What else health care providers need to know about ‘ObamaCare’

Compliance

By Brandi Walkowiak

The Supreme Court of the United States’ recent ruling upholding the constitutionality of The Patient Protection and Affordable Care Act (a.k.a ObamaCare) (Act), as well as the upcoming presidential election have put this Act front and center in the health care world.

The highly publicized and politically charged sections of the Act, such as the so-called man-date, the provisions addressing pre-existing conditions, and the extension of the dependent coverage age to 26, have garnered most of the media attention. However, there are a slew of provisions related to health care fraud and abuse enforcement that have gotten much less attention, but could have an equally significant impact on health care providers and entities.

Title VI of the Act, entitled “Transparency and Program Integrity,” creates an invigorated compliance

Prepared for the changing employment relationships between physicians, hospitals

Business of Health

By Michelle Bayer

The business of the practice of medicine is again changing. Back in the early 1990s, many hospital groups purchased physician practices and consolidated physician groups in an effort to maximize profitability. The trend changed after many of these groups were not successful, and private practice again became the preferred practice model.

Now, following health care reform, hospitals and physician groups are again looking for ways to maximize the business of the practice of medicine. This way of thinking has again brought delivery and payment system programs to the forefront, making integrated delivery systems a more desirable alternative to small private practices, and such integrated systems are being advocated and incentivized by the health care reform system. More and more physicians are looking to be employed by hospitals. There are a number of different models

Telemedicine reimbursement required, say new state laws

Compliance

By Mercedes Varasteh Dordeski

The use of telemedicine in Michigan has become much more straightforward with the passage of two new laws requiring private insurers to reimburse health care providers for services provided via telemedicine.

The laws were signed into law by Gov. Rick Snyder this June, and are intended to encourage providers to use telemedicine as a way of increasing access to patients. Importantly, the laws now define what exactly constitutes “telemedicine,” which was previously an open question under Michigan law.

The two laws, Public Acts No. 214 and 215 of 2012, require Blue Cross Blue Shield and other private insurers in Michigan to cover patient visits conducted using telemedicine so long as certain requirements are met.

Although the use of technologies such as Skype and video conferencing between patients and providers is a possibility, the regulations relating to patient confidentiality and secure transmission of patient information must be met.

See “Telemedicine,” page 11

Preparing for the changing employment relationships between physicians, hospitals

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Now, following health care reform, hospitals and physician groups are again looking for ways to maximize the business of the practice of medicine.
At The Health Law Partners ("The HLP"), our unparalleled knowledge of the business of healthcare is coupled with timely, practical solutions designed to maximize value. The HLP attorneys have represented clients in substantially all areas of health law, with particular emphasis on:

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- Civil and Criminal False Claims Defense
- Stark, Anti-Kickback, Fraud and Abuse, and other Regulatory Analyses
- Physician Group Practice Ancillary Services Integration and Contractual Joint Ventures
- Appeals of RAC, Medicare, Medicaid and other Third-Party Payor Claim Denials and Overpayment Demands
- Healthcare Contractual, Corporate and Transactional Matters
- Compliance and HIPAA
- Healthcare Billing and Reimbursement
Fall 2012 RAC update

- CMS recently provided updates and hosted an Open Door Forum on the Medicare Recovery Audit Prepayment Review demonstration program.
- The RAC prepayment review program allows the RACs to conduct prepayment reviews on certain claim types. The program historically resulted in high rates of improper payments.
- The RAC prepayment reviews began in August, with the review of MS-DRG 312 Syncope & Collapse. The program has not been well-received by the industry, with low payment rates.
- The RAC prepayment reviews are in addition to and not in place of prepayment reviews conducted by the Medicare Administrative Contractors (MACs). The RACs will audit claims that are on the basis in 11 claims, including Michigan.
- In the recent Outpatient Prospective Payment System proposed rule for CY 2013, CMS solicited comments regarding changes that could be made on the issue of inpatient versus outpatient admission. CMS sought comments on potential changes, which could provide some clarity regarding inpatient versus outpatient status for purposes of Medicare payment. Comments were due Sept. 4.
- GCI, the Region B RAC, which includes Michigan, recently added a new area for review. GCI is reviewing the administration of Bevacizumab (Avastin), which is used with chemotherapy treatment, to its approved issues list. The approval is based on a collective discussion with various stakeholders, including hospitals.
- The memorandum provides a very precise articulation of the language required in A LJ orders for a hospital to effectuate the order. The memorandum's instructions to contractors, however, are very specific in terms of the precise situation in which an A LJ order would trigger the contractor to pay a hospital full Part B reimbursement, including observation.
- The memorandum's instructions to contractors, however, are very specific in terms of the precise situation in which an A LJ order would trigger the contractor to pay a hospital full Part B reimbursement, including observation. Unless the medical record for the inpatient hospital claim at issue includes a physician's order for observation, the only way a hospital will receive reimbursement for observation is if the A LJ's order instructs the contractor to pay observation. Specifically, the A LJ's order must clearly specify "observation level of care" for the hospital to receive payment for observation.
- If the A LJ includes this language in the order, then line-item charges for observation may be added if otherwise appropriate, as the A LJ's order substitutes an order to admit for observation that would be included in the record.
- A hospital with a claim that is without an order for observation in the medical record or without an A LJ's specified order for reimbursement for observation will not receive reimbursement for observation services.
- The very precise articulation of the language required in A LJ orders for a hospital to receive observation, highlights the importance that hospitals specifically request the alternative relief from an A LJ to be full Part B reimbursement, including observation services and all underlying care.
- The CMS memorandum is a very positive improvement in the effort to realize accurate Part B reimbursement for hospitals where a contractor has denied an inpatient short-stay claim because the admission was not medically necessary. Although the memorandum still evokes some limitations, it is, to date, the clearest indication from CMS that contractors are now required to effectuate an A LJ's order for Part B reimbursement where an inpatient claim has been denied for medical necessity.
- It also highlights to hospitals the crucial importance of the appeals process, especially the A LJ hearing stage. Hospitals should understand that encouraging an A LJ to order reimbursement for observation and all underlying outpatient care is a legal, not clinical, argument. During appeals, it is essential that hospitals evince legal arguments and authorities to persuade an A LJ to issue a precise order for Part B reimbursement, including observation services and underlying outpatient care.

