400 or mbush@fhwnlaw.com.

Getting started

Through its incentive program, CMS hopes to encourage meaningful use of EHR by providers. EHR technology captures patient data, which can then be used to facilitate the electronic exchange of health information and improve clinical processes, as well as track and submit clinical quality measures to improve population and public health outcomes.

Stage 1 of meaningful use implementation begins in 2011 and 2012. In early 2011, eligible professionals and hospitals may begin registering for the EHR Incentive Program via the EHR Incentive Program website.

Providers must be enrolled in Medicare, Medicare Advantage or Medicaid and have a National Provider Identifier (NPI).

After successfully registering, providers can begin using "certified" EHR technology to demonstrate meaningful use.

On Aug. 30, 2010, the Office of the National Coordinator for Health Information Technology announced that the Certification Commission for Health Information Technology and the Drummond Group, Inc. were the first technology review bodies authorized to test and certify EHR systems for compliance with the rule.

This means that EHR vendors can begin to have their products certified. By purchasing certified products, providers can be assured that the products support achievement of meaningful use objectives.

During Stage 1, eligible professionals and hospitals are required to have 80 percent of patient records implemented into certified EHR technology, and must use the technology to meet certain objectives and measures.

Eligible professionals that work at multiple locations and do not have certified EHR technology available at all of them may still demonstrate meaningful use if 50 percent of their total patient encounters occur at locations where certified EHR technology is available.

In 2011, eligible professionals and hospitals seeking to demonstrate meaningful use will be required to submit data related to these objectives and measures to CMS or the states via attestation. Beginning in 2012, the submission will be made electronically.

Meeting core objectives

One of the major changes in the final rule reduced the number of "core" objectives providers are required to meet. In its proposed rule published in January 2010, CMS had required eligible professionals to meet 25 measures and eligible hospitals to meet 23 measures in order to demonstrate they were meaningfully using EHR.

However, under the final rule, eligible professionals must meet 15 of the core requirements, and eligible hospitals must meet 14.

Among the core set of objectives are computerized physician order entry, drug and allergy interaction checks, protection of electronic health information and the capability to exchange key clinical information among providers and patient-authorized entities.

All providers must also choose and meet an additional 10 measures from a "menu set" of procedures, such as drug-formulary checks, medication reconciliation (i.e. identifying the complete list of medications any particular patient has been prescribed) and capability to submit electronic data to immunization registries. However, providers may defer up to five of them until the next implementation stage (explained in further detail below).

During Stage 1, eligible professionals have to report on 20 of 25 of the chosen meaningful use objectives and eligible hospitals have to report on 19 of 24 meaningful use objectives.

The reporting period is 90 days for the first year and an entire year for each subsequent year. Essentially, this means that providers need only implement and demonstrate 90 days of meaningful EHR use for the first year.

What to expect down the road

CMS intends to propose two additional Stages through future rulemaking. These future Stages will expand upon the Stage 1 criteria outlined above.

Additionally, CMS will reevaluate the measures and potentially institute higher thresholds that providers must meet to demonstrate meaningful use. In Stages 2 and 3, there also will be a greater emphasis on health information exchange across institutional boundaries.

TheraMatrix

Continued from page 7

[Blue Cross] had promised that they would not put [TheraMatrix] at a competitive disadvantage. Meanwhile, they're telling Ford, 'Hey, don't do this.'"

Then, when word got out that TheraMatrix was coming up with a similar program for DaimlerChrysler, Blue Cross dropped TheraMatrix entirely from its provider list.

'We just barely hung on'

MacWilliams said that was grounds for tortious interference.

"Blue Cross didn't have the legal right to do that, because they are a nonprofit, benevolent health care corporation," she said, "and their goals as a business are to promote savings, not to kick someone out of a network because it would impact their bottom line."

The months that followed, Whitton said, were "devastating," and resulted in laying off 60 employees, reducing business hours among its 13 Michigan clinics, and cutting benefits.

"We cannot see a patient unless a doctor writes a prescription and sends that patient to us," Whitton said. "Then, Blue Cross tells thousands of doctors, 'If you send them to TheraMatrix, we're not going to pay for it.'

"There was no way we could sustain with that kind of a loss, and we just barely hung on."

Blue Cross added TheraMatrix back onto the provider list 18 months later because, Whitton said, the political pressure was mounting. Patients who had been coming to TheraMatrix for years bombarded Blue Cross with letters of complaint, and union officials also voiced their dissatisfaction.

"[Blue Cross] hoped that letting TheraMatrix back in the network would shut them up about this," MacWilliams said.

But because TheraMatrix was now at the bottom of the provider list, there was the misconception that TheraMatrix did something wrong to get there, such as billing fraud or breach of standard of care. When Blue Cross originally sent letters to insurance agents, doctors and companies alerting them of TheraMatrix being off the provider list, there was no indication why.

It meant engaging in massive damage control, with Whitton and COO Robert Read meeting with doctors who had long been with TheraMatrix and assuring them that there was no foul play.

In 2008, TheraMatrix filed suit against Blue Cross in Oakland County Circuit Court.

E. Powell Miller of The Miller Law Firm, P.C. in Rochester said that in his experience in business litigation, plaintiffs like TheraMatrix risk a lot in going up against corporations such as Blue Cross.

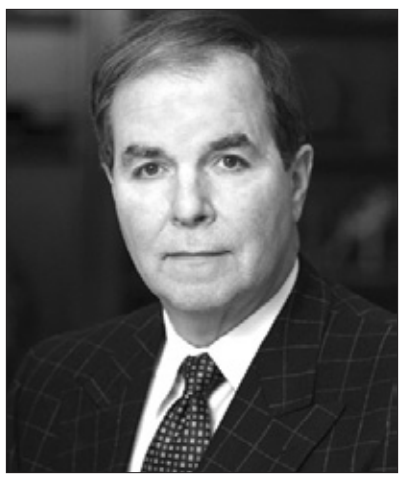
"I've represented many small companies who were abused and decimated by bigger companies and have seen the extraordinary devastation it can wreak on employees' confidence and culture," he said. "There's a tremendous struggle for that small company to survive."

