HEALTHCARE MICHIGAN

April 2014
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Health Care Law Issue

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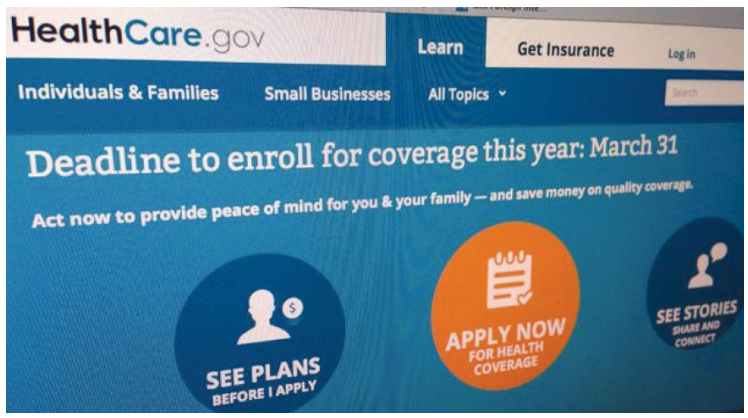
What Happens Next On The Health Law?

By Julie Appleby, Mary Agnes Carey and Phil Galewitz; KHN Staff Writers

Just because open enrollment for people who buy their own health insurance formally closes March 31 doesn't mean debate over the health law will take a hiatus. After more than four years of strident rhetoric, evidence about how the law is actually working is starting to trickle in. Here are seven things to watch before the next enrollment period begins in November:

1) How many enrolled, really? Rightly or wrongly, this figure has become a yardstick by which some are measuring the law's success. But no one can give an accurate accounting yet.



President Barack Obama announced March 27 that the administration had hit the 6 million enrollment mark -- the revised projection of the nonpartisan Congressional Budget Office (which had initially forecast 7 million before the disastrous rollout of the online marketplaces last October).

As of March 1, another 4.4 million consumers had been deemed eligible for Medicaid, the state-federal insurance program for low-income Americans.

Final tallies of enrollees may come in mid-April, but those figures won't be the last word either. That's because not everyone who signs up for a private plan will pay their first premium, and they aren't cov-

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SGR Fix: Send Regrets Only

By Joseph Weiss, MD, FACP

In response to the news, physicians likely will respond less in anger and more in regret. The news I refer to is that there will be no SGR fix this year, only another patch.

Joseph Weiss, MD

(Editor's Note: The Sustainable Growth Rate Formula, SGR, is a controversial and increasingly unpopular formula that Medicare uses to determine physician pay. It essentially defers cuts to the program making them cumulative year over year until the program is reformed or its draconian cuts enacted. Annual 11th hour solutions by Congress, keeping rates flat or slightly increasing them, have been recurring for more than a decade.)

Physicians should not heap invective on the American Medical Association or the presiding officers of our specialty societies. Nor should we point fingers at fellow physicians for not convincing legislators that the need for SGR reform was urgent.

However, we can feel sorry both for the country and ourselves. The patch as it now stands is mischievous at best and malicious at worst. The haste of the House to pass it and the failure of the Senate to debate the matter represents an ugly example of the failure of American governance to meet its responsibilities.

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Casting Aside Reform Bill, Congress Passes Another Medicare Patch

The U.S. Senate March 31 voted in favor of yet another temporary measure in a long line of Medicare payment patches, casting aside broadly supported legislative policy that instead would have reformed the Medicare payment update system, according to an American Medical Association Report.

"The AMA is deeply disappointed by the Senate's decision to enact a 17th patch to fix the flawed sustainable growth rate (SGR) formula," AMA President Ardis Dee Hoven, MD, said in a statement following the vote. "Congress has spent more taxpayer money on temporary patches than it would cost to solve the problem for good."

The $21 billion patch was passed in a vote of 64 to 35, which took place on the eve of an SGR-imposed payment cut of 24 percent. The patch will extend the current 0.5 percent update through the end of the year and freeze payment rates from January to March of next year.

"This bill perpetuates an environment of uncertainty for physicians, making it harder for them to implement new innovative systems to better coordinate care and improve

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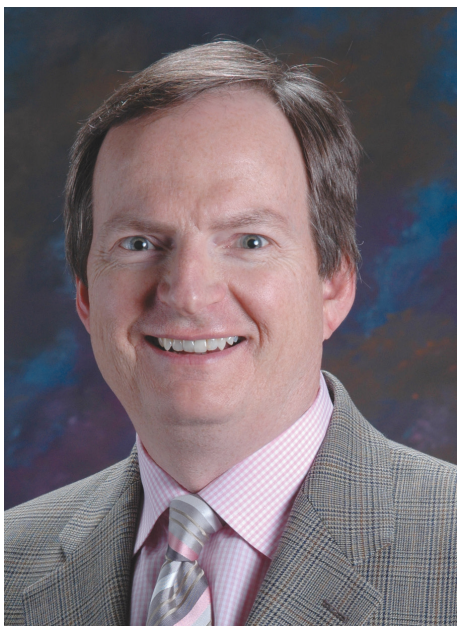
Spare the Rod, Spoil the Child

So long as little children are allowed to suffer, there is no true love in this world.
Isadora Duncan (1877 – 1927)



By Daniel Ryan, MD

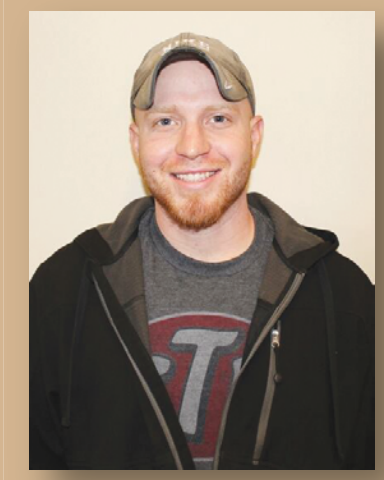
Before one is allowed to drive an automobile, a training course is recommended and passage of a state mandated certification test is required. Flying an airplane necessitates a certain level of training and experience before one is licensed to take the controls unsupervised. Civilized society is much safer when important tasks are done by those that are qualified, certified, licensed, and reviewed, whether styling hair or doing brain surgery. But one of the most important jobs to both the community and the individual requires no previous experience or training, no licensing or certification, and there is really not even an age requirement. That is the task of parenting.

April is National Child Abuse Prevention Month. It is truly a sad commentary that we feel the need to designate a month to increase awareness of the preventable problem of child neglect and abuse. Children suffer from this hidden epidemic and increasing awareness of the public regarding the statistics, causes, effects, and solutions is the goal of this campaign. We all pay the price of this scourge but the toll on kids is shameful. The United States has one of the highest reported incidences of child abuse among developed nations.