Andrew Wachler is the principal of Wachler & Associates PC. He counsels health care providers and organizations nationwide in a variety of health care legal matters. In addition, he writes and speaks nationally to professional organizations and other entities on health care law topics such as Medicare/Medicaid and other third-party payer audit defense, Stark and fraud and abuse, HIPAA, and other topics. He can be reached at (248) 544-0888 or awachler@wachler.com.

The Michigan Medical Law Report welcomes articles from readers for its special feature sections. Submissions should be seven pages or less, double spaced (approximately 800-1,000 words). Submission does not guarantee publication. Proposed articles should be sent to: editor@omi.lawyersweekly.com. For more information, please call 1-800-678-5297.
Proposed rules designed to remove barriers for physicians to use physician assistants

By Robert Ivery

On Nov 8, 2011, Public Act 210 of 2011 went into effect removing statutory language that prevented physicians, both MDs and DOs, from delegating the prescription of controlled substances to physician assistants (PAs).

In essence, these statutory amendments provide that physicians:

1. May delegate in writing to a PA the ordering, receipt and dispensing of complimentary starter dose drugs included in Schedule 2 through 5 controlled substances.
2. Are no longer required to sign an official form listing the physician’s signature as the required signature if that official form is signed by a PA to whom the physician has delegated (in writing) the performance of medical care services.
3. May delegate (in writing) the task of making calls or rounding on patients in private homes, public institutions, emergency vehicles, ambulatory care clinics, hospitals, intermediate or extended care facilities, HMOs, nursing homes or other health care facilities to PAs without restrictions on the time or frequency of visits;
4. May delegate (in writing) to a PA the preparation of Schedule 2 through 5 controlled substances (the names and DEA registration numbers of both the physician and PA must be used with each prescription).

Unfortunately, there was nothing within the statutory amendments that removed certain existing administrative rules that limited a physician’s authority to delegate the prescribing of Schedule 2 controlled substances to a PA.

Moreover, the statutory amendments contain language that contemplates that administrative rules may be promulgated to further define which drugs or classes of drugs physicians shall not be able to delegate to PAs, and what procedures and protocols shall be followed in order to be consistent with federal and state drug control and enforcement laws.

In response, on July 13, 2012, proposed amendments to the Boards of Medicine and Osteopathic Medicine & Surgery administrative rules were drafted.

These proposed administrative rule amendments are intended to eliminate any restrictions on a physician’s ability to exercise his/her judgment to delegate to a PA the prescribing of Schedule 2 controlled substances, and to clarify and reduce the requirements for the written authorization physicians must use in order to delegate the performance of medical care services and/or the prescription of controlled substances to PAs.

The proposed administrative rule amendments will make it clear that a physician who supervises a PA must have a written authorization to delegate to a PA the performance of medical care services and/or the prescribing of schedule 2 through 5 controlled substances.

This written authorization must contain the effective date of the delegation, name, license number and signature of the supervising physician and the PA, and set forth any limitations or exceptions to the delegation of any medical care services and/or controlled substance prescribing.

Under the proposed administrative rule amendments, this written authorization must be reviewed and updated prior to the renewal of a PA’s license (i.e., at least every 2 years) or in the interim as needed. A copy of this written authorization must be maintained in each separate office location of the physician where the delegation occurs.

If the proposed administrative rule amendments are adopted, supervising physicians are well-advised to seek legal review of the written delegation authorization to assure its accuracy, thoroughness and compliance with applicable federal and state laws as well as third-party payor billing rules and guidelines.

According to the Michigan Department of Licensing & Regulatory Affairs (LARA), both the aforementioned statutory and proposed administrative rule amendments are necessary in order to address a significant physician shortage in Michigan that may predict a worsen before it gets better.

