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INSIDE THIS ISSUE

Academy Moves into Promising Future

Elayne R. Biddlestone, Executive Vice President/Chief Executive Officer

Excerpt from the Executive

As the AMC/NOMA staff prepares to move into another office space on October 1st (see sidebar) I find myself reflecting on the past. As I sifted through the archives, files and pictures of the organization, I could not help but notice the pictorial documentary of the previous homes of the Academy. Although organized medicine in Northern Ohio officially began in 1824, the documented location of an actual "home" for the Academy occurred in 1898.

Our First Official Home

In 1898, the Medical Library Association purchased a building at 2318 Prospect Avenue which was formally opened in October 1898. In 1902, the Academy of Medicine of Cleveland began to hold general meetings at the library site. In 1906, a two-story addition was completed including an auditorium that enabled the Academy to hold all of its meetings at the library location. In addition, the library itself contained over 30,000 volumes, meeting rooms and a museum. In 1920, the Academy opened its offices on the second floor.

(Continued on page 3)

This fall, the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) will move from its present offices in the Realty One Building to another I-77 and Rockside location. Our new headquarters at Park Center I is just minutes away at 6100 Oak Tree Blvd., Ste. 440, and offers the AMC/NOMA ample meeting space in three different locations along with on-site catering service. The new location will continue to allow the AMC/NOMA to provide a central meeting point for physicians in our region.

This move was necessary due to the purchase of the Realty One building by the Ohio College of Podiatric Medicine. The AMC/NOMA had a valid lease with Realty One and we were able to negotiate with them to assure that the costs of our move were completely covered and did not impact the budget of the organization.

The AMC/NOMA strategic plan contained a directive for change — change to a new name and logo that clearly incorporates our regional focus. Therefore, the AMC/NOMA plans to utilize our relocation as an opportunity to launch this initiative. Watch for our new look in the next issue of the *Cleveland Physician.*

Preparedness is Key in Pandemic Influenza Planning

On August 29th, the AMC/NOMA co-sponsored a conference entitled "Preparing for Pandemic Flu" with the Case Center for Science, Health and Society, The Cleveland Department of Public Health, the Cuyahoga County Board of Health, The Center for Health Affairs and the Cleveland Museum of Natural History. The session brought together physicians, business leaders, health department professionals, emergency services personnel and others who learned of and shared local strategizing in the event of widespread outbreak. Among the presenters were **Stephen Gordon, MD; Robert Salata, MD; Nathan Berger, MD** and **George Kikano, MD.**

The all-day event held at the Cleveland Museum of Natural History illustrated that preparations for pandemic flu are unique in that it has the potential to last for a long period of time and could cause widespread illness, overwhelm our health

(Continued on page 4)

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Academy moves
(Continued from page 1)

The Academy On the Move

Expanded growth in the Cleveland area along with an increase in the number of volumes and journals attained by the Medical Library created the need for more space. Originally, the plan was to expand at the current site, however, that plan was altered when Western Reserve University offered the Medical Library a site at the corner of Euclid Avenue and Adelbert Road. In the 1920s, Mrs. F.F. Prentiss, a descendant of David Long, M.D., Cleveland's first physician (and an AMC/NOMA nominated inductee in the Medical Hall of Fame) offered a large contribution to the Medical Library Association in memory of her late husband Dudley P. Allen, M.D. She had one stipulation — the new library had to be built at the Euclid Avenue/Adelbert Road site. The decision was made to construct the Allen Memorial Medical Library.

On November 16, 1926, six days after the dedication of The Allen Memorial Medical Library of the Cleveland Medical Library Association, the Academy formally opened its new headquarters at the library, where it would remain for 34 years.

In October 1959, an offer from the T.W. Grogan Company included a proposal to relocate the Academy offices to 10525 Carnegie Avenue and remodel the space at no charge to the Academy. An auditorium with ample seating and free parking were major assets. Therefore, on November 13, 1960 the new quarters were dedicated and the Academy settled into our new home, where it remained for 19 years.

The winds of change blew through again in the late 1970s when it was determined that the Academy needed to move again. The Ohio College of Podiatric Medicine had purchased the building for its own use, and therefore the Academy board determined that a move was once again necessary.

In April, 1979, the Academy moved a few blocks southeast to the sixth floor of 200 University Circle Research Center (now the Coroner's offices.)

After 14 years at the research center location, the Academy leadership began to evaluate the need for the Academy to consider a location that was more regional in focus. A properties committee was formed and after careful review and membership surveys it was determined that if the Academy wanted to expand our membership base and become a force in the region it would be necessary to relocate our offices to a more central location. Based on review of the region and our potential membership base, it was clear that the I-77 and Rockside area served this purpose — one that would provide the easiest access for physicians from all portions of Northern Ohio. The decision was made to move our headquarters and in December 1993 the Academy once again packed up and moved to "the center of the county."

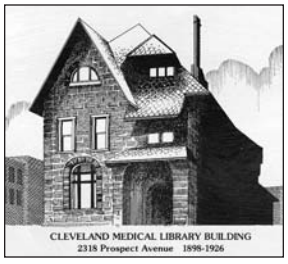
The move proved to be prophetic for the Academy. Since relocating to this area, the Academy board and physician leadership have been instrumental in revitalizing the organization and revamping our focus. It became clear that the Academy needed to become THE organization representing physicians in Northern Ohio. In 1999, we added the Northern Ohio Medical Association name and became the AMC/NOMA, changing our focus to a regional organization (watch for our new name and logo in the next issue of the magazine.) Our bylaws allow the AMC/NOMA to accept physician members, associate members, group members, medical advocacy members, resident members, medical student members and other categories from the contiguous counties in Northern Ohio. Since moving to this area our membership has more than tripled and the AMC/NOMA is now an independent regional organization representing 4,000 physicians in this region and at the Ohio Statehouse.

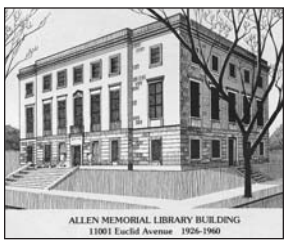
The More Things Change the More They Stay the Same

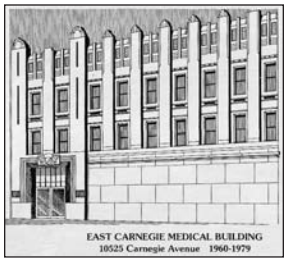
Ironically, the move by the Academy to our newest location in the Park Center I Building on Oak Tree Boulevard is precipitated by the purchase of our current building by the Ohio College of Podiatric Medicine. However, the new building offers ample meeting space and free parking and will adequately serve the needs of the Academy and its membership. Indeed, the new location incorporates three buildings on one campus and the Academy may use meeting rooms in all three of the buildings with on-site catering capabilities.