Pointing out 'harmful' matter

But Rodger D. Young, who co-counseled the case, said the prime strategy was using adverse witnesses from Blue Cross, something that resonated with the seven-member jury at trial.

"If depositions are prepared in the right way," Young explained, "they provide a powerful basis upon which to call adverse witnesses to trial and display very, very harmful information for the other side."

These witnesses included a former Blue Cross vice president, who was in charge of the Ford matter, and a current Blue Cross vice president.



"If depositions are prepared in the right way, they provide a powerful basis upon which to call adverse witnesses to trial and display very, very harmful information for the other side."

— Rodger D. Young, Young & Susser

"I don't know if they directly admitted [that what Blue Cross did] was 'wrong,'" Young said, "but they made enough admissions on cross-examination so the jury was able to infer that Blue Cross breached the contract with TheraMatrix and interfered with the relationship with Chrysler."

And when e-mails discussing plans to terminate TheraMatrix from Blue Cross' provider list were presented, "They really couldn't dispute it because they were fundamentally footprints in the snow that they couldn't deny."

On July 22, 2010, the jury found for the plaintiffs, and awarded $4,100,293 for breach of contract and $449,052 for tortious interference.

Laurine S. Parmely, counsel for Blue Cross Blue Shield of Michigan, said the company is reviewing for grounds for appeal.

"We're disappointed in how [the verdict] turned out, but we don't see this as more than a simple, contractual business dispute between two parties," she said.

Meanwhile, Young said TheraMatrix may file another suit to seek damages for money lost during the 18-month hiatus from Blue Cross' provider network. As well, he added, there could be counts of anti-trust and anti-competitiveness asserted against Blue Cross, as officials from the Michigan Attorney General's Office and the U.S. Department of Justice monitored the trial.

In between it all is Whitton's mission of rebuilding his company and fixing its reputation in the medical community. He said that TheraMatrix's annual net profits from its outpatient clinic services used to average $1 million; in the years after it was dropped from Blue Cross, the company's been operating in the red.

"Is it reparable? We're not quite sure," he said. "We were No. 1 on many, many physicians' referral lists. Now we're at the bottom of the list. It's like we're not even on it."

A Verdicts & Settlements report on *TheraMatrix Services, Inc. v. Blue Cross Blue Shield of Michigan* can be found at www.milawyersweekly.com.

If you would like to comment on this story, please contact Douglas J. Levy at (248) 865-3107 or douglas.levy@mi.lawyersweekly.com.

Contractor

Continued from page 13

And since the regulations define government contracts and subcontracts as contracts for "non-personal services," their contracts do not fall within the definitions.

While this position has strong regulatory support, it has been challenged by the OFCCP. Specifically, in a series of administrative rulings, the OFCCP has successfully asserted its position that a health institution participating as an HMO-style provider and contracting with regional administrators for the TRICARE program are government subcontractors.

In *OFCCP v. UPMC Braddock* (2009), an Administrative Review Board (ARB) held that three Pittsburgh hospitals qualified as subcontractors and fell within OFCCP jurisdiction, despite the fact that they did not directly contract with the government.

In *Braddock*, each Pittsburgh hospital at issue had an HMO contract with the University of Pittsburgh Medical Center (UPMC) Health Plan to provide medical services to government employees covered by the UPMC Health Plan pursuant to a contract between the Health Plan and the United States Office Personnel Management (OPM).

The ARB ruled that the hospitals were federal subcontractors because the hospital's provision of medical services and supplies constituted a critical component of UMPC Health Plan's contract with the government. Significant to the ARB ruling was the fact that the UPMC Health Plan depended on the hospitals to offer medical services and supplies for UPMC to meet its obligations to the government.

In the *UPMC Braddock* decision, the OFCCP drew a tenuous distinction from an earlier 2003 decision in *OFCCP v. Bridgeport Hospital*. In *Bridgeport Hospital*, the ARB considered a case where Blue Cross/Blue Shield (BCBS) held a contract with the OPM to provide health insurance to federal government employees.

Similar to the three hospitals in *Braddock*, the Bridgeport Hospital contracted with BCBS to provide medical care to BCBS policyholders. In *Bridgeport*, however, the ARB determined that the hospital was not a subcontractor because its contract with BCBS was for reimbursement of covered services.

Also, the ARB in *Bridgeport Hospital* found it to be significant that the hospital did not contract to provide or guarantee the services themselves which, as discussed above, was relevant to the ARB in the *UPMC Braddock* case.

In a more recent case, the OFCCP appears to be extending its jurisdictional claim even further to include the position that health care institutions are subcontractors when they contract with health benefit plans that act as regional administrators for the TRICARE program.

In *OFCCP v. Florida Hospital of Orlando*, the OFCCP is targeting TRICARE contracts with its regional administrators (called TRICARE North, TRICARE South and TRICARE West), which require the development of provider networks in their respective regions.

According to the OFCCP position, the regional administrators' contracts with health care institutions to provide medical services to TRICARE beneficiaries creates a subcontractor relationship between the health care institutions and the government.

Like the ruling in *Braddock*, the OFCCP is taking the position that these health care institutions are federal subcontractors because providing health care services to TRICARE beneficiaries is a critical component for regional administrators to meet their obligations pursuant to their contracts with TRICARE.