In order to facilitate continued access to quality medical care in Michigan, the Legislature has determined that a streamlining of the regulations regarding the delegation of medical care services and prescribing of controlled substances by physicians to PAs is needed.

Without such changes, physicians are required to see patients who could otherwise be seen by PAs but for the fact that the PAs could not prescribe schedule 2 medications.

With such changes, Michigan physicians and PAs will both be able to see more patients, thereby increasing access to care.

As of Feb 1, 2012, there are 32,587 MDs and 6,983 DOs who possess a full and unrestricted license to practice in Michigan with the authority to delegate the prescribing of Schedule 2 medications to the 3,809 PAs licensed in Michigan.

It should be noted that at least two other states in the Great Lakes Region, Minnesota and Wisconsin allow PAs to prescribe Schedule 2 medications as a delegated act of supervising physician (although Illinois, New York and Ohio prohibit it).

LARA will hold a public hearing 9 a.m. Oct 3, 2012, in Lansing to receive comments on the proposed administrative rule amendments. Additional information regarding the public hearing is available by contacting Desmond Mitchell, policy analyst, at mtchell@lara.michigan.gov.
Regulatory considerations for physicians participating in ACOs

Compliance

By Suzanne Nolan

Most health care practices and their owners have been focusing on how the expansion of health insurance coverage under the Patient Protection and Affordable Care Act (PPACA) will lead to increased demands for their services, or the feasibility of joining an Accountable Care Organization. Consequently, many practices may not be aware of the Act’s requirements that apply to practices that, in their role as an employer, sponsor a group health plan.

Importantly, such practices must begin complying with some of these requirements now.

In many cases, both a practice and the health care insurer must work together to implement certain changes and keep employees informed of these changes.

Preparing for and meeting the requirements that become effective in 2012-13 is a fairly straightforward task.

First, the most urgent requirement is for plan sponsors to begin distributing a Summary of Plan Benefits and Coverage (Summary). The plan’s health insurer is responsible for preparing the Summary.

The Summary must provide enrollees with easy-to-understand information about their health plan benefits and coverage. The employer, as the plan sponsor, or the plan administrator (depending on whether the plan is self-insured or insured), has the obligation to distribute the Summary to enrollees and prospective enrollees in a group health plan.

Starting with the first day of the first open enrollment period that begins on or after Sept. 23, 2012, plan sponsors or plan administrators are required to provide a Summary to enrollees and potential enrollees in a group health plan.

Therefore, plan sponsors must make sure that the health insurer has prepared the Summary, and make arrangements to distribute the Summary to its enrollees.

Second, employers who are sponsors of self-insured plans must begin paying a Patient-Centered Outcomes Research Institute fee in the amount of $1 per covered life for plan years beginning on or after Oct. 1, 2012, and ending before Oct. 1, 2013.

The fee will increase to $2 for the next plan year, which will be paid to the U.S. Treasury to fund that will pay for research that evaluates the cost-effectiveness and clinical effectiveness, and the risks and benefits of two or more medical treatment or services.

Third, employers who issue W-2s to 250 or more employees must start reporting the cost of annual health care coverage on an employee’s W-2, beginning with W-2s issued in January 2013.

Because employers may be confused about the inclusion of this information on their W-2s, employers should let employees know that this is being done to make employees aware of the cost, and does not mean that health insurance benefits are taxable.

Fourth, for tax years beginning after Dec. 31, 2012, the Act caps the amount of salary reduction contributions that an employee can make to a health flexible spending account (FSA) at $2,500.

Employers are responsible for changing plan documents for their FSA plans to reflect this new limit, making sure that participants in the FSA are given appropriate notice of this change, and for making sure that enrollees are given accurate enrollment materials.

Preparing to meet the requirements that become effective in 2014 requires significant advance planning during 2013 to determine how the availability of health insurance exchanges in 2014 will impact the coverage that they provide.

Employers also must prepare to address the “pay-or-play” mandate. This mandate does not require employers to offer group health insurance to employees; rather, it requires a large employer — defined as one with 50 or more full-time equivalent employees — that offers a group health plan to comply with it.

Pursuant to the pay-or-play mandate, starting in 2014, large employers that provide group health insurance to employees will be required to either provide affordable group health care coverage offering minimum essential benefits, or pay a penalty.

Health Insurance Exchanges are expected to make adequate health insurance policies at affordable prices available to individuals and small employers.

The Small Business Health Options Program (SHOP) component of the exchanges will offer employers in the small business health insurance market (those with up to 100 employees) and their employees a variety of choices for coverage.

SHOPs are intended to give these employers access to the types of health plans that are now available only to larger employers. Accordingly, employers that purchase health insurance for employees through a SHOP may qualify for a small business tax credit.

Employers also should be aware of certain changes that their health plans must make for 2014 when certain prohibitions on what plans can do can go into effect for all plans, including those that were grandfathered.