Child abuse and neglect includes physical abuse, sexual predation, emotional and psychological trauma, and ignoring medical needs of the child. Abused children who grow up to be healthy, well-adjusted adults that do not abuse their own children have certainly beaten the odds. Most runaways, adolescent prostitutes, and teenage delinquents report having been victims of abuse as children. Signs of abuse are generally well known to medical personnel. Among them are unexplained fractures and contusions, especially in unlikely locations, repeated injuries, circular or donut-shaped burns from cigarettes or scalding, injuries in various stages of healing, and unusual behavior such as aggressiveness or withdrawal. Parents will often be defensive or concoct an unlikely explanation for an injury.

Every day, four to seven children die from abuse and neglect. Incredibly, a majority of these kids are under four years old. This occurrence is not predicted by income level, race, religion, or ethnic or cultural groups. Abuse victims are likely to mistreat their own children and the sad cycle continues for generations. A high percentage of those in prison were abused as children, especially among women prisoners. Substance abusers were frequently neglected and/or abused. The monetary costs, both direct and indirect, are estimated at $124 billion annually. In this area, we are not immune. Just ask the pediatricians, emergency physicians, and pediatric intensivists. In Michigan, there were 34,000 confirmed cases of abuse and neglect in 2012, of which 2216 occurred in Genesee County.

In Genesee County, we are fortunate to have an advocate for abused children in The Whaley Children's Center. The Center is a place for sheltering, protecting and nurturing victimized kids. Their mission is to provide tools for children and families that have experienced trauma to reach their full potential. Dedicated staff and volunteers help the Center pursue its goals. Please take the time to send a generous donation to The Whaley Children's Center or a similar organization in your area. Encourage family, friends and colleagues to do the same. A pipe dream would be that such facilities will someday have to discontinue operations because of a lack of clientele. Until that day, give until it feels good.



In Memoriam

Landon Mabry 1986-2014

Landon was the son of publisher Mark Spiess and wife Callie. He was unexpectedly called to heaven last month and will be forever loved and missed by family and friends. Landon lived in Longmont, Colorado. Rest in peace Landon, you will forever be your mom's angel boy.

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Is it my fault? Attending v. Resident Physician Liability

By Miranda Welbourne Eleazar

A variety of individuals can be involved in the care and treatment of any patient in a hospital, from nurses and aides to residents and attending physicians. When something goes wrong that provides a basis for a medical malpractice action, any combination of those individuals may be sued. In addition, the hospital and any professional corporations that employ physicians also may be brought into the lawsuit on the basis of their employees' actions. When residents are employed by hospitals and attending physicians are employed by separate professional corporations, residents may be sued in an attempt to demonstrate liability of the hospital based on the actions of the hospital's resident employees. In those cases, the question of whether the attending or resident is responsible for the care and treatment at issue can be a key issue in determining liability of the individual defendants. The allocation of liability is further complicated by the limited knowledge and experience many residents have in the various specialties involved in medical malpractice actions.

Michigan Courts analyze the issue of who is liable for alleged malpractice, resident or attending physicians, under the principles of agency. The attending physician is the principal and the resident physician is the agent of the attending physician, authorized to act on behalf of the attending physician with those actions binding on the attending. Based on that agency relationship, the attending physician can be held liable for breaches in the standard of practice on the part of residents as if the attending physician was the individual who breached the standard of practice, regardless of whether the attending was actually at fault. An attending physician also may be held liable for negligently supervising the resident. That does not mean, however, that a resident physician is always free from liability. Instead, both the attending and resident can be found liable if it is shown that the resident breached the standard of care, causing the patient's injury, and the attending was responsible for the resident. Courts have not found, however, that the opposite is true and residents are liable for their attending physicians' breaches in the standard of practice. In summary, both residents and attending physicians can be held liable for their own independent breaches of the standard of practice; attending physicians can also be held liable for breaches in the standard of practice of residents working for them; but residents generally cannot be held liable for simply observing wrongful acts or omissions of their attending physicians. Attending physicians may also be liable for the actions of their partners when they are jointly employed in a partnership or acting jointly on a case. Consider these factors when asking, is it my fault?

MIRANDA J. WELLBOURNE ELEAZAR is an Attorney with Sullivan, Ward, Asher & Patton, P.C. She represents health care systems and professionals in addition to utility companies, ski resorts, and large corporations in complex personal injury cases including medical malpractice, product liability, general negligence, and premises liability. She formerly worked in New York City at McDermott, Will & Emery, a large international law firm, in the areas of toxic torts, pharmaceutical defense, and product liability. In 2013, she was named a Michigan Rising Star for Super Lawyers. Miranda was admitted to practice in both New York and Michigan and she has a J.D. degree, cum laude, from the University of Michigan Law School.

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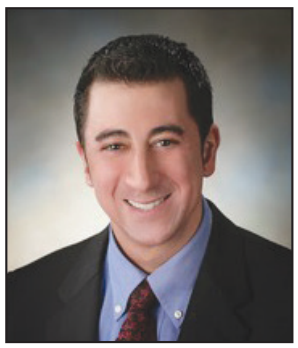
1 Vickers v. St. John Hosp. & Boccaccio, 1998 Mich App LEXIS 1330 at *14 (1998), Thomas v. Vantuinen, 2007 Mich App LEXIS 418 at *13 (2007).
2 Id.
3 Vickers, supra.
4 Gilpin v. Marcus, 1999 Mich App LEXIS 801 at *9 (1999).
5 Thomas, supra, at *16.

Physician Employment Guidelines Per the AMA



By Robert Iwrey

It seems like every ten years or so the pendulum swings towards or away from physicians seeking employment from hospitals as opposed to heading off on their own or joining existing private practices. Over the last few years, the pendulum has swung towards hospital employment. A number of factors have arguably led to this trend including the desire by many physicians to focus their attention on practicing medicine and shifting the burden of billing, third party payor audits, EMR and compliance with the new myriad of federal healthcare to the hospitals that have the resources to employ administrative staff to address such matters. In light of this hospital employment swing, the AMA issued guiding principles for physicians entering into employment arrangements. The six AMA principles address: (1) conflicts of interest; (2) patient advocacy; (3) contracting; (4) hospital medical staff relations; (5) peer review/ performance evaluations; and (6) payment agreements.