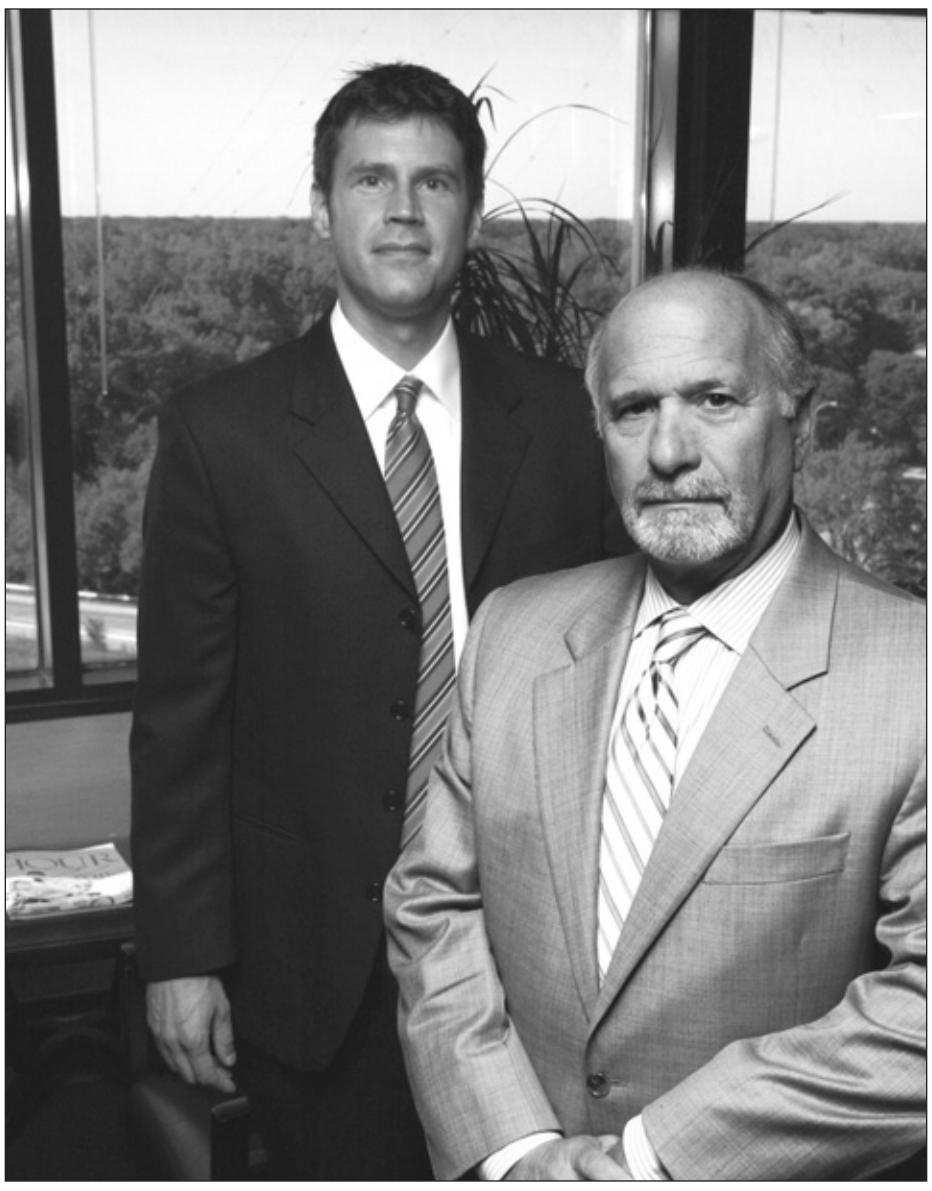
Both the *Braddock* and *Florida Hospital of Orlando* cases are being challenged and their outcomes will have important implications for health care institutions' compliance with DOL notice requirements.

In light of these rulings, health care institutions should evaluate their federal contracts and grants to assess whether they may be considered government contractors by the OFCCP.

Assessing inherent risks

Cauterization procedure leads to flash fire; negligence vs. malpractice

By Douglas J. Levy



LW photo by Douglas J. Levy

Scott Weidenfeller (left) and David J. Winter of Sommers Schwartz, P.C. contend that a recent case involving a 75-year-old woman who was burned in an ICU flash fire was the result of ordinary negligence, not medical malpractice.

Was it medical malpractice or ordinary negligence?

Attorneys for Valerija Milosevic, a 75-year-old woman who sustained massive first- and second-degree burns in an ICU flash fire, contend it was the latter.

After all, said co-counsel Scott Weidenfeller, the resident who was suturing the plaintiff's face had the thermocauterization device — which reaches up to 900 degrees — too close to the pure oxygen flowing into her non-rebreather mask.

And, the Henry Ford Macomb Hospital doctor testified on the stand, he knew there were things printed on the unit, but he never read any of it.

"Right on the device, the manufacturer put a warning that says, 'Do not use in a rich oxygen environment,'" said Weidenfeller, of Sommers Schwartz, P.C. in Southfield. "It's our position that this makes it ordinary negligence, and it doesn't take any specialized medical or scientific training to look at a device that heats up to 900 degrees and has a warning right on it. To plow forward in that circumstance is general negligence."

But the doctor's admission and the device itself weren't presented until the middle of trial — long after Macomb County Circuit Court Judge Diane M. Druzinski ruled that medical malpractice law would apply to this action. Her reasoning was the cauterization procedure was considered a surgery.

Lee A. Stevens of Feikens Stevens Kennedy & Galbraith PC in Detroit, who represented Henry Ford Macomb, said the judge was correct to rule as she did.

"It was a question of treatment modality and technique in application of that modality," he said.

Medical-malpractice defense attorney Bruce A. Vande Vusse echoed his sentiments. He pointed to *Bryant v. Oakpointe Villa*, a 2002 Michigan Court of Appeals case that set ground rules on how judges are to decide whether ordinary or professional negligence — or both — will apply.

"Even within that dichotomy, it isn't always clear," said Vande Vusse, of Foster, Swift, Collins & Smith, P.C. in Farmington Hills. "When you're using physicians who are using complicated tools that have inherent risks with them, which electrocautery would have, fire is probably a more remote risk than a common risk. That fits pretty easily, in my view, in the medical-malpractice niche."

As a result, even though the jury awarded $165,000 in economic damages and $1.05 million in non-economic damages, the latter damages are reduced to $408,000 because of caps. Had the negligence claim been accepted, there would have been no non-economic caps.

So Weidenfeller and co-counsel David J. Winter and Lisa Esser will ask at judgment to have the law of ordinary negligence applied and, if necessary, have the case retried on it.