Among the most important prohibitions, health plans cannot:

• Impose annual limits on the dollar value of benefits for a beneficiary or participant (but may impose limits on specific types of benefits that are not essential benefits).

• Impose waiting periods for coverage longer than 90 days, except for pre-existing conditions; or

• Reduce to zero existing coverage for pre-existing conditions (this prohibition is already in effect for those younger than 19).

Clearly, the burden of making these changes falls on the shoulders of the insurers who will need to modify the plans they offer for 2014 and perhaps the plans they currently employ. Insurers should understand that insurers are required to make these changes, and be prepared to deal with the expected premium increases.

Practices should consult with legal counsel to make sure that they are complying with all of these requirements.

In deciding whether to continue to offer group health insurance after the exchanges begin operating, practices, with the assistance of legal counsel, need to consider the financial effect such a decision may have on the practice.

The fee will increase to $2 for the next plan year, which will be paid to the U.S. Treasury to fund that will pay for research that evaluates the cost-effectiveness and clinical effectiveness, and the risks and benefits of two or more medical treatment or services.

By Amy Fehn

The Medicare Shared Savings Program (MSSP) was established by Section 3022 of the Affordable Care Act, and allows large employers who wish to participate in an Accountable Care Organization (ACO).

The ACO and its participants may share in any Medicare program savings achieved, provided that certain quality measures and program requirements are met.

Because the receipt of shared savings is conditioned on meeting the program requirements, physicians participating in the MSSP through an ACO will likely be asked by the ACO to attest to their compliance with these requirements in participation agreements.

Accuracy of data submitted

ACOs will be required to report on certain quality measures that will impact the amount of shared savings that the ACO receives, and will in turn impact the physicians’ share of the distribution.

ACOs will rely upon physicians to accurately report this information. Because these reports will determine compensation from the federal government, false statements could result in False Claims Act liability for any individual who reports information that he or she knows or should know is inaccurate.

Beneficiary inducements

Another MSSP program requirement prohibits ACO participants from providing gifts or other remuneration to beneficiaries as inducements for receiving items or services from, or remaining in, an ACO, or with ACO providers/suppliers in a particular ACO.

Certain items or services may be provided to beneficiaries free of charge or at a discount if they are reasonably connect to the beneficiaries care, are preventive care items or services, or advance a clinical goal for the beneficiary (such as adherence to a drug or treatment regimen, a follow-up care plan, or chronic disease management).

For example, a provider participating in the MSSP could give a Medicare beneficiary with hypertension a blood pressure monitor.

Items such as gift cards or tickets to sporting events would not be permissible.

The specific beneficiary inducements permitted by the MSSP represent a waiver of the Civil Monetary Penalties (CMP) statute. Therefore, failure to adhere to these guidelines not only could subject the ACO to sanctions, but also could potentially subject the physician to penalties for violating the CMP.

Marketing

Marketing materials regarding ACO participation in the MSSP must be submitted to the Centers for Medicare & Medicaid Services (CMS) for approval and must use template language developed by CMS, if available.

Marketing materials may be targeted toward beneficiaries of certain races or ethnicities in certain conditions, but must not be used in a discriminatory manner or for a discriminatory purpose.

Marketing communications cannot violate the beneficiary inducement provisions See “Accountable care,” page 14

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Check details before signing an employment agreement

Employment

By Melinda Balian

Some physicians may approach signing an employment contract like signing a new cellphone plan — in other words, they do not take the time to negotiate or discuss the terms, and rather choose to “take it or leave it” approach. However, what all physicians should know is that signing an employment agreement with a new employer is much different — and much more consequential — than signing up for a new phone.

An employment agreement can control a physician’s entire career, including several limiting the physician’s options if he or she finds a new and better position, or wants to change employers. Accordingly, it is important for physicians to carefully review and understand all the terms contained in the agreement, without just assuming they have no choice but to sign on the dotted line.

Here are just a few of the key provisions typically found in physician employment agreements that should always be clarified prior to execution:

- **Non-compete provisions:** In many non-physician agreements are governed by the Michigan Antitrust Reform Act (MARA). Generally speaking, non-compete agreements must be “reasonable” in scope, duration, and geographic breadth. In addition, they are “reasonable” under MARA, non-compete agreements must be designed to protect an employer’s reasonable legitimate business interest, and not just to restrain trade. In order to be “reasonable” in relation to an employer’s competitive business interest, a restrictive covenant must actually protect against the employee’s gaining some undue advantage from the employer, but not prohibit the employee from using general knowledge or skill.

When it comes to employment agreement which contains a non-compete, it is important to note that, generally speaking, Michigan courts have accepted non-compete ranging from one to three years.

Further, physicians should keep in mind that geographic limitations with a larger radius are more widely accepted in rural areas (given that patients will travel a larger distance), but in urban areas a smaller such as is typical because patients will not travel as far for care. The bottom line for any non-competition provisions is that it must be reasonable.

- **Non-solicitation provisions:** There can be much broader in scope and length than non-competition provisions. In many non-physician employment agreements, the language may be written in such a way as to prevent the former employee from providing services to any current and/or former client, etc.