When addressing conflicts of interest and patient advocacy, the Principles emphasize that "a physician's paramount responsibility is to his or her patients." For potential conflicts of interest where a physician's employer may have provided the physician with financial incentives to over- or under-treat patients, the AMA provides that "patient welfare must take priority" over any conflicting interest of the employer and the employed physician must make "treatment and referral decisions based on the best interests of their patients." The AMA cautions that employed physicians should not be retaliated against or deemed to be in breach of their employment agreements by their employers for asserting patient interests and that physicians should be "free to engage in volunteer work outside of, and which does not interfere with, their duties as employees."

With regard to contracting, the Principles provide that physicians should be able to freely enter into contracts with hospitals, health care systems, medical groups, insurance plans and other entities as permitted by law and medical ethics without coercion and such arrangements should be negotiated in good faith. The Principles expressly urge both the employer and the employee to "obtain the advice of legal counsel experienced in physician employment matters when negotiating employment contracts." All too often, well-respected attorneys who do not specialize in the field of healthcare fail to address important issues such as covenants not to compete and/or solicit patients or malpractice insurance when drafting / reviewing employment contracts due to their lack of expertise on the subject. Typically, the review of a proposed employment contract only involves a handful of billable hours, and the benefit of having such a review is immeasurable when considering the duration of a physician's career.

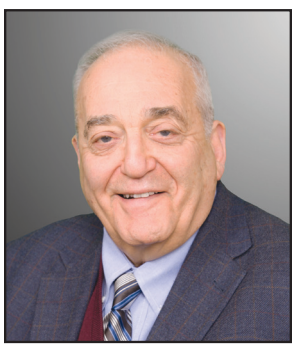
With regard to hospital medical staff relations, the Principles emphasize that employed physicians should conduct themselves in accordance with the medical staff bylaws, standards, rules, regulations and policies, but should be free to exercise their personal/professional judgment when voting, speaking and advocating and should not be retaliated against for doing so.

With regard to peer review/performance evaluations, the Principles provide that peer review procedures should be uniformly applied, free from undue influence of Employer HR activities/ administrators, and should include due process for the involved Physicians.

Lastly, regarding payment agreements, the Principles recognize that employed physicians have the right to review an employer's billing to assure the accuracy of the claims submitted under their names. Furthermore, the Principles state that Employers should indemnify and defend employed physicians for any billing violation which is not the fault of the employed physician where the employer does the billing.

ROBERT S. IWREY is a founding partner of The Health Law Partners, P.C. with offices in Michigan, New York and Atlanta. He graduated with High Distinction from the University of Michigan in 1988. While there, he was an Executive Member of the Psi Chi National Honor Society and was a member of the Golden Key National Honor society. In 1993, he earned his J.D. at Wayne State University Law School, where he was awarded the American Jurisprudence Award in Advanced Legal Writing and was an award-winning member of Moot Court. He has been a practicing litigator since 1993.

Observations on Tuomey/Halifax and Beyond



By Gilbert M. Frimet

For over four decades, since the advent of the Anti-Kickback Statute through the later enactment of Stark I and II (with interpretive regulations), the healthcare community and the courts have wrestled with the weaving and unweaving of provider arrangements and their ultimate legality.

The presence and addition of exemptions, safe harbors and Stark exceptions have attempted to achieve a more realistic balance and harmony in provider planning. Referrals for profit, the inducement to refer, and the Tit for Tat desire to avoid self-management by some providers and the resistance to harnessing of uncontrolled monetary impulses have created an impressive circle of activity for law enforcement and the courts. We may not have found the most practical or realistic solutions in our efforts to cost contain, but we have doggedly adhered to Stark and Anti-Kickback for want of a better way.
U.S. v Tuomey and U.S. v Halifax are two recent legal opinions that confirm the approach we are pursuing.

In Tuomey, U.S. District Judge Seymour, has with deft strokes in dealing with Tuomey's post-trial motions shown active deference to a jury verdict for the government in finding a violation of Stark and as well awarded answered all of Defendant Tuomey's motions for full relief as a matter of law.

Of particular interest was Tuomey's raising of "the advice of counsel defense" reaching into the testimony at trial. Judge Seymour cites the testimony of Tuomey's well experienced former government attorney expert in this matter that the Tuomey formula is not acceptable, and after firing this attorney, defendant sought the opinion of another attorney more to its liking. At this point, Tuomey probably flunked the "Red Face" Test.

Another of Tuomey's arguments was that the severity of the government's request for significant damages violated the 8th Amendment to the U.S. Constitution. Again, without merit. Other defense arguments are similarly disposed of.

Halifax appears to be a much closer case. Halifax hospital entered into an employment agreements with six (6) medical oncologists. These doctors received varied bonuses based on personal performance, but also in connection with revenue derived from referrals for designated health services. Referral revenue went into the general pool under the agreement. The pool was held to be a violation of Stark.

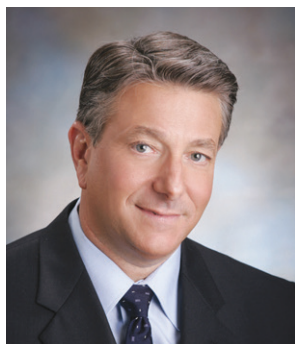
Clearly, in any scenario, cost containment is likely to control. Regrettably, quality would likely remain a junior partner. Fraud and abuse constraints are not likely to change much in the near future.

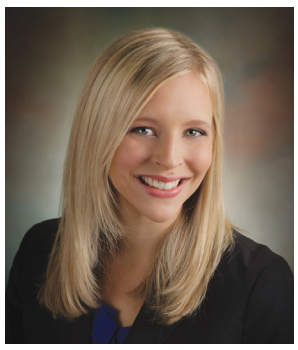
Major policy shifts in our Health Care Delivery System particularly with the Affordable Care Act may auger for some basic change and in limited sectors. In the meantime, the Safe Harbors and Stark exceptions afford the most provider protection and point the way forward.

GILBERT M. FRIMET joined the firm Of Counsel in 2003 and is a member of the Health Care Law Practice Group. He began practicing in Michigan in 1955 and has over 48 years of health and administrative law experience.

He concentrates his practice in the areas of health care law and administrative law. A prolific writer, many articles authored and co-authored by Gil have appeared in Health Care Weekly Review and numerous health and legal publications. Gil received his undergraduate degree from Wayne State University and his L.L.B. and J.D. from Wayne State University Law School.
A member of the State Bar of Michigan, the American Bar Association and the American Health Lawyers Association, Gil is also a member of the state bar's Health Care Law Section.

Recent Developments in Medicare Audits and Appeals





By Andrew Wachler, Esq. and Jessica Forster, Esq.