"That's the distinction, the exercise of medical judgment, and it's a big shield that they can hide behind," Winter said. "… If all [the hospital] can lose is $400,000, and they know it's going to cost you $40,000 or $50,000 to try it, the cap has a chilling effect on the right to a trial by jury."

A fall and a fire

Plaintiff's counsel contended that Edith and Michael Torres, Milosevic's daughter and son-in-law, had housed her for 20 years, and she was a contributing member of the household by way of cooking and watching the children.

Milosevic suffered a heart attack and was taken to Henry Ford Macomb. But because Milosevic was heavily medicated and agitated, she was restrained to her bed. When a nurse removed the restraints, Milosevic fell and sustained a massive cut over her left eye and forehead. That led to the cauterization procedure, then, 15 minutes into it, the fire.

Nurses who testified included a 40-year veteran, all of whom said they had never seen such a cauterization unit used in ICU while a flowing oxygen tank was in close proximity — and said they were shocked that such a procedure was done the way it was.

The defense, however, said that Dr. Nathan Fierce followed standard procedure, with an expert asserting the resident applied the appropriate technique.

"We were taken aback by that," Weidenfeller said, "and we were also worried that perhaps we were seeing the case differently than the jurors, because to us it was black and white; 'You lit the woman on fire.'"

But Vande Vusse said that the theory of the warning label on the cauterization device can only go so far.

"I don't think I buy that," he said. "You still have to be using it in a skilled sense; realistically, the issue is, should the resident have known [the risks] by virtue of his training? I think it's a simplistic analysis to say any juror sitting there can read the warning, but any juror sitting there wouldn't have a clue as to how it's to be used and the risks of it."

Visualizing damages

The jurors — which included a lab tech, an ICU nurse and a nursing home worker — almost didn't get to see pictures of the burns, as the defense tried hard to preclude those from evidence.

"They claimed they were more prejudicial than probative, and that all they showed was a bunch of soot on her face, basically," Weidenfeller said.

But Druzinski ruled that because plaintiff's claims were for scarring and pain and suffering, the pictures were allowed.

Weidenfeller said his team's strategy was to not show the unsettling images — taken by family members via camera-phone an hour after the accident, as the Clinton Township-based hospital claimed it never took photos — until near the end of the case.

"We wanted to make sure the jury heard the case first before they saw them," he explained, "because psychologically, we wanted the jury to be open to listening to our case, then see what the result was."

"And we didn't keep throwing that picture up there" as a means of hammering it into the juror's minds, Winter added.

In the end, the jury found for the plaintiff and awarded $165,000 in economic damages and $1.05 million in non-economic damages based on the medical malpractice claim. They didn't, however, find for an ordinary negligence claim that plaintiff's counsel filed for Milosevic's fall from the bed.

"She was on an upward trajectory of healing. And [the hospital] cut it short," Weidenfeller said, who asserted that the fall from the bed was one of the reasons why Milosevic is now in a nursing home. "And where she would have ended up, we don't know. She was improving, but because of that fire, she regressed. … It was a problem for us to prove how much better she would have gotten after that heart attack. … We think the jury just wasn't sure, and they did not award all the damages from that."

Stevens said it is to be determined whether Henry Ford Macomb plans to appeal the medical-malpractice verdict.

A Verdicts & Settlements report on *Torres, et al. v. Henry Ford Macomb Hospital* can be found at www.milawyersweekly.com.

If you would like to comment on this story, please contact Douglas J. Levy at (248) 865-3107 or douglas.levy@mi.lawyersweekly.com.

Fulton

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away wrote, the circumstances dictated it.

"It is also important to emphasize that not all traditional medical malpractice cases can or will be expressed in statistical or percentage terms, nor is plaintiff required to express proximate causation in percentage terms. The plain language of the statute requires that proximate causation in traditional malpractice cases be expressed by showing that the defendant's conduct was *more probably than not* a cause of the injury not by statistical or percentage terms."

Justice Elizabeth A. Weaver joined Hathaway's decision, while Chief Justice Marilyn Kelly and Justice Michael F. Cavanagh concurred.

Justice Stephen J. Markman concurred in the result only, finding O'Neal's claim to be a "lost opportunity" claim "because it is possible that the bad outcome here, i.e. suffering a stroke, would have occurred even if plaintiff had received proper treatment." He wrote that O'Neal's statistical evidence raised a genuine issue of fact.

Justice Robert P. Young Jr. dissented, complaining that the majority is simply looking to overturn the decisions it didn't like from the previous court under former Chief Justice Clifford W. Taylor.

"Chaos and confusion in the law only promote *more* litigation," Young wrote. "The decisions the new majority has issued today in this case will thus benefit *only* those who profit from litigating medical malpractice cases. …

"Today's decision returns this Court to an era in which the bench and bar must decipher this Court's split opinions in order to figure out what principles of law they collectively articulate. It's no small challenge to respond in dissent to the various opinions that shred our medical malpractice laws."

> **"Chaos and confusion in the law only promote more litigation. The decisions the new majority has issued today in this case will thus benefit only those who profit from litigating medical malpractice cases."**
>
> — Justice Robert P. Young Jr.

All seven justices wrote opinions in this case, although only four of the opinions specifically discussed the use of *Fulton* in a traditional medical malpractice case and/or the mathematical equation that should be used to establish a lost opportunity case under MCL 600.2912a(2).

Young argued that the court "radically transform[ed]" the law "by equating *causation* of the injury with *risk* of the injury."

"This shift is significant because a traditional medical malpractice injury creates liability for *the entire injury*, while a lost opportunity claim creates liability only for that portion of the increased risk of injury attributable to a defendant."

Howard, who represented O'Neal, said the decision is similar to a 2008 case, *Stone v. Williamson* (Lawyers Weekly No. 06-67230, 83 pages), in which the Supreme Court held the plaintiff's case was a traditional malpractice claim, and not a lost opportunity claim, under the statute.