In the medical arena, because patients have the right to choose their practitioner, the language may not be written in such a fashion. Nevertheless, what practices groups are now doing to circumvent this is to include a provision in the employment agreement that, upon termination, the physician will “take all steps necessary to transfer his/her patients to the practice.”

Such provisions obviously provide a greater umbrella of protection to a prac- tice-group-employer than the physician-employee.

- **Bonus compensation:** Another hot issue is how any bonus will be defined and calculated. Typically, it is best if there is specific language in the agreement on how the amount of any bonus shall be calculated, i.e., by the amount of the bonus, it shall be determined by the amount of medical/surgical fees attributable to the employee and said amount shall be determined by the amount billed incident to employee’s services or under the provider’s National Provider Identifier (NPI) number.

Concomitant with determining the calculation of any bonus is ensuring that a physician has the contractual right to inspection and audit of the records, which typically include a medical accounting computer system for the medical/surgical services billed under his/her NPI number.

- **Location of employment:** Often times practice groups have multiple locations, and as such, will have a generic clause in the employment contract that it has the right to assign the physician to any office location at its discretion.

Skilled nursing facilities (SNFs) and nursing facilities are required to make available information regarding the identity of each member of their governing body, and all officers, directors, members or partners, and agents of each such entity, for at least the most recent three years.

Further, SNFs and nursing facilities are required to have a compliance and ethics program (Program) in operation that “is effective in preventing and detecting criminal, civil, and administrative violations.”

The Act sets forth specific components of the Program which include that it:

1. Establish compliance standards and procedures that are reasonably capable of reducing the prospect of violations;
2. Assign personal with overall responsibility to oversee the compliance;
3. Not delegate discretionary authority to individuals the organization knew or should have known had a propensity to engage in criminal, civil or administrative violations;
4. Take steps to effectively communicate its standards and procedures to all employees and agents, such as requiring training;
5. Implement monitoring and audit systems, including systems designed to detect violations;
6. Take appropriate and consistent disciplinary action against responsible individuals;
7. Take all reasonable steps to respond to a detected offense; and
8. Periodically reassess its compliance program.

Moreover, the Act includes provisions aiming at encouraging self-reporting. For example, the Act provides for a reduction in civil penalties up to as much as 50 percent for SNFs and nursing facilities that timely report and correct deficiencies.

Exceptions to this include instances where there are repeat deficiencies, or where there is a systemic deficiency that is found to result from a pattern of harm that jeopardizes the health and safety of its residents.

The Act also enhances its Medicare and Medicaid integrity provisions. The Act imposes specific deadlines for reporting and returning overpayments. Those who make false statements on applications or contracts to participate in Federal programs or those who knowingly or not return an overpayment will be subject to fines up to $10,000.

In addition, the Act revises the intent requirement of health care fraud and expands to provision that a person “need not have actual knowledge” or “specific intent” to commit a violation. The Act also provides for “suspension of Medicare and Medicaid payments pending an investigation of a “credible allegation of fraud.”

Provisions aimed at conflicts of interest and referrals are also found in the Act.

For example, hospitals must submit annual reports to the Department of Health and Human Services, some physician owners or investor, the nature of the ownership; procedures in place to require referring physician owners or insurers to disclose the relationship to patients; and that the hospital does not direct or indirectly condition any physician ownership or investment on making or influencing referrals.

The physician ownership or investment also must appear on the hospital’s public website and in its advertising. As another example, physicians must maintain and provide access to documents relating to written orders or requests for payment for durable medical equipment, certifications for home health services or referrals for other items of service as specified by the Government.

In addition, under the Act, the HHS secretary will establish a self-referral disclosure protocol.

On top of the substantive provisions, the Act expressly grants increased funding for fraud and abuse to the tune of an additional $10 million a year for 2011-20.

In sum, providers, health care entities, and manufacturers must ensure they are versed in the Act’s new requirements for combatting health care fraud and abuse.

In addition, the Act’s provisions signal to the industry where the government will focus its enforcement efforts.

Accordingly, providers and health care entities should use this as another opportunity to evaluate their compliance programs, and make sure their procedures and protocols are in order in light of the government’s dedicated resources, the new transparency requirements, and potential civil and criminal enforcement penalties.

**Obamacare**

Continued from page 1

set of requirements to combat fraud and abuse, as well as new reporting requirements for providers, hospitals, drug companies and nursing facilities.

Notably, there is a places particular emphasis on financial relationships between providers and health care manufacturers.

For example, beginning in March 2013, drug, device, biological and medical supply manufacturers must annually report to the government the amount and nature of certain payments to physicians or teaching hospitals such as consulting fees, research, royalties, and grants.

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Compliance

By Robert Iwrey

Having a medical license to practice in the state of Michigan is not a right but a privilege, and it can be taken away or restricted for failing to abide by various statutory bases set forth within the Michigan Public Health Code (MPHC).