I believe that the Academy leadership made a great decision in 1993 when they moved our headquarters to this area, and based upon the expansion and growth in this region, I also believe that other businesses and professions will begin to move here due to its central location.

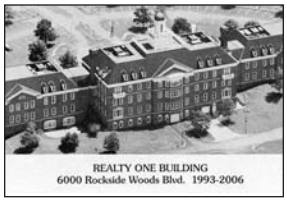
The roots of the Academy of Medicine of Cleveland run deep. Since the inception of organized medicine in Northern Ohio in 1824, change has been constant — mergers, name changes, new logos and new locations. But the overall mission and purpose of the organization has remained the same — to support physicians in being strong advocates for all patients and to promote the practice of the highest quality of medicine. A building is nothing but a structure, but I am confident that our new quarters for the organization, like the past ones, will serve as a meeting place for our members as they face the future of medicine. The profession of medicine, which this organization serves, can count on the Academy to represent your interests and the great profession of medicine for years to come. ■


CLEVELAND MEDICAL LIBRARY BUILDING
2318 Prospect Avenue 1898-1926


ALLEN MEMORIAL LIBRARY BUILDING
11001 Euclid Avenue 1926-1960


EAST CARNEGIE MEDICAL BUILDING
10525 Carnegie Avenue 1960-1979


UNIVERSITY CIRCLE RESEARCH CENTER
11001 Cedar Avenue 1979


REALTY ONE BUILDING
6000 Rockside Woods Blvd. 1993-2006

Pandemic Flu

(Continued from page 1)

care system, create high levels of absenteeism across the workforce, and even result in shortages of essential goods. In addition, vaccines may not be readily available and antiviral drugs may not be effective. An important point raised during the discussion on hospital preparedness plans stressed there should be more time spent in efforts for vaccine development and preparing a vaccination plan — including prioritizing who gets the vaccine. It was agreed that this is not a single institutional problem but that all area health care systems should work together on this issue.

Health professionals are concerned that the continued spread of a highly pathogenic avian H5N1 virus across eastern Asia and other countries represents a significant threat to human health. The H5N1 virus has raised concerns about a potential human pandemic because: it is especially virulent; it is being spread by migratory birds; it can be transmitted from birds to mammals and in some limited circumstances to humans, and like other influenza viruses, it continues to evolve. Although pandemic flu may not be inevitable, preparedness is warranted.

An overview of Cuyahoga County's pandemic flu plan illustrated key preparedness points: taking outbreak prevention measures; creating a credible response plan; integrating non-health partners such as city services and law enforcement; streamlining communications to the public; and handling patients presenting to area hospitals. Steps yet to be completed in the plan include a personal preparedness campaign, volunteer recruitment (see related article page 15) and surge-capacity issues.

Dr. George Kikano, past president of the AMC/NOMA, offered insight into the important role physicians, especially primary care, will play as part of the regional response in the event of a pandemic. He provided data that illustrated most patients would in fact seek care from their physician first — putting doctors on the front line; therefore, physician offices must be prepared as well as hospitals. He suggested utilizing practice-based research networks to collect surveillance data and determine if there is an impending problem. He also stressed the important role organized medicine and the AMC/NOMA should play in educating and communicating to physicians and the public regarding the need to prepare for not only the possibility of pandemic flu, but also other disasters that might occur in our region.

***Dr. George Kikano** with President **Paul Janicki, MD,** following his presentation during the Pandemic Flu conference last month at the Natural History Museum.*

Because the AMC/NOMA strategic plan calls for our organization to continue work on this and other public health projects in the community, we intend to remain integrally involved in the process. For more on local and national pandemic planning, visit www. pandemicflu.gov, www.ccbh.net, and www.clevelandhealth.org. ■

CLEVELAND PHYSICIAN

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Highlights of the AMA 2006 Annual Meeting

Delegates Pass Several Important Resolutions During Summer Conference

- The AMA resolved that comprehensive health system reform, which achieves access to quality health care for all Americans while improving the physician practice environment, be of the highest priority. Such comprehensive reform includes medical liability, Medicare and Medicaid, insurance coverage, health care disparities, prevention, quality and safety issues.
- The AMA adopted policy that any individual, company or other entity that establishes or operates store-based health clinics should adhere to a series of principles, including ensuring that the clinic has a well-defined and limited scope of services, and that health care practitioners staffing the clinics have direct access to and supervision from physicians.[1]
- The AMA resolved to advocate for and support initiatives that minimize physicians' financial burden of adopting and maintaining electronic medical records. The AMA will also continue efforts to define and promote standards that will facilitate the interoperability of health information technology systems. The AMA also approved policy that public and private insurers should not require the use of electronic medical records.[2]
- The AMA voted to continue closely monitoring any new "transparency" programs unveiled by health plans to determine the impact on physicians. The AMA also will communicate concerns about current transparency programs to health plans, employers and patients, and continue to educate physicians about the complexities of claims adjudication and payment processes.[3]
- The AMA voted to support the development and adoption of a consistent format for estimating and publicly reporting health care administrative costs, in order to facilitate unbiased comparisons across insurers and from different sources. The AMA also voted to support efforts to educate the medical profession and the public about health care costs, including administrative costs and the costs of defensive medicine.
- The AMA voted to support a requirement that individuals and families earning greater than 500 percent of the federal poverty level obtain, at a minimum, coverage for catastrophic health care and evidence-based preventative health care, using the tax structure to achieve compliance. Upon implementation of a system of refundable tax credits or other subsidies to obtain health care coverage, this requirement would apply to individuals and families earning less than 500 percent of the federal poverty level.
- The AMA approved various recommendations on influenza vaccine distribution, such as to ensure adequate vaccine distribution among high-priority populations. It was also resolved to advocate for the sale of every manufacturer's vaccine supply directly to health care providers. The AMA will urge vaccine makers and distributors to provide an ordering system that gives priority to small and medium-sized practices.

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[1] The AMC/NOMA Board of Directors has reviewed this issue extensively, including several drafted letters raising concerns over continuity of care, physician supervision, duplication of services, and more to the respective corporate leadership and local print media. At the September meeting of the Board, policy on this subject is expected to be set, a fuller reporting of such will be featured in the November/December issue.

[2] The AMC/NOMA Board of Directors will evaluate a new AMC/NOMA policy regarding electronic health records at their September 2006 meeting. Details to follow in the November/December issue.

[3] Over the past few months, AMC/ NOMA physician leadership has met with the medical directors from United Health Care and Anthem Blue Cross/Blue Shield — two insurance companies that have rolled out practice measurement and pay-for-performance programs. An article by Dr. Epstein from UHC appeared in the last issue of the magazine, and an article by Dr. Weisman from Anthem appears in this issue. The AMC/NOMA board would like to hear from our members if they are experiencing problems with these programs. ■

By Michael Wise, J.D. /AMC/NOMA Lobbyist

The summer months are typically very quiet in the government capitals as the legislators are home either vacationing or campaigning. However, AMC/NOMA continues its work on SB 88, our effort to expand the use of Alternative Dispute Resolution (ADR) through the use of mandatory arbitration. AMC/NOMA has also significantly increased its focus on judicial races.