"*Stone* helped define what is a 'lost opportunity' case and what isn't," she said. "The court in *O'Neal* accepted that same analysis, and went on to say that you don't use *Fulton* in traditional malpractice cases. I think that's how the two cases interplay together."

Howard said the statistics, viewed in a light favorable to the plaintiff, showed O'Neal had only a 5 percent or less chance of having a stroke if he had received the proper treatment. Those chances jumped to 20 percent because he didn't receive a timely transfusion.

"They actually quadrupled his chances of having a stroke," she said. "For that reason, we've always maintained that we could establish, more often than not, that if he had that treatment, he would not have had the stroke."

St. John Hospital's attorney, Christina A. Ginter of Kitch Drutchas Wagner Valitutti & Sherbrook, said the decision doesn't make a significant change in the law.

"There's no majority in the reasoning, so there's no new law or test developed by this case," she said. "I don't think this opinion clarifies the test determining what is a traditional malpractice case and what is a lost opportunity case, so I think we're left with the law that existed prior to this decision."

If you would like to comment on this story, contact Brian Frasier at (248) 865-3113 or brian.frasier@mi.lawyersweekly.com.

Decision in a nutshell

The Case: *O'Neal v. St John Hospital & Medical Center, et al.*, (Lawyers Weekly No. 06-73761, 88 pages).

The Facts: Plaintiff suffered a stroke after an alleged misdiagnosis delayed the proper treatment. He alleged a traditional medical malpractice case against the hospital and doctors.

The Decision: *Fulton*'s "50 percentage point" differential analysis shouldn't be used in cases pled as traditional medical malpractice claims.

From The Decision: "*Fulton*'s analysis was erroneous because it misconstrued proximate causation as it applies to a traditional malpractice case. Under the *Fulton* subtraction formula it is mathematically impossible for there to be more than one proximate cause. … *Fulton* transformed the burden of proof in traditional malpractice cases from a proximate cause to the proximate cause because it allows for only one proximate cause in any case."

"It is also important to emphasize that not all traditional medical malpractice cases can or will be expressed in statistical or percentage terms, nor is plaintiff required to express proximate causation in percentage terms. The plain language of the statute requires that proximate causation in traditional malpractice cases be expressed by showing that the defendant's conduct was *more probably than not* a cause of the injury not by statistical or percentage terms."

From The Dissent: "Chaos and confusion in the law only promote *more* litigation. The decisions the new majority has issued today in this case will thus benefit *only* those who profit from litigating medical malpractice cases. … Today's decision returns this Court to an era in which the bench and bar must decipher this Court's split opinions in order to figure out what principles of law they collectively articulate. It's no small challenge to respond in dissent to the various opinions that shred our medical malpractice laws …"

"[T]oday, the majority makes a radical transformation of medical malpractice law and again jettisons traditional causation doctrine by equating *causation* of the injury with *risk* of the injury. This shift is significant because a traditional medical malpractice injury creates liability for *the entire injury*, while a lost opportunity claim creates liability only for that portion of the increased risk of injury attributable to a defendant."

Reporting

Continued from page 1

three months preceding his death, Young was taken to a physician by his foster mother on several occasions:

Jan. 2, 2003 — Young was seen by his family physician where concerns of his refusal to toilet train and inability to gain weight/weight loss were addressed. He was referred for a developmental assessment at Children's Hospital for his failure to thrive.

Feb. 15, 2003 — Young was examined in the Children's Hospital emergency room by a first-year resident and another physician. His foster mother indicated that she was seeking a second opinion as to Young "was not growing" and because he was having tremors.

She further indicated Young had been referred for a developmental assessment at Children's Hospital for his failure to thrive and described the history of abuse by his biological parents including their substance abuse (and the fact that Young tested positive for cocaine at birth). Marks or scars were observed on Young's skin, which were attributed to eczema.

Abuse was not suspected because of the history of eczema and because the foster mother appeared to these physicians to be genuinely concerned and caring.

Feb. 25, 2003 — Young was seen by a neurologist at Children's Hospital. The neurologist did not notice any scars, bruises, or marks, had no reason to suspect any child abuse or neglect, and ordered further tests to determine the reason for Young's failure to gain weight.

March 5, 2003 — Young was seen again by his family physician that referred him to a pediatrician. No scars, bruises or other marks were observed.

Following these physician appointments and Young's murder, a lawsuit was filed against the physicians who saw him at Children's Hospital on Feb. 15 and Feb. 25, 2003 (Children's Hospital and the Detroit Medical Center also were sued).

The claim against the physicians was they were required by MCL 722.623 to report suspected child abuse/neglect, and their failure to do so makes them liable for Young's death.

MCL 722.623 requires physicians to make a report to DHS when they have "reasonable cause to suspect child abuse or neglect."

The physicians moved for summary disposition, arguing that their medical judgment used in the course of a physician-patient relationship resulted in their decision to not report and therefore the claim was for medical malpractice and not ordinary negligence.

The Wayne County Circuit Court agreed, dismissing the claims against the physicians (without prejudice, allowing the case to be filed again, complying with medical malpractice requirements).

The Court of Appeals reversed, finding that although a physician-patient relationship existed, the physician's decision to not report did not require the use of medical judgment. The Court of Appeals reached this conclusion based on the fact that MCL 722.632 imposes the reporting requirement on physicians and non-physicians (e.g. professional counselors, social workers, social service technicians, etc.).

Its reasoning was that if non-physicians and physicians must make the same decision whether to report, then it cannot be said that medical judgment is to be used in the decision making process (the fact that medical judgment is actually used apparently is lost on the Court of Appeals).

Because the Supreme Court's majority refused to hear this appeal, the Court of Appeals decision is the law. The result of this new law is that physicians must change their practices to protect themselves from failure to report child abuse/neglect claims and resulting damage awards.

> **The result of the new law is that physicians must change their practices to protect themselves from failure to report child abuse/ neglect claims and resulting damage awards.**

No longer can a physician rely on medical judgment when assessing whether a mark on the skin is eczema or the result of physical abuse. The same is true when treating fractures, which could be the result of an innocent fall, brittle bone disease or an instance of abuse.