In the past few months, important developments have occurred that directly impact Medicare providers, particularly hospitals. It is important for providers to be aware of these developments and modify their audit appeals strategy appropriately. First, in February 2014, the Centers for Medicare & Medicaid Services (CMS) announced that effective February 22 Recovery Audit Contractors (RACs) suspended sending additional documentation requests (ADRs) to providers for post-payment audits and RACs can continue to conduct automated reviews through June 1, 2014. February 28 was the last day that Medicare Administrative Contractor (MACs) could send prepayment ADRs for RAC Prepayment Review Demonstration. CMS stated in its announcement that because it is in the procurement process for the next round of Recovery Audit Program contracts, it is important for CMS to transition down the current contracts so that the RACs can complete all outstanding claim reviews and other processes by the end date of the current contracts. CMS also announced that it will not conduct post-payment patient status reviews for claims with dates of admission October 1, 2013 through October 1, 2014. Although RAC audits will return, this is an important reprieve for Medicare providers.

In addition, in March, in a bipartisan effort two senators unveiled a proposed bill titled the "Two-Midnight Rule Coordination and Improvement Act of 2014." The proposed bill would require a number of important changes, including the Secretary of the Department of Health and Human Services to consult with interested stakeholders, including hospitals, to determine criteria for short-stay inpatient admissions. The bill would also require CMS to develop a payment methodology for shorter inpatient stays. The bill describes the payment as "…a reduced payment amount for such inpatient hospital services than would otherwise apply if paid…or be an alternative payment methodology." This is an important development and if passed would allow hospitals a clear and efficient means to be paid for shorter inpatient stays.

Finally, another important update involves the Office of Medicare Hearings of Appeals' (OMHA) announcement that effective July 15, 2013 it temporarily suspended the assignment of most new Administrative Law Judge (ALJ) hearing requests for 24 months. OMHA announced that the delay is due to a large increase in appeals, which has caused a backlog in pending cases at the ALJ level. In February 2014, OMHA held a Medicare Appellant Forum with the purposes to inform OMHA appellants on the status of OMHA operations, discuss initiatives to reduce the growing backlog of OMHA-level appeals and suggest steps that appellants can take to make the administrative appeals process more efficient. Although OMHA provided steps for providers to incorporate into their appeals to increase the efficiency of the process, the primary concern for providers was the delay in the assignment of ALJ hearing requests. OMHA's temporary suspension contradicts 42 C.F.R. 405.1016 which requires an ALJ to issue a decision no later than 90 days from the date OMHA receives a timely filed request for ALJ hearing. The delay raises due process issues for providers, particularly for providers facing post-payment audits. After an unfavorable reconsideration decision, providers challenging a post-payment audit cannot prevent recoupment of alleged overpayments. When the ability to recoup overpayments after the reconsideration level of appeal was originally allowed, it was with the understanding that an ALJ would issue a decision within 90 days from the receipt of an ALJ hearing request. However, with the two-year delay of an assignment of claims to ALJs, providers will have to withstand recoupment of alleged overpayments for more than two years. This could cause providers facing large overpayment demands to experience significant financial strain, and possibly go out of business, before they have an opportunity to present their case at an ALJ hearing, and thus, is an issue ripe for a due process challenge.

ANDREW B. WACHLER is the principal of WACHLER & ASSOCIATES, P.C. Mr. Wachler has

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Disabilities Discrimination Claims by Hearing Impaired Patients

By Richard Bouma

Healthcare providers know they must offer accommodations to patients with disabilities. Yet many providers have been surprised to find themselves facing inreasingly aggressive claims of unlawful discrimination, particularly claims brought on behalf of hearing-impaired patients.

Those claims can lead to large payments. Trinity Health Systems (Iowa), for example, paid $220,000 to resolve a claim that it failed to provide deaf patients with a sign language interpreter. A New Jersey jury awarded $400,000 (not covered by malpractice insurance) against a rheumatologist for failing to provide a sign language interpreter for a deaf patient.

The Department of Justice has announced a "Barrier-Free Health Care Initiative." It is affirmatively looking for cases to bring against health care providers who fail to assure that their deaf patients have access to meaningful and understandable access to their medical information.

Requirements. The Americans with Disabilities Act requires providers to make reasonable accommodations to meet the needs of patients who have disabilities.

Reasonable accommodation varies, depending on the circumstances of each case. Generally speaking, in the case of a hearing impaired patient, the provider must assure that there is "effective communication" between the provider and the patient. As appropriate, the provider must offer auxiliary aids and services, at no cost to the patient, to facilitate effective communication. Sometimes, but not always, a provider must offer a sign language interpreter for a hearing-impaired patient.

Key factors as to what is appropriate in a particular circumstance include the nature, length, complexity and context of the communication, and the patient's normal mode of communication. If, for example, a patient visit is brief and routine, and if the patient has nothing unusual to discuss with the provider, short written notes or even lip-reading might be appropriate. On the other hand, if a discussion will be complex or

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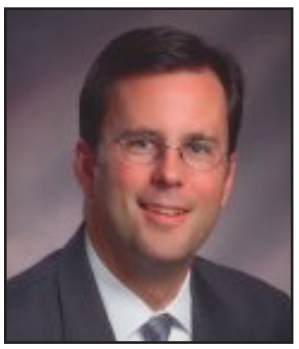
Recent Enforcement Actions Demonstrate the Necessity of HIPAA Electronic Security Policies and Procedures



By Daniel J. Schulte, J.D.

HIPAA's Privacy Rule and Security Rule (as updated/modified by the HITECH Act) requirements may seem like overkill for many healthcare practices. Conducting and documenting a risk assessment, the implementation of security procedures and the training of employees may not seem necessary when you only have 2-3 employees and a couple of computers in your office. However, these are important requirements for you to fulfill. They are aimed at increasing the protection of electronic protected health information. There is no small practice exception. Recent enforcement activity demonstrates that these laws are being enforced and those found not to be in compliance are being sanctioned with significant financial penalties. Consider these two cases:

The first involves a small health plan that leased digital copiers. The copiers (as all digital copiers do) contained hard drives storing much of the information copied. When the lease of the copiers expired the health plan turned them in and leased new ones. The problem is that the health plan did not think to delete the information (which contained protected health information) on the hard drives first. The copiers were released to another party (which turned out to be the CBS Evening News). It discovered that the copiers had protected health information on their hard drives and reported to the agency responsible for HIPAA enforcement, the Health and Human Services Office of Civil Rights ("OCR"). OCR investigated and found that the health plan had not conducted the risk assessment (if it had it might have know about the hard drives of the copiers) or adopted any security policy (that would have included a policy of removing records from equipment with a hard drive before disposal). OCR fined the heath plan $1,215,780 and mandated it comply with a "corrective action plan" requiring it to do what was required by HIPAA/HITECH.