Update on SB 88

With regard to SB 88, on Wednesday, July 19th the AMC/NOMA staff and myself met with Senator Kevin Coughlin*, the Chair of the House Judiciary Committee Representative John Williamowski, staff from the legislative service commission (LSC), and staff from Speaker Husted's office to discuss the House process for SB 88. SB 88 has been assigned to the House Judiciary Committee. Chairman Williamowski has agreed to work with us on an Amendment to SB 88. This Amendment may be considered at the time of Senator Coughlin's sponsor testimony. This will likely take place shortly after the November elections. It is yet to be determined which House representative will sponsor the Bill in the House but this process is also moving forward.

Our Amendment will address the Statute of Limitations issue that I discussed in our last issue. As you may know, Ohio provides for a one year Statute of Limitations for Medical Malpractice claims. Both the plaintiff's bar and the defense bar have strong opinions about SB 88 and its effect on this one year Statute of Limitations. SB 88 provides for mandatory arbitration BEFORE the filing of a lawsuit.

The plaintiff's bar wants to ensure that a plaintiff does not lose the constitutionally protected right to file a lawsuit in court in the event that the arbitration concludes after the expiration of the statute of limitations. The solution proposed by plaintiff's attorneys is to toll the Statute of Limitations once a plaintiff files a Notice of Intent to sue. The Notice triggers the mandatory arbitration process. So, if a plaintiff files a Notice six months after the injury, and the arbitration takes eight months, the plaintiff would still have six more months to file his lawsuit. This could result in a suit taking place twenty months after the injury instead of the current twelve months.

The defense bar and insurers vigorously oppose any type of Tolling provision. Once a Notice is filed, costs begin to be incurred (loss costs), and an eight-month extension of the Statute, as discussed above, is not acceptable. Loss costs are a critical issue for the defense. AMC/NOMA needed to find a solution that balanced the plaintiff's right to a jury trial and the necessity to control loss costs.

A solution did materialize through the input of Representative Williamowski at the July 19 meeting. It was proposed that in lieu of a tolling provision, SB 88 should contain a modification of the Statute of Limitations to provide a limited time period for a plaintiff to file a suit if the arbitration decision is rejected. In addition, SB 88 will contain tight deadlines to ensure that only in extenuating circumstances would a rejected arbitration process result in any actual extension of the Statute of Limitations. Further, with the conclusion of the mandatory arbitration, the case may of course be resolved, or at least liability determined. Finally, at a minimum, a good deal of discovery will have taken place and both sides will be in a much better position to evaluate and possibly settle their dispute. This is an excellent compromise, obtained at the July 19 meeting that balances the right of a plaintiff to reach a jury while promoting a fair, efficient, and economical legal process. The actual Amendment language was subsequently discussed with LSC and will be available at the next meeting of the House Judiciary Committee meeting.

Ohio Supreme Court

Coincidentally, the Ohio Supreme Court recently issued an Opinion on the use of visiting judges to resolve cases at the Common Pleas level. This case impacted medical malpractice cases because both sides in a malpractice case often decided to use a visiting judge because their case would be heard faster and by a judge with solid experience in medical malpractice. Now, with the Ohio Supreme Court ruling, that option will no longer be available. One positive item from the Supreme Court was that it opined positively on the use of ADR; "Ohio's leadership in recognizing the benefits of Alternative Dispute Resolution has been evident throughout the state <cite omitted>. As court dockets grow more crowded and litigation costs more expensive, methods of Alternative Dispute Resolution should be encouraged <cite omitted>. Ultimately, for these public policy questions, the Ohio General Assembly, and not this court, is the proper body to resolve public policy issues <cite omitted>." This language will be helpful should SB 88 become law and then be subsequently challenged in the courts.

Common Pleas Races

AMC/NOMA is increasingly active in the judicial area. On May 25, 2006 AMC/NOMA met with Judge Richard McMonagle, who is also the former Administrative Judge for the Cuyahoga County Court of Common Pleas. We discussed with Judge McMonagle how AMC/NOMA might become more constructively involved in the Common Pleas judicial races. The

(Continued on page 7)

Vote & Vaccinate

Nov. 7, 2006

On Election Day, The Academy of Medicine Cleveland/Northern Ohio Medical Association, in partnership with The Cuyahoga County Board of Health, Cleveland Department of Health and Parma Hospital with conduct our 7th Annual Vote & Vaccinate program in neighborhoods where pneumonia and influenza vaccination rates for seniors are reportedly low.

Participating area polling sites:

Pilgrim Congregational United Church of Christ
Open Door Baptist Church
Normandy High School
Helen Brown Senior Center
Royal Redeemer Lutheran Church
Parma Heights Baptist Church
Ridgewood United Methodist Church

The Vote & Vaccinate program is a parallel event to voting and is not connected to the Board of Elections. The goal is to offer senior citizens an opportunity to get vaccinated when they go out to vote on Election Day.

Judge was informative and also encouraging of our efforts. As an outcome of this and subsequent meetings within AMC/NOMA, we may be providing, for the first time, a review of the Common Pleas races in our annual voter's guide. For future reference, the contested Cuyahoga County Common Pleas races are:

Ron Suster vs. Roger Kramer,
John P. O'Donnell vs. John F. Corrigan,
Marilyn Cassidy vs. John D. Sutula,
Shirley Strickland Saffold vs. Michael Blumenthal,
Peggy Foley Jones vs. Christina Russo,
Dick Ambrose vs. Laura Gallagher,
Jeff Hastings vs. Hollie Gallagher, and
Kathleen Sutula vs. Suzanne Blum.

At the Supreme Court level, **Dr. John Bastulli** hosted a fundraiser at his home on June 29, for Supreme Court Justice Terrence O'Donnell and Court of Appeals Judge Robert Cupp who is running for the vacant Supreme Court seat. This event was quite successful and both Judges Cupp and O'Donnell* appear well positioned in their respective races.

Election 2006

Speaking of political races, 2006 continues to appear to be an historic election. More turnover could occur at the statewide level than any year since 1982. This turnover will certainly be individual turnover because there are no statewide incumbents running to retain their current seats except for Judge O'Donnell. The turnover could also be partisan because almost all the Republican candidates have polled behind their Democratic

(l to r) Justice Terrence O'Donnell, ***Raymond Scheetz, MD*** *and Judge Robert Cupp during a recent event at the home of* ***John Bastulli, MD,*** *VP of Legislative Affairs for the AMC/NOMA.*

opponents at one time or another this summer. The only exceptions are Betty Montgomery who appears to be a lock on election to her old office of Attorney General and Judges O'Donnell and Cupp.