In all these and other situations where the patient's condition could be the result of abuse, the physician must suspend medical judgment and imagine how a layman would view the condition before deciding whether there is reasonable cause to suspect child abuse/neglect.

In cases of doubt, physicians should make a report to DHS that child abuse is suspected to protect themselves from failure to report claims. This practice should be followed even if the physician's medical judgment dictates otherwise because if the physician is wrong and fails to report, the proper exercise of medical judgment will not be a defense.

According to the law, physicians and non-physicians will be treated alike, despite the different training, experience and judgment that is brought to the decision making process by physicians.

Physicians also would be wise to contact their medical malpractice insurance carrier to determine whether a claim alleging a failure to report child abuse/neglect is covered under their policy now that the Court of Appeals has determined that this claim does not involve medical judgment and, therefore, is not medical malpractice.

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It is important to note that incentive payments will not be provided to physicians at the time of purchase. Rather, payments will be made retroactively and only if the government is satisfied that the physician meets the criteria for meaningful use of a certified EHR.

Electronic

Continued from page 3

level password protection and be capable of producing audit trails and tracking all uses and disclosures. Additionally, the system should be capable of producing an electronic version of a patient's medical record that can be shared with the patient upon request.

Additional contractual issues

When entering into contracts with vendors, physicians should be aware of the following important contractual provisions: the length of the term of the license to use the software and the respective rights of the parties to terminate the license during or following the initial term; the number of users that are licensed to use the software; whether or not there are restrictions on the ability to transfer the license; the representations and warranties made by the vendor as to the ownership of the software and its future performance; vendor indemnification for breach of representations and warranties. They also should know whether or not source code escrow protection will be provided; payment amounts and terms; acknowledgements of customer's exclusive rights to its own data; software acceptance procedures; vendor training and support; the listing of hardware requirements; software maintenance and bug fixing obligations; transition services support following termination; and arbitration, choice of law and venue provisions.

Physicians should strongly consider having contracts reviewed by an attorney experienced with the review of information technology contracts and the meaningful use incentives.

Mind-body

Continued from page 12

hopelessness, eating disorder and alcoholism." During one call, she even told a crisis worker that she was feeling suicidal. HBH approved an "Individual Plan of Service" in which Karen McLean was scheduled to begin outpatient therapy on Feb. 15, 2000.

But she died on Feb. 14.

Mack said there is a lack of continuity of care in the mental health system.

"It's the whole community mental health structure," Mack said. "Mental health agencies are so focused on self-determination, and that needs to be fixed. It should be more about treatment, stability, and restoration of capacity."

The Court ruled that the trial court properly concluded that the medical care or treatment exception to governmental immunity includes treatment for mental illness, and that Karen McLean was a patient under the exception; the court erred in concluding that the exception applied to Harma.

Whether Karen McLean was a patient at the time of her death will have to be developed factually, said Sickels.

The opinion makes "one more step in trying to fix the mental health system," Mack said. "Maybe the agencies will have to focus on restoring someone's capacity rather than just letting them do what they're going to do.

"These people are in the business of treating the mentally ill. They need to be held accountable. Now you're exposed to liability for failure to provide appropriate care."

If you would like to comment on this story, please contact Carol Lundberg at (248) 865-3105 or carol.lundberg@mi.lawyersweekly.com.

Red Flags Rule update:

Will physician practices be subject to enforcement?

Identity theft

By Suzanne D. Nolan, Esq.

Suzanne Nolan is an associate at Frank, Haron, Weiner and Navarro, PLC. Her practice focuses upon business and intellectual property transactions, including trademark, patent, copyright licensing, and e-commerce transactions for all types of entities, including health care providers. She also advises healthcare clients on HIPAA, Stark, and Anti-Kickback Statute compliance and licensing matters. She may be reached at (248) 952-0400 or snolan@fhwnlaw.com.

For the fifth time, the Federal Trade Commission (FTC) has delayed enforcement of Red Flags Rule, which is designed to protect against identity theft.

For most health care providers, enforcement of the Rule is scheduled to begin on Jan. 1, 2011. For physicians only, enforcement has been delayed until the later of Jan. 1, 2011, or 90 days after a decision in a pending lawsuit filed against the FTC on behalf of physicians is reached.

In addition to the pending lawsuit, legislation has been introduced to exempt certain health care providers from the Rule. Health care providers who are subject to the Rule are required to adopt written policies and procedures that are designed to detect, prevent and mitigate identity theft.

Medical identity theft commonly occurs when a person seeking health care services uses someone else's name or insurance information to obtain medical care or prescription drugs.

The consequences to the victims can be quite severe and include having insurance benefits exhausted by the thief, and having information about the identity thief's medical treatment recorded in the victim's medical records. Recording such information can have life-threatening consequences for the victim if inappropriate care is given as a result of the faulty information.

Given the seriousness of medical identity theft, the FTC has not backed down from its position that providers who deliver services to patients and permit patients to later pay for those services are "creditors" subject to regulation under the Rule.

It will take an outside force, such as legislation or a court order, to change the FTC's position. The proposed legislation, introduced in the U.S. Senate on May 25, 2010, will primarily benefit small health care practices and/or practices in which the providers personally know all of the patients.

The legislation would exempt a health care practice with 20 or fewer employees from the Rule by excluding it from the definition of a "creditor." A "health care practice" is defined as a business whose primary service is providing health care through licensed health care professionals employed by the business.

In turn, a health care professional is defined as an individual engaged in providing health care and licensed under state law to do so. Such professionals include physicians, dentists, podiatrists, chiropractors, physical therapists, occupational therapists, marriage or family therapists, optometrists, speech therapists, language therapists, hearing therapists, and veterinarians.

Once a provider has more than 20 employees, it will be considered a creditor and will be subject to the Rule unless the FTC grants it a general business exemption.