The second involves a dermatology practice. An employee took a thumb drive from the practice to do some work at home. The thumb drive contained 2,200 patient records and was stolen from her car. The practice properly reported the loss of the thumb drive in compliance with HIPAA/HITECH, immediately took other reasonable steps to recover the thumb drive. OCR investigated and ultimately fined the practice $150,000. Why? Because the investigation revealed that the practice had not conducted a security assessment (which would have included an assessment of the risk of letting employees take electronic records home) or adopted an electronic security policy (which should have prohibited employees from taking this information out of the practice in an unencrypted format). In addition to the fine, OCR mandated that the practice comply with a corrective action plan that, like the health plan in the case above, required it to comply with all the requirements of HIPAA/HITECH.

What these cases tell us is that the government is stepping up its enforcement action against without regard to the size of a covered entity and that doing the right thing after a security breach will not be good enough. If you cannot demonstrate that you have conducted a risk assessment, adopted a security policy and otherwise complied with HIPAA/HITECH you will face large financial penalties that will make you wish you had in addition to having to meet the requirements you were trying to avoid.

DANIEL J. SCHULTE is a Member of Kerr, Russell and Weber, PLC. He is co-chairperson of the firm's Health Care Practice Group and is chairperson of the firm's Recruiting Committee.

Mr. Schulte's practice includes all aspects of the transactional, operational and regulatory legal services sought by small business owners with a concentration in representing health care professionals. Services routinely provided include the formation of business entities, preparation and review of business and corporate contracts, the purchase and sale of ownership interests in business entities and/or their assets and the purchase, sale and leasing of real estate. Mr. Schulte represents health care professionals in state regulatory matters, including disciplinary and other licensing disputes with the State of Michigan, and federal regulatory matters including fraud and abuse issues. He also counsels on the anti-kickback and Stark laws, preparation of compliance programs and responding to and negotiating settlements in connection with government enforcement actions.

Mr. Schulte is an expert on association law and is primarily responsible for the firm's representation of the Michigan State Medical Society and the Michigan Dental Association. His association law experience includes the drafting and review of new legislation and the preparation of Amicus Curiae Briefs for filing in the Michigan's Supreme Court and Court of Appeals on a variety of topics effecting health care professionals practicing in Michigan.

Mr. Schulte is a member of the State Bar of Michigan, the American Bar Association, the Michigan Association of Certified Public Accountants, the American Institute of Certified Public Accountants, the American Health Lawyers Association and the American Society of Medical Association Counsel. He has published articles and made presentations to a variety of groups on many topics including the Health Insurance Portability and Accountability Act of 1996, compliance plans for health care professionals, business succession planning, asset protection, estate and tax planning.

Mr. Schulte is a graduate of the Wayne State University Law School. Prior to entering law school, Mr. Schulte was a Senior Auditor with Coopers and Lybrand in Detroit. Mr. Schulte received his undergraduate degree in Economics and Management from Albion College.

National Practitioner Data Bank Hospitals Must Be Prepared for Updated Reporting Requirements

By Keith Wright

After 13 years, the Health Resources and Services Administration ("HRSA") is expected to release an updated National Practitioner Data Bank ("NPDB") Guidebook this summer. The NPDB arose from Congress' determination that a national database was needed "to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance." To fulfill that need, the Health Care Quality Improvement Act of 1986 ("HCQIA") authorized the Secretary of the Department of Health and Human Services to establish the NPDB to collect information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. In addition to creating the NPDB, the HCQIA also provided standards for hospitals conducting professional review and immunity from damages based on professional review actions.

The Guidebook provides guidance to hospitals on the NPDB's querying and reporting requirements. A hospital is required to query the NPDB whenever a practitioner applies for medical staff appointment or for clinical privileges and every two years thereafter. If a query is not made, the hospital is presumed to have knowledge of any information reported to the NPDB concerning the practitioner. Failing to query also provides a plaintiff's attorney with the opportunity to query the NPDB and use that information against the hospital, but not the practitioner, in a malpractice lawsuit.

The HCQIA also requires hospitals to report adverse clinical privileges actions based on a physician's or dentist's professional competence or professional conduct that adversely affects, or could adversely affect, the health or welfare of a patient. Reportable adverse actions include professional review actions that adversely affect privileges for a period of more than 30 days or acceptance of a surrender of clinical privileges while under investigation. If a hospital does not report an adverse clinical privileges action, the hospital loses the HCQIA's immunity protections for three years and the hospital's name is published in the Federal Register.

HRSA's draft updated Guidebook was made available for public comment prior to finalization. One change that is likely to cause concern for both hospitals and physicians relates to HRSA's position that a hospital must report a physician that resigns while under Focused Professional Practice Evaluation ("FPPE"). Using FPPE will likely cause issues because FPPE:

1. is a process defined by the Joint Commission and may not be familiar to hospitals using different accreditation.

2. compliance will be difficult as the Joint Commission may change the FPPE standards at any time.

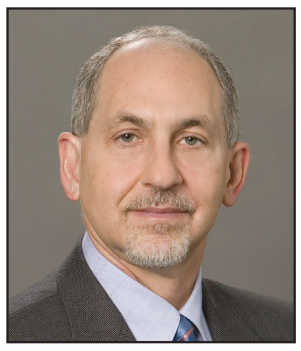
3. is not necessarily related to professional competence or conduct adversely affecting patients due to the Joint Commission requiring a period of FPPE for all physicians obtaining privileges at the hospital for the first time or requesting expanded privileges.

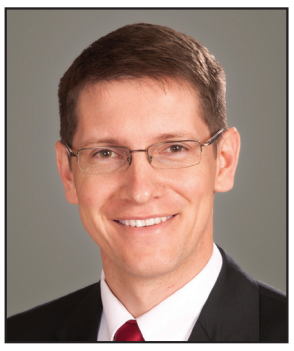
4. is generally conducted at the department level, not by the hospital or Medical Staff Executive Committee, which has historically been viewed as triggering the investigation requirements for purposes of NPDB reporting.

In addition to this change, there are many more impacting reporting and querying obligations. As such, hospitals should be prepared to carefully review and understand any new reporting and querying requirements to avoid sanctions, such as loss of professional review immunity.

KEITH WRIGHT is an attorney in Kitch Drutchas Wagner & Valitutti's Healthcare Corporate and Regulatory, and Commercial Litigation Practices. He focuses his practice on representing hospitals, physicians, and other providers on medical staff, privileging/credentialing issues, health care regulatory, transactional, corporate and compliance matters.