In the Legislative races, The Ohio House and Senate look to stay in Republican control but at slimmer majorities. Senator DeWine has polled both ahead and behind against Congressman Brown. The U.S. Congress should stay Republican but again, at slimmer majorities.

Finally, AMC/NOMA also has a comprehensive tracking system of all health care related legislation in the General Assembly. If you are interested in receiving a copy of this document, please contact Elayne Biddlestone at (216) 520-1000.

*The Northern Ohio Medical Political Action Committee (NOMPAC) has endorsed Senator Coughlin for his long-standing commitment to organized medicine and his work on SB 88, and NOMPAC believes in the judicial philosophy of interpreting, not making the law and therefore also endorses Judges Cupp and O'Donnell. Watch your mail soon for our members-only comprehensive Voter's Guide 2006. ■

AMC/NOMA 2006 Voter's Guide

The Academy of Medicine Cleveland/Northern Ohio Medical Association Legislative Committee, in concert with our lobbyists, is currently updating a voting guide for the upcoming election on Tuesday, Nov. 7, 2006. As always, a summary of issues and candidates will be provided and will be made available exclusively to our physician membership.

In this critical 2006 General Election, one-third of the United States Senate and the entire House of Representatives of the 110th Congress will be chosen; in addition, 36 States, including pivotal Ohio, will elect their Governors.

Look for the AMC/NOMA 2006 Voter's Guide in your mail soon!

For information on any legislative issues the AMC/NOMA takes positions on, contact Elayne Biddlestone at (216) 520-1000.

A Smoke Screen at the Ballot Box

Voters may find themselves confused by opposing options on the issue of smoking throughout the state when they approach the ballot box in November.

One group wants voters to approve a constitutional amendment that could undo local smoking bans and create a statewide smoking policy. Another advocates on the proven dangers of secondhand smoke and calls for an all out smoking ban in Ohio's workplaces. Voters will choose between an outright smoking ban or leaving it up to restaurants and bars to decide whether to permit it under a pair of issues submitted for the Nov. 7 ballot. Smoke Less Ohio, sponsors of an issue that would allow smoking in bars, bowling alleys, enclosed areas of restaurants and some other areas, filed a petition last month that would pit that issue against SmokeFreeOhio's proposed ban on smoking in all public buildings. A group called SmokeFreeOhio, backed by the American Cancer Society and other health groups including the AMC/ NOMA, filed a petition July 28 to ban smoking in public buildings. Twenty-one Ohio communities have total public smoking bans. Smoke Less Ohio is proposing a constitutional amendment, which state law says would supersede the state law change that SmokeFreeOhio seeks. A court battle is likely either way.

Editor's Note: The AMC/NOMA partnered with SmokeFreeOhio last fall when the group held a press conference on their signature gathering to date that allowed them to place the issue before voters. Bolstered significantly by the recent Surgeon General's report on secondhand smoke dangers, the initiative also has the full support of the physician members of the AMC/NOMA. Tune in to the special Healthlines *program on this subject when Dr. Derek Raghavan of the Cleveland Clinic discusses the issue the week of Oct. 30 at 5:45 p.m. on WCLV 104.9.* ■

Anthem Blue Cross and Blue Shield Value Network: How Will It Affect Your Practice?

By Thomas Weisman, MD, Anthem Blue Cross and Blue Shield Medical Director for Northern and Central Ohio

Anthem Blue Cross and Blue Shield's Value Network is a response to demands from some of our largest customers, GM, Ford, Daimler-Chrysler, Kroger and others. They are looking for ways to reduce the growth in the amount they spend for health care across the nation, and have asked us to identify the most efficient providers of care. Although our ultimate goal is to develop objective measures of medical care quality, that goal is not reachable in the time frame necessary to meet our customers' needs. There is no request for quality data or differentiation during this first phase. This article will tell you:

- How this network was chosen
- How it will impact your patients
- How it will impact your practice
- What you can do to improve your and your group's ranking
- Implications for the future

Anthem Blue Cross and Blue Shield needed to have something in place company-wide by January, 2007. Efficiency measures are more developed, and that is the direction we and our customers have chosen. These large customers are self-insured. They directly pay for the covered health care costs incurred by their employees. The health plan's role is to administer the benefits and adjudicate the claims. In the future, however, this economic efficiency data will become part of the larger quality/efficiency/value efforts that are the shared goals of providers, payers and our customers.

The focus of this effort was on 12 specialties only:

- Cardiology
- Dermatology
- General Surgery
- OB/GYN
- Ophthalmology
- Orthopedics
- Pulmonary
- Neurology
- Gastroenterology
- Oncology
- Otolaryngology
- Urology

These specialties control approximately 50% of total health care spending. **Primary care is not involved,** nor are any other specialties at this time.

How this network was chosen

Using DxCG Episode Treatment Grouper software, all costs related to an episode of care are rolled up into a single total. The components include: Professional, Institutional Inpatient, Institutional Outpatient, and Pharmacy. An episode starts with an ER visit or hospitalization, with a look-back period to capture such costs as preoperative workup, and a clean period at the end of the episode, where no further costs are incurred related to that particular event or diagnosis. Episodes are risk adjusted and only like episodes are compared.

> *"In the future economic efficiency data will become part of the larger quality/efficiency/value efforts that are the shared goals of providers, payers and our customers."*

For each type of episode and risk category, an "expected episode cost" is calculated based on local network averages. Cleveland episodes are compared only to Cleveland averages, not regional or statewide averages. For each episode a responsible provider is identified. This is the physician with the largest number of RVU's. Then the physician's specialty is verified. Only episodes with physicians practicing within their specialty are included. A cost efficiency ratio is calculated based on the severity and case-mix adjusted "expected" cost per episode.

Physicians are selected at the group level, with a minimum of 30 episodes to qualify. Groups with fewer than 30 qualifying admissions are automatically placed in the efficient group. This yields a listing of groups with efficiency ratios typically ranging from 1.8 to .6 (80% higher to 40% lower than the Cleveland average). Depending on the particular specialty, geography, and the number of providers in each range, the cutoff between the designated efficient and nonefficient groups is usually between 1.1 and 1.2.

How it will impact your patients

At this time, only Kroger employees will be participating in this program starting January 1, 2007. Although Kroger has more than 50,000 employees scattered thru each of the fifty states, there are practically none in Cleveland. These employees will have a provider guide that identifies the designated efficient provider groups. If they choose to go to an efficient provider, they will have a lower co-pay and/or deductible than if they choose to go to a network provider not so designated. The patient will still be able to choose any provider, but there will be economic consequences to choosing a nondesignated specialist physician.