As such, compliance with the MPHC is the key to avoiding a licensing action. In order to facilitate such compliance, physicians are encouraged to actively participate in an effective compliance plan at their respective work sites. If the physician is a solo provider or member of a group that does not have a compliance plan, he or she should develop, implement and maintain an active compliance plan that includes:

1. Designating a compliance officer or contact;
2. Implementing written standards and procedures;
3. Conducting appropriate training and education;
4. Developing open lines of communication;
5. Conducting internal monitoring and auditing;
6. Responding appropriately to detected offenses and developing corrective action; and
7. Enforcing disciplinary standards through well-publicized guidelines.

Although each of these elements plays a role in facilitating compliance, emphasis should be placed on conducting internal monitoring and auditing, as this can help identify a previously unknown issue and provide one with an opportunity to take proactive, prophylactic measures to address the issue prior to the issue resulting in a licensing investigation.

In addition, emphasis must be placed on appropriate documentation of the medical record. The majority of licensing actions are based, at least in part, upon a lack of appropriate documentation in the medical record.

For example, if a patient is non-compliant with the physician’s instructions, such non-compliance should be documented. If not, a subsequent review of the physician’s medical records may lead the reviewer to conclude that the physician, not the patient, failed to follow up.

Moreover, while there is no standard form utilized by all physicians for documenting patient encounters, incorporating the S.O.A.P format (i.e., subjective, objective, assessment and plan) is strongly advised, as record reviewers will look to see if each of these elements is present in the documentation.

Importantly, as of December 2006, a physician is required to maintain a record for each patient for whom he or she had provided medical services, including a full and complete record of tests and examinations performed, observations made and treatments provided.

Furthermore, with the recent push towards adopting and meaningful use of electronic health records (EHR), physicians should be mindful of issues such as self-populating record fields, which can result in significant inconsistencies in the medical record.

For example, due to a self-populating field, the medical record may state in one area: “Patient has no complaints of pain.” In some cases, EHR systems may automatically generate a prescription, including strength and form, based on the notes in the record.

In such instances, the physician must ensure that the prescription generated by the EHR system is appropriate for the patient. Though the system is convenient in generating the prescription, nothing can substitute for the professional judgment of the physician.

Second, if the physician does, in fact, change the EHR system-generated prescription, the physician must ensure that such alterations also are reflected in the exam note itself. Other health care licensees will rely on that exam note to make future decisions on refilling the prescription or prescribing another medication.

Liability also can arise by missing simple spelling errors, despite spell check (e.g., writing “care” instead of “case”). The ease with which certain tasks can be completed with an EHR system can result in increased carelessness where such mistakes could have much greater implications, including risks of patient safety, medical malpractice claims or audit activity — all of which could lead to a licensing action.

Lastly, due to the growing epidemic in Michigan regarding prescription drug abuse, there has been an increase in actions against physicians for illegitimate prescribing of controlled substances.

Administrative Complaints may issue against a health care licensee for (i) a “violation of general duty, consisting of negligence or failure to exercise due care … whether or not injury results … or (ii) incompetency.” Both of these bases essentially allow a licensing action for not following the applicable standards of care.

The applicable standards of care, while not delineated by statute, have been developed by the various health care licensing boards (including the Boards of Medicine, Osteopathic Medicine & Surgery and Pharmacy) to include a consideration of the following:

1. Michigan Guidelines for the Use of Controlled Substances for the Treatment of Pain, developed by the Michigan Board of Medicine and the Michigan Board of Osteopathic Medicine and Surgery;
2. Michigan Board of Pharmacy Guidelines for the Use of Controlled Substances for the Treatment of Pain;
3. Responsible Opioid Prescribing: A Guide for Michigan Physicians — a book endorsed by the Michigan Department of Licensing & Regulatory Affairs (LARA) as representing the standard of care in Michigan; and

Physicians who prescribe controlled substances are well-advised to familiarize themselves with these publications and the standards of prescribing controlled substances in Michigan.

Moreover, with regard to MAPS, while not required by statute or administrative rule, prescribing licensees are “encouraged to register to MAPS Online to request prescription data on patients … [since] using MAPS Online before and during treatment … can alert [the licensee] to any past ‘doctor shopping’ or questionable behavior.”

Physicians should not take this “encouragement” lightly.

Michigan’s Bureau of Health Professions and both state and federal law enforcement have taken the position that the applicable standards of care require physicians to perform MAPS queries regularly on patients for whom they prescribe controlled substances, and that failure to do so is a breach of the applicable standard of care.
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The law also provides that insurers “shall not require face-to-face contact between a health care professional and a patient for services appropriately provided through telemedicine.” While health care industry guidance from professional organizations such as the Federation of State Medical Boards or American Osteopathic Association suggests that there should be at least one face-to-face encounter before a physician should treat a patient using telemedicine, which can be especially beneficial for patients who are elderly, home-bound, or with reliable means of transportation.