Litigating Physician Non-Competition Agreements in Michigan





By Michael Rhodes and Warren Krueger

Michigan's physician-patient privilege law restricts a health care provider's ability and legal duty to disclose patient information for purposes of litigation. Interestingly, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA") provides exceptions to the disclosure of patient information for litigation purposes. But the absence of a corollary exception under Michigan's privilege statute nevertheless prohibits disclosure of that information – at least is the conclusion the Michigan Court of Appeals has reached. This quirk in Michigan law carries significant consequences.

That is, recovery of monetary damages in litigation requires a party claiming damages to prove them. In other words, if damages are not proven, they are not recoverable. And in the healthcare setting, proving damages may require access to patient information.

Take for example a lawsuit involving a physician's breach of a non-competition agreement by treating the patients of his former employer. This was the situation faced by the Court of Appeals when it analyzed the extent to which patient information can be disclosed under Michigan's privilege law for litigation purposes. The extent of the former employer's damages depends on the amount of treatment provided by the physician to those patients. However, determining the extent and nature of that treatment requires reviewing the patients' records. But because Michigan law prohibits disclosure of patient information without patient consent, even by a judicial order, the former employer cannot review that information and prove its damages.

Recently, a federal court in Michigan analyzed the Court of Appeal's ruling and did little to change the result. While the federal court did not fully agree with the Michigan Court of Appeals reasoning, it did not come and say that the ruling was totally incorrect. As a result, the current state of the law appears to be that any healthcare provider that has patient information cannot be compelled to disclose that information in litigation that does not involve the patient, unless the patient consents to disclosure.

The interesting and seemingly unexplored consequences of this ruling may be how it affects business associates of health care providers, and how litigants explore the records and business practices of adverse parties in discovery. The term "business associate" has a specific definition under HIPAA, a definition which was recently expanded by the Health Information Technology for Economic and Clinical Health Act ("HITECH"). Boiled to its simplest terms, it means any person or entity that obtains protected health information from a covered provider for purposes of assisting the provider in completing its duties. Interestingly, the Michigan privilege law is limited by its terms to prohibiting only "a person duly authorized to practice medicine or surgery" from disclosing information. It creates no corollary prohibition on business associates. Thus, a savvy litigant in dire need of patient information may subpoena patient records form a business associate that is not barred from disclosure by the Michigan privilege statute.

Again, this is an unexplored and potential powder-keg for unassuming litigants, particularly those who are now business associates under the extended HIPAA definition. They may not only find themselves in the litigation crosshairs of a desperate plaintiff, but also entangled in a messy dispute with the covered entity they serve.

MICHAEL RHODES has been a licensed attorney in the State of Michigan since 1978. He represents various healthcare providers on issues ranging from the structuring of professional corporations and professional limited liability companies, to compliance with the Stark and Anti-Kickback laws and regulations, HIPAA, and other applicable state and federal laws. Mr. Rhodes has represented various individual medical practitioners and small group practices in merger, acquisition, and sale of practices, including adding or terminating individual practitioners. Recently, Mr. Rhodes has worked with various medical practices and other business entities in implementing applicable aspects of the Affordable Care Act. Mr. Rhodes is a member of the American Bar Association and State Bar of Michigan Health Law sections, and was named Lansing Health Care Lawyer of the Year in Best Lawyers 2014.

WARREN KRUEGER has been a licensed attorney in the State of Michigan since 2010. Mr. Krueger's practice focuses on employment issues in the healthcare setting, and advising clients in regulatory investigations. In this regard, he has represented healthcare providers in HIPAA investigations, internal audits, and also advised clients on issues related to Stark and Anti-Kickback compliance. Mr. Krueger is a member of the American Bar Association and State Bar of Michigan Health Law sections, the American Health Lawyers Association, and has co-authored articles for client publications.

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been practicing healthcare law for over 25 years. He counsels healthcare providers and organizations nationwide in a variety of healthcare legal matters. In addition, he writes and speaks nationally to professional organizations and other entities on healthcare law topics such as Medicare appeals, Stark and fraud and abuse, HIPAA, and other topics.

Mr. Wachler graduated Cum Laude from the University of Michigan and was the recipient of the William J. Brandstorm Award. He graduated Cum Laude from Wayne State University Law School.

JESSICA FORSTER is an attorney at Wachler & Associates, P.C. Ms. Forster represents healthcare providers and suppliers in the defense of RAC, Medicare, Medicaid and third party payor audits. She has widespread experience in defending hospital RAC audits and medical necessity audits of other Medicare providers such as home health agencies and physician practices.

Ms. Forster graduated Cum Laude from Wayne State University Law School and was nominated to the Order of the Coif. While in law school, Ms. Forster was a senior member of the Moot Court Program and served on the Moot Court National and Outside Competition Teams. She was also an elected officer of the Student Health Law Association. Ms. Forster had the honor of interning for Chief Judge Gerald E. Rosen of the Federal District Court for the Eastern District of Michigan. Ms. Forster graduated Magna Cum Laude from Albion College with a B.A. in Political Science and a concentration in Public Policy from the Gerald R. Ford Institute of Albion College.

Business As Usual With the Latest SGR Temporary Fix . . . But This One Includes a Stunning ICD-10 Delay

By David Ottenwess and Stephanie Ottenwess

Late in the evening on March 31, 2014, the Senate easily passed the Protecting Access to Medicare Act of 2014 which had just been passed by the House four days earlier. The Bill is now waiting for President Obama's signature. The passage of the Bill is good news/bad news. The significance is that the Medicare Sustainable Growth Rate (SGR) formula will not be implemented for one year. This represents the 17th delay of the implementation of SGR which ultimately will represent a 24% Medicare physician pay cut. The bad news is that there is yet to be a permanent proposal for reforming the formula. Also, on a surprising note, the Bill included the delay of implementation of ICD-10 until October, 2015, at the earliest.

Congress created the SGR in 1997, a formula that would tie the amount of money budgeted for Medicare payments to the projected growth of the economy. Unfortunately, health care costs have by far outpaced economic growth which has created a multi-billion dollar shortfall in funding for Medicare payments. As a consequence, Congress has approved "doc fix" bills 16 times since 2003 resulting in the latest fix on March 31st so that more money could be appropriated to Medicare funding in order to avoid cuts in Medicare reimbursement rates for physicians.

Interestingly, the highly influential American Medical Association, along with other organizations representing physician specialty groups, were urging a "no" vote on the Bill. It is their position that a permanent fix to the doctors' perenial problem must be addressed now rather than constantly adjusting the SGR.