How it will impact your practice

It won't directly at this time. This does not in any way change your contract with Anthem Blue Cross and Blue Shield. Both designated and nondesignated physicians will stay on their current fee schedule. The difference would only be in the patient's responsibility for the contracted fee. If an employer such as GM, Ford or Daimler-Chrysler were to adopt such a program in the future, it clearly would have a potentially much larger impact if volume were to shift to providers designated as more efficient.

What you can do to improve your and your group's ranking

The largest single contributor to total episode cost is the facility component. Where you choose to do a procedure can determine whether you are designated an efficient provider or not. Some hospitals have higher cost and reimbursement structures than others. Similarly, there can be as much as a 200% difference between the facility cost of a hospital outpatient surgical department and a free-standing outpatient surgery center. For those specialties where outpatient imaging is a significant practice component, there is a similar range in costs between hospital imaging centers and freestanding ones.

Where you do your surgery and send your high-tech imaging largely determines where your group ranks on the efficiency spectrum. Clearly, some physi-

(Continued on page 9)

cians have more choice than others in this regard.

Implications for the future

Efforts to engage employees by incenting them to consider their own health costs are part of a movement towards transparency. As meaningful and accurate quality information becomes available it will, along with accurate and understandable cost information, enable people to make more rational decisions regarding their care. Some people put price or cost above all other factors; however, many choose to pay higher prices for higher perceived quality. But even those willing to pay more will need to be convinced that their expenditures are truly purchasing better quality, a more satisfying patient experience and better outcomes.

Editor's Note: Dr. Weisman recently presented the information herein to the AMC/NOMA Executive Committee, which consistently reviews programs such as this from insurers as they begin to roll out and impact physicians in our region. For more on an insurance issue or any questions you may have, contact the AMC/NOMA at (216) 520-1000. ■

Managing Medicare Expectations

The Academy of Medicine Cleveland/Northern Ohio Medical Association was proud to co-sponsor a recent summer seminar entitled *"Managing Medicare Expectations"* which aimed to clarify the myriad billing and coding issues experienced within the Medicare program. Sessions that were part of the two-day event schedule included evaluation & management service issues and the strict definitions of "medical necessity" to CERT reviews and electronic funds transfer options. Held at University Hospital's Wolstein Auditorium, the seminar was both well-attended and well-received by participants who included physicians, non-physician practitioners, compliance officers, as well as billing/coding staff from hospitals and independent practices. Topics were presented in large part by PalmettoGBA Provider Education staff and continuing education credits were available. Several of the "Hot Topic" sessions were highly interactive with a host of questions from the audience on the latest Medicare changes, documentation review and especially the various levels and types of E/M services. The new national provider identifier, or NPI, was a major focus as well as new rules governing claims submissions coming from CMS.

SPECIAL NOTE: See the registration insert in this issue for details on the AMC/NOMA's upcoming annual seminar for practice managers and office staff, **"Solving the Third Party Payor Puzzle."** Presenters from Anthem, PalmettoGBA, Medical Mutual, United HealthCare and ODJFS will inform and clarify participants on all the latest billing/coding issues related to the physician practice. Join us this Nov. 15 — AMC/NOMA members and their staff can register at a significant discount price! Call Kristine Snider at (216) 520-1000 ext. 314.

To Compete or Not to Compete . . .

By Michael Jordan

All too often, physicians agree to covenants not to compete in employment agreements without carefully evaluating the ramifications of the covenant. In the eagerness to begin employment, issues that might arise in the future often fall by the wayside. Later, as relationships change and new opportunities arise, the physician will ask, "hey, is this thing enforceable?"

The answer, in classic legalese, is: *maybe.* Ohio courts have upheld and enforced covenants not to compete when such covenants are reasonable on their face and do not constitute a restraint on trade. The Ohio Supreme Court has examined the issue of the reasonableness of such covenants and established the following test:

> A covenant restraining an employee from competing with his former employer upon termination of employment is reasonable if (1) it is no greater than is required for the protection of the employer, (2) does not impose undue hardship on the employee, and (3) is not injurious to the public.[1]

Attorneys often refer to a rule of thumb that a covenant is more likely to be enforced if it is no greater than five miles in scope and one year in duration. Further, under Ohio law, a court is empowered to "blueline" a covenant to make it enforceable if a court believes that, as written, it is overbroad. A court could determine that a 20-mile prohibition is overbroad and reduce the geographic scope, but find that the covenant is otherwise enforceable.

What might make a covenant enforceable or unenforceable varies with the facts of each particular case. Courts often consider, for example, the effect upon the public if a physician is prohibited from practicing within a certain geographic area. The court will therefore be interested in the particular physician's specialty and how available those services are in the geographic market in dispute. Further, what is the targeted patient base? Nursing home residents have "patient choice" statutes that conflict with the ability of an employer to attempt to stop physicians from treating such patients. The American Medical Association has opined that covenants not to compete may be "unethical."

> Covenants-not-to-compete restrict competition, disrupt continuity of care, and potentially deprive the public of medical services. The Council on Ethical and Judicial Affairs discourages any agreement which restricts the right of a physician to practice medicine for a specified period of time or in a specified area upon termination of an employment, partnership, or corporate agreement. Restrictive covenants are unethical if they are excessive in geographic scope or duration in the circumstances presented, or if they fail to make reasonable accommodation of patients' choice of physician. (VI, VII) Issued prior to April 1977; Updated June 1994 and June 1998.[2]

"The key point is that a covenant not to compete should never be taken lightly and always be viewed as a critical term of an employment agreement."

However, while some courts have found that Opinion persuasive and ruled that such covenants are not enforceable as limiting patient choice, others have found that the AMA opinion does nothing more than advocate that such covenants are to be strictly construed.

Very candidly, the particular judge to whom the case is assigned will have his or her own predilections in terms of whether they are willing to enforce a covenant. Some judges simply do not like covenants not to compete. Others will enforce them if they believe enforcement is warranted by the facts. In making the determination of whether an employer's business interest is protectible, the court will evaluate several factors. These factors include: How much time and effort the employer has invested in establishing patients and other business contacts for the employed physician? Does the employer have an interest it truly can protect, such as an exclusive right to provide services at a hospital or facility? How much training did the physician receive from the employer and how long has the employer provided the business service it seeks to protect? For example, a court might enforce a covenant against a physician who was trained to treat sleep disorders by an employer with an established sleep disorder center if the physician leaves such employment and attempts to compete in violation of a covenant.

Very often, these evidentiary disputes are determined in connection with a motion for temporary restraining order or preliminary injunction, which are typically filed by an employer who wishes to prevent an employed physician from competing. This generally results in a flurry of depositions and a hearing, conducted as a "mini-trial," before the court. These proceedings can become expensive and are likely to lead to the assertion of other claims between the parties and continued litigation.