Additionally, telemedicine services are subject to the regular terms and conditions between the patient and the insurer, such as co-payments, co-insurance, deductibles, and approved payment amounts. It is important to note that the bill only applies to private health insurers in Michigan, and payment for government-funded health care programs such as Medicare or Medicaid are subject to different payment rules. Health care providers who wish to use telemedicine in conjunction with treating Medicare and Medicaid patients should consult with a health care attorney to determine the exact scope of reimbursement rules.

Overall, the new laws give a green light to providers to use real-time interactive technology to treat patients. This could have extensive implications in fields of practice such as mental health counseling, psychiatry, or psychology. Additionally, physicians may now schedule appointments with patients via telemedicine, which can be especially beneficial for patients who are elderly, home-bound, or with unreliable means of transportation. The new laws are a start to embracing the positive changes brought about by technology.
**VERDICTS & SETTLEMENTS**

**Woman asserts doctor misdiagnosed her symptoms of brain bleed not present on first visit, says defense; jury agrees NO CAUSE**

Plaintiffs Carol and Mark Sells sought compensatory damages from defendants Dr. John Sosa, Orion-Oxford Urgent Care PC and William Beaumont on claims of medical malpractice.

On Oct. 10, 2008, Carol Sells developed a severe headache on the right side of her head, and could not sleep. It continued through the next night. She had no history of migraines.

On Oct. 12, Sells went to Orion-Oxford Urgent Care, where Sosa evaluated her. He noted in the medical record "? Sinusitis triggering a migraine headache," and prescribed a Z-pack antibiotic. He told Sells to take Tylenol or Motrin for the headache and rest. Sells followed treatment orders for the next two days, but there was no improvement, and she stayed home from work.

On Oct. 15, Mark Sells found Carol Sells at home sweating profusely and unresponsive. At a hospital, she was diagnosed with a right temporal parietal intraparenchymal hemorrhage, with a significant shift of the midline structures. A bleed was later identified in Abraham's upper GI tract, which had been resected during the surgery. Lindsey performed an insidious hernia repair March 1, 2007. Because of the difficulty with pain management, Abraham was provided with a non-steroidal anti-inflammatory drug (NSAID), as the pain reliever she was taking was inadequate.

Following Abraham's March 3 discharge, she contacted Lindsey with complaints of continuing pain. She was given a prescription for Toradol, a strong NSAID, and continued to rotate her NSAID medication.

A bleed was later identified in Abraham's GI tract. The bleed's location was found in the duodenum, in the upper GI tract, which had been resected during the gastric bypass surgery.

Plaintiff asserted that Sosa did not obtain a full physical exam before making a diagnosis and formulating a treatment plan, did not order or obtain necessary diagnostic and radiological tests, and misdiagnosed plaintiff with sinusitis.

Defendant contended that plaintiff did not have symptoms likely indicating intracranial bleeding or sinus thrombosis upon her first visit for treatment. It also was argued that patients who experience what plaintiff eventually had also have other symptoms of a stroke, such as weakness on one side of the face, difficulty speaking and blurred vision, which plaintiff experienced three days after Sosa treated her.

The jury found for the defendant and issued a no-cause-of-action verdict.

**Damages sought for ulcer after hernia repair**

Bleed found in woman's upper GI tract after her gastric bypass surgery NO CAUSE

Plaintiff Theresa Abraham sought compensatory damages from Dr. Hugh Lindsey on claims of medical malpractice for development of an ulcer that followed hernia repair, which was necessitated by gastric bypass surgery.

Abraham underwent Roux-en-Y gastric bypass in 2003, and in 2006 went to Lindsey for evaluation of a hernia resulting from the surgery. Lindsey performed an insidious hernia repair March 1, 2007. Because of the difficulty with pain management, Abraham was provided with a non-steroidal anti-inflammatory drug (NSAID), as the pain reliever she was taking was inadequate.

Following Abraham's March 3 discharge, she contacted Lindsey with complaints of continuing pain. She was given a prescription for Toradol, a strong NSAID, and continued to rotate her NSAID medication.

A bleed was later identified in Abraham's GI tract. The bleed's location was found in the duodenum, in the upper GI tract, which had been resected during the gastric bypass surgery.

Plaintiff argued that defendant inappropriately prescribed NSAIDs to a post-Roux-en-Y gastric bypass patient, causing an ulcer in the resected portion of the GI tract.

Defendant contended that the care provided was entirely appropriate and within the standard of care. It was further asserted that the contraindication for use of NSAIDs in a post-gastric bypass patient is generally restricted to the immediate post-gastric bypass surgery time period. The jury deliberated for three hours before returning a no-cause-of-action verdict favoring defendant.

**Estate claims doctor improperly assessed abdominal pain**

Bleed was most likely a spontaneous one, standard of care followed, says defense NO CAUSE

Ronaxone Fileger, personal representative of the Estate of James Buckingham, sought compensatory damages from defendant Dr. Marie Claire Marcoun, on claims of medical malpractice.