It is true that there is bipartisan support for a permanent solution, however, the issue is how to pay for it. Recent events had initiated the momentum for a permanent fix when, in February, 2013, the Congressional Budget Office unexpectedly cut the cost of a permanent fix by over one hundred billion dollars based on lower projections for Medicare spending. In February, 2014, bipartisan Congressional leaders released a joint proposal for permanently reforming the formula. Unfortunately, an agreement on how to pay for the fix could not be reached. Finally, Senate Majority Leader Harry Reid (D-Nev) and House Speaker John Boehner (R-Ohio) worked together on the current last minute SGR stop-gap. One of the biggest surprises found in the Bill, however, was the inclusion of the ICD-10 delay. This was unexpected because Marilyn Tavenner, Head of the Centers for Medicare and Medicaid Services, had recently declared that there would be no extensions. Moreover, in the hours after the Senate vote, questions were already raised as to whether the delay would last longer than one year. Other changes in the Bill include a delay in the enforcement of the controversial two midnight payment rule for hospitals and a suspension of recovery audits of medically unnecessary claims, both until March, 2015.

Although physicians have survived another year without the drastic SGR reductions, the fix is only temporary and Congress still has much work to do to remedy this looming problem. Over the next year Congress has three options: pass another "doc fix" Bill, pass a Bill overhauling Medicare payments, or see skyrocketing costs of doctors who treat Medicare patients.

DAVID M. OTTENWESS is the Managing Partner of Ottenwess, Taweel & Schenk, PLC. A litigator for over 25 years, he concentrates his practice in the area of civil litigation matters, including professional liability claims, general health care law defense, contracts, labor and employment, public utilities, constitutional and election law. Mr. Ottenwess is an AV® rated attorney who has been inducted into the American Board of Trial Advocates and has been named to Michigan Super Lawyers in medical malpractice defense litigation from 2007 to 2012. In 2011, he was appointed by a federal judge to serve as a Special Master in the decades-long litigation involving the United States Environmental Protection Agency and the Detroit Water and Sewerage Department litigation. Mr. Ottenwess is a frequent speaker before healthcare providers and attorneys and is currently the Trial Section chair with the Michigan Defense Trial Counsel.

STEPHANIE P. OTTENWESS is a partner with Ottenwess, Taweel & Schenk, PLC. She practices in all areas of healthcare law, providing counsel to clients in transactional matters; healthcare litigation; compliance; fraud and abuse; provider and supplier enrollment; reimbursement matters; and, third party payor audit appeals. Ms. Ottenwess is also an experienced litigator and appellate practitioner. For the past 20 years, she has successfully defended major healthcare institutions and practice groups as well as individual practitioners in State and Federal Courts, including the Sixth Circuit Court of Appeals.

Disabilities continued from page 5...

difficult (cancer diagnosis or treatment options, for example), the provider must offer communication assistance to assure that the patient has an adequate opportunity to understand his or her condition and treatment options. Using auxiliary aids or services as needed, a provider should assure that communication with a hearing-impaired patient is as effective as the provider's communication would be with a patient who does not have that disability.

Strategy. Does this mean that a provider must provide a sign language translator whenever a patient demands one? No. Courts have noted that providers need not offer interpreters merely because a patient demands it.

The provider must use good judgment. The test for each circumstance is whether patient communication, supported by auxiliary aids and services (including an interpreter, handwritten notes, teletype devices, or other services), meets the standard of effective communication, as appropriate for the visit. The burden is on the provider to offer accommodation that will result in effective communication appropriate for the treatment situation. The provider can choose a reasonable means for meeting that standard.

Obviously, though, if a provider chooses not to comply with a patient's request for an interpreter, chart documentation will be a key means of defense if the patient later brings a discrimination claim. During the patient visit, the provider should actively chart facts showing that there was clear communication with the patient, that the patient understood what she was being told, and was able to get all her questions understood and answered.

Providers must understand both their obligations and their legal rights when treating disabled patients.

RICHARD BOUMA, a partner with the Michigan law firm of Warner Norcross & Judd, has represented health care providers for more than 30 years.

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ered unless they do. In addition, consumers who signed up through insurers or on nongovernment sites are not yet included in the count. And finally, the administration on March 26 relaxed the deadline for some people, including those who encountered computer glitches while trying to enroll.

2) Who has signed up?
Prior enrollment reports have shown the vast majority to be 35 and older with more women than men. Much attention will be focused on the coveted demographic, ages 18 to 34, who have accounted for just over a quarter of enrollees. While insurers hope for young enrollees, they can also benefit if older ones are in good health.

Despite all the attention on national numbers, state and local enrollment figures are more important in any case because insurance markets are state-based, and big numbers or youthful enrollment in some places won't make up for shortfalls in others. State markets are expected to vary significantly, with some seeing bigger premium increases next year because they have older and sicker enrollees, while others with a more robust mix are more likely to see rates hold steady.

3) Has the law put a dent in the number of uninsured?
This is a key question for a law designed to reduce the nation's 48 million uninsured. It will take a while, though, to track changes. For one thing, no information has been released about how many of those who signed up were previously uninsured. Also, data so far includes those who signed up through the state and federal online markets, but not those who purchased coverage elsewhere, or who enrolled in job-based plans they had previously turned down.

A McKinsey consulting firm telephone survey in February found that 27 percent of those purchasing coverage were previously uninsured, while a Gallup poll in March found the uninsurance rate falling. Both studies have limits, however, and cannot be considered the final word. Right now, "we have a pretty good sense the number of uninsured has gone down, but not a clue as to by how much," said Larry Levitt of the Kaiser Family Foundation. (Kaiser Health News is an editorially independent program of the foundation.)

4) Will insurance plans, prices and rules be the same in the next enrollment period which begins Nov. 15?
No. Right now, insurers are assessing their new enrollment and associated health care costs for the first three months of the year, which will help them set rates for next year. Most of them must submit those rates for review by state regulators by spring or early summer. But don't expect to see the new rates until next fall, just before open enrollment begins. Analysts say much will depend on who enrolled this year and how healthy they turn out to be. Some predict big premium increases in some areas, while others say insurers are protected from the impact of large claims by provisions of the law that insulate them from unexpectedly high medical costs. Rule changes for next year will also factor into rate decisions. Insurers warn they may have to raise prices if they're forced to offer greater selection of doctors, hospitals and drugs in their networks.

5) Will Medicaid participation grow?
As of March 1, 4.4 million people had been deemed eligible for Medicaid, but it's unclear how many are newly eligible for the program or actually enrolled. That number doesn't count people who have enrolled through their state Medicaid agency. Because there is no deadline for enrolling in Medicaid, final tallies for 2014 won't be available until next year.