Practical tips: It is critical to pay attention to the covenant at the time of signing. What is the geographic scope and time duration? If the employer has multiple facilities, is the geographic scope of the covenant limited to the facility where the employed physician operates or does it apply to every facility? Obviously, that will have a dramatic impact upon the geographic scope of the intended covenant. Should the covenant be applicable to all circumstances involving termination of employment, or can the employer be persuaded that a covenant should not be enforceable if the employee is terminated without cause by the employer? The key point is that a covenant not to compete should never be taken lightly and always be viewed as a critical term of an employment agreement.

Mr. Jordan is a partner at the law firm of Walter & Haverfield, where he practices as a member of the Healthcare and Litigation groups, primarily representing physicians in a variety of business and dispute resolution matters.

[1] *Raimonde v. Van Vlerah, 42 Ohio St.2d 21 (1975).*

[2] *AMA Code of Medical Ethics, Council on Ethical and Judicial Affairs, E-9.02 Restrictive Covenants and the Practice of Medicine.* ■

Resident Recruitment a Success

More than 100 incoming residents and fellows at the Cleveland Clinic were introduced to the benefits of membership in the Academy of Medicine Cleveland/Northern Ohio Medical Association on July 1 as part of their orientation schedule. **James Taylor, MD,** AMC/NOMA President-Elect was on hand to welcome the new staff and espouse the many achievements of the only regional medical association representing physicians in our Northern Ohio area. Several other events of successful resident recruitment occurred at local hospitals this summer including presentations by President **Dr. Paul Janicki** at a Huron/SouthPointe Hospital joint orientation session; **Dr. Raymond Scheetz** at the Cleveland Clinic, **Dr. John Bastulli** addressed newcomers at St. Vincent Charity Hospital and **Dr. George Kikano** spent time with the residents entering the University Hospitals program. In all, more than 440 recruits were signed up as AMC/NOMA resident members this year. ■

*AMC/NOMA President-Elect **Dr. James Taylor** presents to new residents at the Cleveland Clinic, coincidently on the 40th Anniversary of his own residency.*

Residents learn of the many benefits of membership in a dedicated, regional physician organization. During recruitment activities this year, more than 440 young physicians from area hospital programs were signed up as resident members in The Academy of Medicine Cleveland/Northern Ohio Medical Association.

PREPARING FOR THE BUSINESS ASPECTS OF PRACTICING MEDICINE

The AMC/NOMA sponsored free seminar for 3rd and 4th year residents.

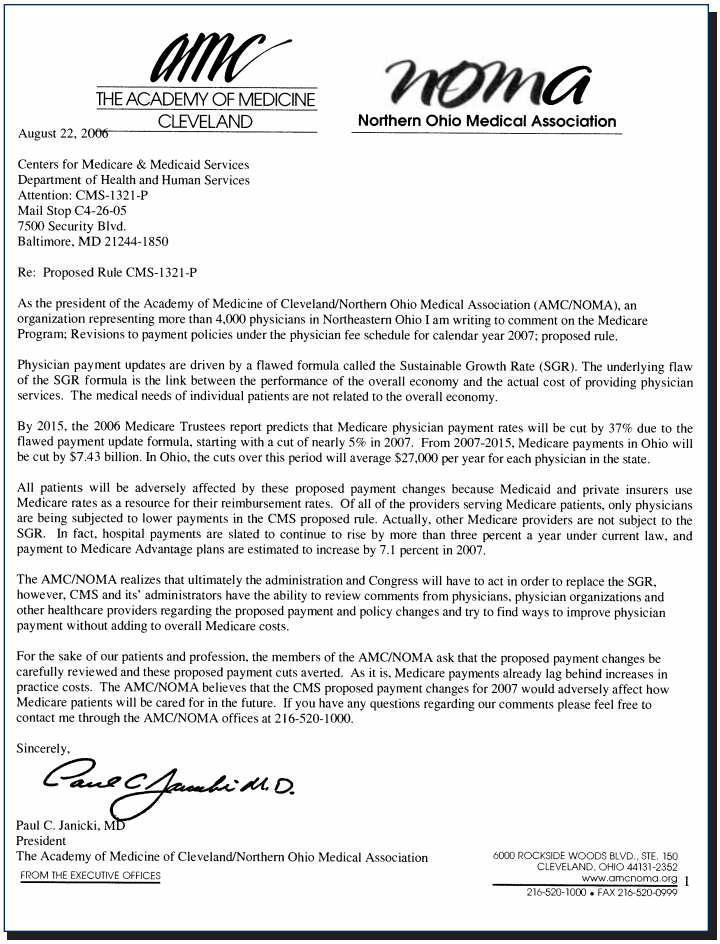
DATE: October 4, 2006
LOCATION: HealthSpace Cleveland
TIME: 5 PM

Speakers from McDonald Hopkins Co., LPA; Squire, Sanders & Dempsey; Hilb Rogal & Hobbs; Sagemark Consulting and Walthall, Drake & Wallace LLP will enlighten residents on topics that include: legal and other issues for new physicians joining a practice, estate planning for young physicians, disability issues-planning for your future, benefits available to physicians, as well as business & tax aspects of a medical practice.

Strength In Numbers

We are faced again this year with the need for Congress to forestall the scheduled cuts to Medicare physician payments — a nearly 5 percent reduction totaling $117 million to Ohio doctors next year alone. As you know, the sustainable growth rate (SGR) formula is inherently flawed because it penalizes physicians when the growth in utilization of medical care is greater than growth in the gross domestic product. The Academy of Medicine Cleveland/Northern Ohio Medical Association has written to leaders in the U.S. Congress including Sen. Bill Frist, MD, Majority Leader and House Speaker Dennis Hastert, urging them to take action and enact legislation this year repealing the cuts slated for Jan. 1, 2007. Members can write a letter from our Web site and ask their members of Congress to prevent physician payment cuts in 2007, secure a positive payment update that accurately reflects practice cost increases (for 2007 MedPAC has recommended rates be increased 2.8%) and replace the unsustainable growth rate formula with a payment system that prevents the need for congressional intervention year after year! To do this, simply go to www.amcnoma.org, click on the prominent **"Stop the 2007 Cuts to Medicare Physician Payments!"** link where you will be directed to an "Action Alert" sample letter one can easily email to representatives — And you can add your voice to the fight, literally, as the American Medical Association is featuring a legislative hotline that will connect you directly with your representatives' voice mail by calling (800) 833-6354.