Buckingham, 74, was admitted to Harper-Heart Hospital on March 22, 2008, for treatment of respiratory problems. Because of atrial fibrillation irregular
the bleed came from the hospital’s internist (in with the Coumadin). In addition, it was argued that the bleed was from anti-coagulopathy) which involved inflammation of the muscles in the near future when she would have her other hip replaced.

Rather than wait for Kenyon, Jeffrey sought the services of another orthopedic surgeon, who tried to convince her to wait. Jeffrey refused, and although a subsequent operation to try to gain joint length equality was successful, the leg length equality was gained by actually moving the right femur forward by adjusting the hip replacement prosthesis. 5 cm.

Shortly after, her other hip was re- surgically treated for compartment syndrome and the operation was not a success. The operation was necessary to maintain post-operative feeling and that, even if one leg was a bit longer, it could be balanced out in the near future when she would have her other hip replaced.

On examination at Bronson Hospital, Pone found moderate tenderness and weakness in her right calf and posterior muscle mass. He discharged Robinson with instructions to return if symptoms worsened in any 1 cm. She was given rest, ibuprofen, taping, taping, or a cold, pale foot developed.

The next day, Robinson told WMU’s women’s basketball team was worsen- ing. The trainer was concerned about the possibility of compartment syndrome, which involves inflammation of the muscles in the anterior compartment of the patient’s lower leg. Robinson had lost the ability to dorsiflex (point the toe up), and developed numbness and tingling, but did not return to the ER as instructed.

As a result of the medical malpractice sur- ger, was called. Upon examining the leg and feeling a hard, tense compartment, and developed numbness and tingling, but did not return to the ER as instructed.

As a result of the medical malpractice surgery, Robinson had lost the ability to dorsiflex (point the toe up), and developed numbness and tingling, but did not return to the ER as instructed.

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through which a physician can become affiliated with a hospital, such as: direct employment, physician practice acquisition, clinical integration, medical directorships; and accountable care organizations (ACOs).

Working relationships organized under any of these models should be memorialized through a negotiated written contract or agreement and reviewed by an attorney with health care expertise. Any contracts or agreements for these models should all include careful consideration for these models:

- (1) Defined job responsibilities and accountabilities. What roles are the physician expected to fulfill at the hospital (clinical and administrative)? These should be defined in any written contract or agreement. How much autonomy and independence will the physician have? Who does he/she report to? Can the physician still retain an outside practice?
- (2) Moonlighting activities, inside the hospital and outside. Will the physician be permitted to moonlight for other departments or cover other physicians? Is locum tenens outside of the hospital permitted? What activities require advance permission and from whom? Who will receive the royalties if the physician writes a book or invents a new medical device?
- (3) Privileges. Are the physician’s hospital privileges (if applicable) linked to the contract or agreement such that, if the contract or agreement is terminated, the hospital privileges end?
- (4) Hours worked and on-call requirements. Minimum hours worked for on-call responsibilities should be clearly defined, realistically achievable, and should include all administrative and all other non-clinical duties. Is on-call time compensated separately? On call responsibilities that are open-ended or variable based on the demand by the hospital administrative entity should be avoided, and the call coverage should be shared equally among all physicians in the same practice area. Similarly, work site locations should be specified to the extent that the hospital has numerous locations or branches or satellites spread across far distances.
- (5) Compensation (i.e., fair market value, productivity, quality based or some other arrangement): What ever the form of the compensation, it is essential that the physician understand how fairer compensation will be calculated.
- (6) Subsidies and shared savings. For a physician who is integrating his practice into a hospital or selling his practice’s assets, who receives the benefit for government subsidies for electronic medical records (EMRs)? In an ACO, will the physician participate in any shared savings?
- (7) Terminating the relationship. The definition of any non-clinical relationship should be specified, as well as renewal notice requirements, and the circumstances under which the relationship can be terminated. For-cause terminations should be defined. How much notice is required for non-cause terminations?
- (8) Restrictive covenants. Physicians should carefully consider the scope of any restrictive covenants, and depending on their breadth, require that the physician uproot his family to a new city or, worse, state. The contract or agreement should delineate the situations under which any non-compete or non- solicitation clause will and will not apply. If the physician is terminated without cause or if the hospital breaches the employment agreement, the restrictive covenant should not necessarily apply. If a physician’s employment or arrangement is successfully challenged he will have to patient records?
- (9) Malpractice, continuing legal education, and equipment. Who is responsible for paying these things? Who pays tail coverage?

In conclusion, no matter what form it takes, if you are considering employment with a hospital or integrated entity, it is important that you discuss the arrangement with legal counsel who specializes in health law and can review and negotiate any written contract or agreement, as well as a CPA or accountant who can evaluate the financial aspects of the arrangement and compensation offered.

Such experienced professionals can help you evaluate what form of relationship suits your needs and concerns, and ensure that the relationship undertaken meets your short- and long-term goals.

Michelle Buerer specializes in practice in employment law for health care practices and professionals regarding board structures and employment issues, as well as with credentialing, privileging and licensing matters. She can be reached at (248) 568- 5714 or by email at mbayer@mbayerlaw.com.
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