Health care practices that do not qualify for the small practice exemption would have to seek the approval of the FTC for a general business exemption. The FTC could grant such an exemption to any business that knows all of its patients individually, performs services in or around the residences of its patients, or has not experienced incidents of identity theft.

Given the prevalence of medical identity theft, health care providers will likely qualify for an exemption only if they can show they know all of their patients personally or that they deliver only home-based services.

Given the prevalence of medical identity theft, health care providers will likely qualify only if they can show they know all of their patients personally or that they deliver only home-based services.

For physicians, the outcome of a pending lawsuit may provide permanent relief from the Rule. On May 21, 2010, the American Medical Association (AMA), the American Osteopathic Association and the Medical Society of the District of Columbia filed suit (AMA Suit) against the FTC seeking to prevent the FTC from enforcing the Rule against physicians.

Currently, by court order, the FTC cannot enforce the Rule against physician members of the AMA and the other organizations who filed this lawsuit. This enforcement stay will be in effect until 90 days after an opinion is issued in the FTC's appeal of an adverse decision in a related lawsuit filed by the American Bar Association (ABA) over the applicability of the Rule to practicing attorneys.

In the event any legislation is passed that affects enforcement of the Rule, the legislation will control over the stay put into effect by the court. No further action will be taken in the AMA Suit until a final decision is reached in the FTC's appeal.

The primary legal issue in the AMA case and the ABA case are similar. In the ABA case, the court issued an opinion stating that the FTC could not enforce the Rule against practicing attorneys because Congress did not intend to treat such attorneys as creditors merely because they first performed legal services and then billed their clients for such services. In the AMA case, physicians are seeking a determination that they are not creditors merely because they provide health care to patients without receiving payment in full at the time of providing care to patients. The outcome of the AMA case will, in large part, depend on the legal precedent set by the decision in the FTC's appeal of the ABA case.

Dealing with the uncertainty over enforcement is difficult. Most providers do not want to incur the expense of developing a Red Flags-compliant identity theft program if they will not be required to comply with the Rule.

In the interim, and to be prepared for eventual enforcement, providers should review and strengthen (if necessary) their existing HIPAA Privacy and Security programs. These programs can be incorporated into a Red Flags compliance program.

Providers also should become familiar with the warning signs of identity theft that they are apt to encounter in their practices, determine how to detect such warning signs, and evaluate how to respond to them in order to protect their patients.

Armed with this knowledge, providers should be able, with assistance of counsel, to quickly adopt an effective Red Flags program if they are required to comply with the Rule.

Names

Continued from page 1

certain what the correct entity name is as we often find inconsistencies in this area.

Where the building owner requires the tenant to insure the building, we often do not see the landlord entity listed at all, and where we do, many times the listing is improper. If the landlord is listed as a loss payee, this is unacceptable, as the landlord would have no independent rights to coverage. In short, if the tenant commits arson, the landlord has no coverage.

A major exposure is third party landlord entities that are unrelated to the tenant, and the failure to comply with the terms of an outside landlord lease leads to a significant liability exposure. This is because it is unlikely that the insurance carrier will reform the policy to bring the policy in line with the lease requirements after the fact.

Sloppiness appears to be the norm rather than the exception among many insurance agents in how names are listed and whether such names are consistently listed between policies.

However, even where there is common ownership between the landlord entity and the tenant entity, the insurer may not pay a building loss if the correct landlord entity has not been listed.

Assumed names create major issues. Where a company files an assumed name and the named insured is listed as "ABC Corporation dba: Joe's Consulting," for example, note that only Joe's Consulting would be covered, and other acts of the corporation not doing business as that name may be uncovered. It is best to list the corporation entity name and then also separately list the DBAs.

Nonemploying entities might still be listed on workers compensation policies given the issue of uninsured contractors. For example, where your client hires a contractor to do repairs at your client's building, an injury to the contractor's employee could result in a workers' compensation claim against your client that would otherwise not be covered if the applicable entity is not listed on the policy.

401(k) plan entity names are often left off the general liability policy as a named insured. Most insurers will add such entity names for no charge. Of course, separate fiduciary liability coverage should also be maintained for ERISA claims.

Although it is possible to have many entities listed as named insureds, which is the broadest protection for an entity, the entity listed first is the "captain" of all the insureds and is the only one who can make coverage changes, effectuate cancellations, and bears the sole responsibility for paying the premiums. Be cautious who that entity is.

We find many vehicles owned or leased in the company name that are insured in the personal name of the officer. This leaves the company potentially open to uncovered liability.

If a vehicle is leased by the corporation, for example, and not insured on the business automobile policy but instead on the personal auto policy without the corporation being added as an additional insured, this could create a coverage problem. Moreover, the liability limits are an issue because many personal umbrellas will not extend coverage to a business entity even if listed on the primary automobile policy and this could ultimately expose the business entity to major underinsurance.

The general rule that should be followed is that every entity should insure its own exposures even if the business is owned by the same person that is the named insured on a personal auto policy.

Leases often specify that the landlord is to be listed as an additional insured. If you represent the landlord, automatic landlord additional insured language found on most general liability insurance policies may not provide as broad of protection as you might think.

For example, most policies that provide automatic additional insured coverage to landlords also exclude coverage for renovations and there also are other limitations that apply. Landlords also should always maintain their own independent general liability insurance policy and umbrella policy which list the landlord entity as a named insured.

Past partnerships and joint ventures are not automatically covered under general liability policies. In fact, you should assume that your client has no coverage for any name not listed as a named insured.

Sloppiness appears to be the norm rather than the exception among many insurance agents in how names are listed and whether such names are consistently listed between policies. A simple named insured chart can easily expose gaps that might be addressed before a claim occurs.

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Insurance

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this new tax credit.

In the years 2010 through 2013, the maximum tax credit is 35 percent of a qualified for-profit employer's contributions to its employees' health insurance premiums and 25 percent of nonprofit employer's contributions to such premiums.

Beginning in 2014, the maximum amount of this credit increases to 50 percent (35 percent for tax-exempt organizations) but is available for only two consecutive tax years.