On behalf of our membership, the AMC/NOMA likewise submitted comments to the Centers for Medicare and Medicaid Services (CMS) on the Federal Register site relative to this issue. Doctors are strongly encouraged to do the same at http://www.regulations.gov/fdmspublic/component/main as comments will be accepted until mid-October. While doctors will see a 5.1 % decrease, hospitals will gain a 3 percent increase in their reimbursement rates for outpatient care, but they will get the full increase only if they submit data to the government indicating they're following guidelines that improve patient care. CMS chief Mark McClellan said the cut in doctors' payments and the call for more quality reporting from hospitals reflect a broken payment system in the United States that can't be sustained. Doctors have 60 days to submit their comments on the proposed rule changes. The AMC/ NOMA's comment submission is reprinted here, but our strength is in numbers! Get proactive on behalf of your practice and your profession. ■



AMC THE ACADEMY OF MEDICINE CLEVELAND

NOMA Northern Ohio Medical Association

August 22, 2006

Centers for Medicare & Medicaid Services
Department of Health and Human Services
Attention: CMS-1321-P
Mail Stop C4-26-05
7500 Security Blvd.
Baltimore, MD 21244-1850

Re: Proposed Rule CMS-1321-P

As the president of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA), an organization representing more than 4,000 physicians in Northeastern Ohio I am writing to comment on the Medicare Program; Revisions to payment policies under the physician fee schedule for calendar year 2007; proposed rule.

Physician payment updates are driven by a flawed formula called the Sustainable Growth Rate (SGR). The underlying flaw of the SGR formula is the link between the performance of the overall economy and the actual cost of providing physician services. The medical needs of individual patients are not related to the overall economy.

By 2015, the 2006 Medicare Trustees report predicts that Medicare physician payment rates will be cut by 37% due to the flawed payment update formula, starting with a cut of nearly 5% in 2007. From 2007-2015, Medicare payments in Ohio will be cut by $7.43 billion. In Ohio, the cuts over this period will average $27,000 per year for each physician in the state.

All patients will be adversely affected by these proposed payment changes because Medicaid and private insurers use Medicare rates as a resource for their reimbursement rates. Of all of the providers serving Medicare patients, only physicians are being subjected to lower payments in the CMS proposed rule. Actually, other Medicare providers are not subject to the SGR. In fact, hospital payments are slated to continue to rise by more than three percent a year under current law, and payment to Medicare Advantage plans are estimated to increase by 7.1 percent in 2007.

The AMC/NOMA realizes that ultimately the administration and Congress will have to act in order to replace the SGR, however, CMS and its' administrators have the ability to review comments from physicians, physician organizations and other healthcare providers regarding the proposed payment and policy changes and try to find ways to improve physician payment without adding to overall Medicare costs.

For the sake of our patients and profession, the members of the AMC/NOMA ask that the proposed payment changes be carefully reviewed and these proposed payment cuts averted. As it is, Medicare payments already lag behind increases in practice costs. The AMC/NOMA believes that the CMS proposed payment changes for 2007 would adversely affect how Medicare patients will be cared for in the future. If you have any questions regarding our comments please feel free to contact me through the AMC/NOMA offices at 216-520-1000.

Sincerely,

Paul C. Janicki M.D.

Paul C. Janicki, MD
President
The Academy of Medicine of Cleveland/Northern Ohio Medical Association

FROM THE EXECUTIVE OFFICES

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CLASSIFIEDS

Ohio Medical Reserve Corps Answers the Call

By David O'Reilly, MBA, State OMRC Co-Coordinator; Paul Bender, Ohio Citizen Corps Public Information Officer

Disasters can strike with little or no advanced warning, as this country has witnessed with the terrorist attacks of September 11, 2001 and Hurricane Katrina. In these large-scale emergencies, first responders and the healthcare system quickly become overwhelmed. As lessons were learned from these tragic events, Ohio Medical Reserve Corps was formed to answer the call for additional healthcare professionals during times of community need.

Ohio Medical Reserve Corps (OMRC) is a group of volunteers focused on licensed healthcare professionals. Members are preidentified and willing to respond to an Ohio disaster, which aids in a quicker and more efficient response. In addition, members have the opportunity to address their community's ongoing public health needs. The OMRC system is designed to track a response of credentialed volunteers for emergency relief and to facilitate state and regional planning efforts for deployment of volunteers.

OMRC is a rapidly growing program with current membership of more than 3000 volunteers. Volunteers are coordinated through local units linked to health departments and emergency management agencies. More than half of the state's counties have active units, encompassing all of the major metropolitan areas, including Cleveland. It is projected by the end of 2007, that all Ohio counties will have an MRC unit.

OMRC is a proud program of Ohio Citizen Corps. Ohio Citizen Corps is a community-based initiative that engages citizens in hometown security through public education and training. Ohio Citizen Corps' mission has two separate objectives:

- Increase knowledge and skills through training and education, producing stronger citizens and safer communities;
- Maintain and coordinate a pool of general volunteers who will supplement first responders in the event of a disaster.

The Ohio Department of Health (ODH), Ohio Citizen Corps, and the Ohio Emergency Management Agency work with state and local agencies to continually develop the OMRC. The OMRC committee facilitates state, regional, and local planning by development of consistent, statewide parameters to assist in the deployment of OMRC volunteers. These parameters include registration, training and credentialing.

Ohio's MRC Co-Coordinators are: Dr. Forrest Smith, State Epidemiologist, ODH, and David O'Reilly, Ohio Citizen Corps, who review, comment and approve all local MRC unit applications.

Liability has been a concern of the OMRC committee and volunteers since the beginning of the program. In 2005, the Ohio General Assembly enacted Senate Bill 9 (SB9). Among the provisions of SB9, the State of Ohio has created the basic infrastructure of a statewide integrated volunteer management system. Features of this evolving management system are liability protection for all registered volunteers, professional and nonprofessional in declared disasters and drills. The statute also exempts a registered volunteer's personal information from public disclosure.

ODH, through Health Resources and Services Administration (HRSA) funds, has provided ongoing support for OMRC development and integration through partnership with the Ohio Citizen Corps. Ohio Citizen Corps will continue collaborative endeavors to maintain and develop local MRC units to reach the goal of the presence of a local MRC in each county; to maintain and develop the relationships and planning activities between local Citizen Corps Councils and MRC units; to continue recruitment activities; to assist in the development of response teams.

Integrating OMRC into disaster planning will provide better coordination when a response is needed. This system proved its effectiveness during the Hurricane Katrina crisis as willing medical staff were quickly mobilized to assist with shelter support. Volunteers have also participated in mass flu vaccination clinics inoculating thousands in a short period of time.

When the next disaster will strike is not known. However, because of the OMRC, Ohio is better prepared to respond. You, too, can make a difference. Joining OMRC can add to your skills through training and it provides an opportunity to give back to your community when help is needed the most.