The program for the poor continues to be a political battleground. Democratic architects of the health law envisioned Medicaid as a key tool for insuring more Americans, expanding eligibility to adults with incomes up to 138 percent of the federal poverty level, or $15,800 a year for an individual. Then, the U.S. Supreme Court made state participation effectively optional. While the District of Columbia and 26 states, most of them under Democratic control, moved forward, two dozen others declined to participate.

A handful of states, including Pennsylvania, Virginia and Utah, are considering expansion next year. But lobbying by hospital groups and others has run into ideological headwinds and fears that state taxpayers would bear additional costs despite generous federal funding.

6) How will insurance change for those of us who get it through our employers?
The answer depends on what your employer is doing now. If you work for a large company and have job-based insurance, your employer will probably keep offering it, according to most surveys.

It's trickier to say what will happen for workers at firms that don't offer coverage. That's because all employers were given a pass this year on rules that say if they don't offer health coverage to full-time workers, they could face fines.

The Obama administration then extended that exemption until 2016 for firms with 50 to 99 workers. (Those with fewer than 50 workers were never included and don't face fines.) But starting next year, employers with 100 or more workers must offer insurance to at least 70 percent of workers -- rather than the 95 percent originally called for under the law -- or face fines.

For those with job-based coverage, the health law is also expected to accelerate existing trends, including rising deductibles and copayments for employees. Employers are making those moves to slow rising premium costs and to shift more expenses to workers. Analysts also expect to see an increase in workplace wellness programs, which often give workers incentives to participate. The health law allows employers to offer larger incentives, or up to 30 percent of the cost of coverage. That means workers who choose not to participate or, in some cases, to meet certain health goals, will pay more toward their coverage.

7) What impact will the rollout have on congressional elections?
Look for lots of advertising in vulnerable Democratic districts heading into the fall. If Republicans win control of the Senate (the GOP is expected to keep control of the House, if not increase its majority) that could mean health law defunding bills passed by the House will get a Senate floor vote. While Obama would surely veto them -- and neither chamber is expected to have a veto-proof majority -- the bills would keep anti-health law legislation front and center as both parties battle for the White House in 2016.

Kaiser Health News is an editorially independent program of the Henry J. Kaiser Family Foundation, a nonprofit, nonpartisan health policy research and communication organization not affiliated with Kaiser Permanente. http://www.kaiserhealthnews.com

SGR continued from page 1...

The failure to reform SGR should be a source of concern for physicians. Polls may show that the public still holds physicians in esteem, but Congress

does not. It keeps us hostage, and is unlikely for the foreseeable future to loosen its grip upon our purse.

What to do? For the moment we must, in a suppliant manner, go back to Congress and ask again for an end to the SGR. But probably by the completion of the next 17 SGR patches, physicians will, one by one or two by two, have left Medicare. By then, under SGR, physician wages will be unseemly low and further burdened by too many mandates. Physicians will find it best to chance the marketplace rather than remain abused under the rule of SGR and the politics of cynicism that fashions it.

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quality of care for patients," Dr. Hoven said.

Also included in the bill are a variety of other revisions and "extenders," including:

- The secretary of the U.S. Department of Health and Human Services will be permitted to continue the suspension of post-payment audits by Medicare retrospective audit contractors through June 2015.

Dr. Ardis Hoven: The AMA encourages Congress to continue its work and resolve outstanding issues.

- The Medicare sequester cuts will be revised in 2024 to increase their impact, saving the federal government an estimated $4.9 billion at physicians' expense.

- Implementation of the ICD-10 code set would be delayed 12 months until Oct. 1, 2015.

Transitioning to the new code set will be extremely costly for physicians, and the AMA continues to work to stop its implementation altogether.

Despite some positive provisions included in the bill, physician groups have pointed to the greater overall loss as Congress defaulted to a temporary patch even when an unprecedented bipartisan legislative policy for repealing the SGR formula was at last on the table.

"Remarkable progress was made this past year in reaching a bipartisan, bicameral agreement on policy to repeal the SGR, and the AMA encourages Congress to continue its work and resolve outstanding issues," Dr. Hoven said. "On behalf of Medicare patients and physicians across the country, it is critical that we achieve permanent Medicare physician payment reform."

The AMA will continue to press Congress to pass permanent SGR repeal this year.

Licensing

Name/Profession	License Number/ Effective Date/Action	Basis For Action
MEDICINE Mark Greenbain, M.D. Farmington, MI	43-01-030022 3/10/2014 Summary Suspension	Criminal Conviction
MEDICINE Mark Greenbain, M.D. Farmington, MI	43-01-030022 3/10/2014 Summary Suspension	Criminal Conviction
NURSING David Scott Abernathy R.N. Davison, MI	47-04-236289 3/4/2014 Suspended Summary Suspension Dissolved	Probation Violation Criminal Conviction - Alcohol Related Mental/Physical Inability to Practice Substance Abuse Violation of General Duty/Impairment
NURSING Edythe Alva Jabbori L.P.N. f/k/a Edythe Alva Hicks Farmington Hills, MI	47-03-089738 4/5/2014 Reprimanded	Probation Violation
NURSING April Maurine Jones R.N. Keego Harbor, MI	47-04-284458 3/10/2014 Summary Suspension Dissolved	
NURSING Joseph Lee Kent R.N. Lincoln Park, MI	47-04-199417 4/10/2014 Probation	Violation of General Duty/Negligence
NURSING Cynthia Perkola R.N. Sterling Heights, MI	47-04-182064 3/6/2014 Probation Fine Imposed	Violation of General Duty/Negligence
NURSING Susan Elizabeth Redding R.N. Howell, MI	47-04-261228 3/17/2014 Summary Suspension	Violation of General Duty/Impairment Drug Diversion
NURSING Megan Marie Schneider R.N. Ann Arbor, MI	47-04-290824 4/5/2014 Fine Imposed Reprimanded	Sister State Disciplinary Action Failure to Report/Comply
NURSING Jacqueline V Smith L.P.N. Romulus, MI	47-03-103750 3/6/2014 Probation Fine Imposed	Probation Violation
NURSING Mercedes P Teodoro R.N. Woodhaven, MI	47-04-089859 3/6/2014 Voluntarily Surrendered	Unprofessional Conduct Violation of General Duty/Negligence Lack of Good Moral Character Unethical Business Practice
NURSING Jeffrey Michael Wilson R.N. Whitmore Lake, MI	47-04-286797 3/10/2014 Summary Suspension Dissolved	

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