A nonprofit organization deducts the credit from its employment taxes whereas a for-profit employer deducts the credit from its federal income taxes and, if the credit exceeds its taxable income, can carry the unused portion of the credit forward for up to 20 years.

The credit is intended to offset the higher insurance premiums charged to small group plans. Accordingly, the amount of the credit varies with the number of full-time equivalent (FTE) employees and the amount of average wages paid to these employees.

The maximum credit is available to an employer that has 10 or fewer FTE employees earning less than $25,000 per year on average. The amount of the credit decreases with each additional FTE employee over 10 and for each $5,000 increase in average wages over $25,000. It phases out completely at 25 FTE employees or average annual wages in excess of $50,000.

Determining the number of FTE employees and the average annual wages can be a complicated process. The number of FTE employees is computed by totaling the number of hours worked (but not more than 2,080 for an employee) by all of a practice's employees (but not including owners of the practice), then dividing the total by 2,080 (rounding down if the result is not a whole number).

To compute the average annual wage, the wages paid to all of the employees included in the foregoing calculation are totaled and divided by the number of FTE employees.

The wages and hours of owners of the health care practice and members of their families or households as well as the insurance premiums paid for them are disregarded in computing the credit.

Owners are defined as sole proprietors, partners in a partnership, shareholders owning more than 2 percent of an S corporation and owners of more than 5 percent of a corporation or other entity.

Notably, the credit can result in significant savings. An employer entitled to the full 35 percent credit could recover anywhere from 17.5 to 35 percent of the health insurance premiums it pays for its employees.

Potential cost savings of HRAs

Health care practices of any size, regardless of whether they qualify for the tax credit, may be able to significantly reduce their health insurance costs through the use of an HRA. Although the IRS first approved the use of HRAs in 2002, many employers are unaware of the benefits of HRAs.

Importantly, an employer can achieve substantial health insurance cost savings by using an HRA in combination with a high deductible health insurance plan while providing the same overall benefits to an employee.

The HRA is set up so that only those medical expenses meeting the IRS requirements for deductibility by an employer are paid by the HRA. The employer still requires the employee to pay a small share of the deductible, but the employer uses the HRA to reimburse an employee for medical expenses incurred up to the amount of the deductible under the health insurance plan.

For example, if the deductible under the health insurance plan is $5,000 and the employee's share is $500, the employer would pay up to $4,500 for the qualifying medical expenses incurred by an employee.

These expenses are reimbursed as the employee incurs them. In effect, this arrangement allows the employer to self-insure up to the amount of the deductible. To relieve the burden on the employer, claims to be paid under the HRA are typically processed and approved for payment by a third-party administrator.

The use of an HRA can be effortless for the employee, as HRAs typically permit a health care provider to submit claims directly to a third party plan administrator for payment of the portion of the claim not covered by the health insurance plan.

Implementing an HRA requires close consultation with a knowledgeable health insurance agent. The agent will evaluate the cost savings and the risks associated with the adoption of an HRA-high deductible plan combination.

The savings and risks vary depending on a variety of factors such as the age of the employees in the group, the mix of single adults and families being covered by the health insurance plan and the amount of the deductible under the current health insurance plan.

Agents also can discuss whether it would be beneficial to use a stand-alone HRA. The rules pertaining to such stand-alone plans are different from the rules described with the arrangement described herein. HRAs may be offered in conjunction with other employer-provided health benefits like Flexible Spending Accounts or "cafeteria plans."

By consulting legal counsel about how to qualify for this credit and how to implement an HRA, health care practices may be able to control their health insurance costs while maintaining current levels of benefits.

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An important initial step for a Stark compliance plan should be determining who in the organization will be responsible for compliance.

Stark

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Act to further extend liability to knowingly and improperly avoiding or decreasing an obligation to pay the federal government, which had been interpreted by many to include retention of overpayments related to technical Stark violations.

Finally, in March 2010, pursuant to the Act, material amendments were enacted to Stark, which now specifically requires repayment of Medicare overpayments within 60 days of identifying overpayments (including Medicare payments for DHS rendered pursuant to a prohibited Stark referral).

The Act also mandates a Self-Referral Disclosure Protocol by late September 2010 that permits (but does not require) the government to compromise Stark refunds (SDP).

Revisiting Stark compliance

In light of the recent provisions of FERA and the Act, health care providers are remiss if they fail to take a proactive approach to, and a heightened focus on, compliance.

This is particularly true given the fact that it is likely that the new Stark SDP will reward physicians and health care providers that affirmatively adopt a proactive approach to Stark compliance.

An important initial step for a Stark compliance plan should be determining who in the organization will be responsible for Stark compliance.

Next, the universe of financial relationships should be identified and categorized in order to properly evaluate Stark risk areas and implement policies and procedures for tracking and monitoring financial and referral relationships that fall within the ambit of Stark.

Some areas to evaluate under a Stark compliance plan may include contract management systems and contract review, accounts receivable and accounts payable records, tracking of nonmonetary compensation, and fair market value analysis.

Another key issue for an effective Stark compliance plan is to engage experienced health care counsel to analyze whether, in those circumstances where an arrangement potentially has Stark implications, a Stark violation in fact exists.

For example, if there is no formal written document memorializing the arrangement, the provider should consider whether there are other forms of e-mail correspondence, memoranda, or communications, which support the argument that there is written instrument for purposes of Stark compliance.

Under an effective Stark compliance plan, however, after careful analysis and review, if it is determined that there is Stark violation has occurred, a physician or other health care provider must initiate an approach for determining the consequences of failing to act, potential repayment calculations, who should be approached with the Stark issue, and timing concerns.

Physicians and other health care providers should remain attentive to the SDP, which is expected to be published later this year (and possibly in September) which will hopefully provide more guidance to physicians and health care providers in making determinations related to Stark compliance.

Finally, physicians and other health care providers and suppliers should also be aware that the Act establishes mandatory compliance programs as a requirement for health care providers and suppliers that elect to maintain and establish Medicare billing privileges.

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