Editor's Note: The AMC/NOMA has long been committed to a working partnership with the efforts enlisted above. AMC/NOMA staff regularly attend Cuyahoga County Board of Health meetings at which more localized planning strategies and agendas are discussed. For more on how to become involved in this important public health initiative, see sidebar information. ■

HOW TO JOIN:

- Register at the Ohio Medical Reserve Corps Web site: http://www.serveohio.org/CitizenCorps/mrc/mrc.html .
- Complete an OMRC training course; OMRC credentialing will be completed as part of the registration process. The website listed above can provide training information and schedules.
- Verification of professional license will be made by Ohio Citizen Corps.
- Registration information is provided to local MRC units.
- For more information you may contact David O'Reilly [david.oreilly@ocsc.state.oh.us or (614) 995-1849] and Paul Bender [paul.bender@ocsc.state.oh.us or (614) 728-5177]

And Locally…

The Cuyahoga County Board of Health (CCBH) has recently established the Cuyahoga County Medical Reserve Corps (CCMRC). Our program is part of a larger, national and statewide movement to organize and train medical and nonmedical volunteers to assist during public health emergencies.

A regional volunteer recruitment campaign will take place in August 2006 across six counties, including Lorain, Cuyahoga, Medina, Lake, Geauga, and Ashtabula counties. It is anticipated that as the CCMRC builds its capacity, volunteers will have opportunities to assist public health in many ways, including:

- **Staffing the PODS** (Points of Dispensing) if a situation requires mass dispensing of medication/vaccine to the public within a short period of time
- Assisting public health and first responders during an **influenza pandemic** through activities such as **disseminating supplies** to those not leaving home, assisting the **worried well,** and assisting medical professionals with triage
- **Supporting hospitals** in need of additional staff because of a surge of patients.
- Assisting in **organizing additional volunteers** who respond to help at the time of an emergency.
- Assisting local public health departments in **outreach and disease prevention** efforts to improve the health of their neighborhoods.

An "Orientation to MRC" will take place this fall. If you have any further questions related to these planning efforts, please contact Rebecca Hysing at (216) 201-2001 ext. 1602 or rhysing@ccbh.net

Six Rules to Remember for Identity Theft Avoidance

By: David M. Rosen, assistant U.S. attorney, Eastern District of Missouri

Rule #1: The best way to avoid identity theft is to limit criminals' access to your identity and account information. You can do this by removing identity information from public documents, destroying paperwork you no longer need, and limiting "offers" which come to you that a criminal may use to open accounts in your name. The following steps will help you to accomplish this goal.

Rule #2: Whenever possible, remove your Social Security Number from any public documents such as driver licenses.

Rule # 3: Shred anything you discard that has identifying information about you (SSN, DOB) or about accounts you own (bank, brokerage, etc.). Be aware that this sort of information can appear on cover and end pages of documents which relate to your accounts. If you discard financial records such as monthly statements, cancelled checks or tax records, shred them.

Rule #4: Do not give out identifying information over the telephone or the Internet unless you are sure with whom you are communicating.

Rule #5: At least once a year, order a copy of your credit report from www.annualcreditreport.com or call (877) 322-8228, or complete the Annual Credit Report Request Form found at www.ftc.gov/credit and mail to: Annual Credit Request Service; P.O. Box 105281; Atlanta, GA 30348-5281.

Review your report to be sure that you recognize all accounts reported and all inquiries about your account. There are services that will review your credit report on a weekly basis and email you the results. You may also be entitled to a free copy of your report if you are the victim of identity theft.

If your home computer is connected to the Internet, use a firewall. These may be purchased or downloaded.

Your computer's hard drive contains personal information. When disposing of a computer you must do more than delete the files. Go to www.hq.nasa.gov/office/oig/hq/harddrive.pdf and see "Clearing Information From Your Computer's Hard Drive."

Stop all prescreened credit offers by contacting (888) 567-8688.

Stop the three credit bureaus from sharing information about you with marketers for promotional purposes by contacting: Equifax, Inc., Options, P.O. Box 740123, Atlanta, GA 30374-0123; Experian, Consumer Opt-Out, 701 Experian Parkway, Allen, TX 75013; and TransUnion, Marketing List Opt-Out, P.O. Box 97328; Jackson, MS 39288-7328.

Stop most direct mail marketing to you for five years by writing to: Direct Marketing Association; Mail Preference Service; P.O. Box 643; Carmel, NY 10512; or go to www.dmaconsumers.org/cgi/offmailinglist. Stop most telemarketing to you for five years by writing to: Direct Marketing Association; Telephone Preference Service; P.O. Box 1559; Carmel, NY 10512; or go to www.dmaconsumers.org/consumers/offtelephonelist. Stop most unsolicited offers for mortgages or to refinance your home by writing to: DataQuick, Attn: Opt-Out Dept., 9620 Towne Center Dr., San Diego, CA 92121; or call the Acxium U.S. Consumer Hotline at (877) 774.2094.

Be aware that criminals will file a change of address form so that they can receive your mail. If you notice that your mail service has significantly changed contact the U.S. Postal Service to learn if a change of address form has been filed. Criminals also will steal your outgoing mail to get check you have written to pay bills. They then use solvents to remove the payee information. If you write checks out by hand, instead of on a computer, use inks that are solvent-resistant. Most gel pen inks, like the uni-ball Gen Impact pen, are solvent-resistant.

Rule #6: Criminals will send you emails with wonderful offers. Eventually they will ask for identity or account information to assist you in receiving some benefit. Do not fall for this trick. Watch for the shoulder surfer. This crook stands near you at the ATM or the store checkout line to look over your shoulder and read the numbers on your credit or debit card, and watch you use your PIN. With this information they can access your accounts.

Verify all the information on your monthly account statements. Did you write all of the check reflected? Did you incur each credit charge? A gang stole 500,000 customer accounts from a major credit card company. Every six months, they charge $1 to each account. Most people assume it is some fee of which they are unaware and the criminals get $1,000,000 each year. Most banks and credit companies allow you to go online and check your accounts daily. The sooner you catch the criminal at work, the sooner you can limit the damage.

Do not assume that a call you receive from someone trying to collect on a debt is a wrong number. Get the details so that you may learn if your identity has been used. It is not uncommon for the victim to be unaware of the fraud until months or years later. After the criminal obtains credit, and defaults, the first you may hear of this is when someone tries to collect on the debt. While you should not give out any information, you should request documentation of the claim so that you can see if someone has used your identity.

Beware of email requests that appear to be from your bank, Internet service provider or another business telling you that they need to confirm information like your SSN, account numbers or PINs. You are directed to what appears to be an official site where you are asked to provide the information. This is always a scam to get your information. No bank, Internet service provider or business will ask you to provide such over the Internet or by phone. Only a crook will make such a solicitation.

What to Do When You First Learn You Are a Victim

If you believe that you have become a victim of identity theft or fraud, there are steps you need to take immediately. The most important is to contact law enforcement and demand that a report be taken. Do not limit your attempts to the local police, but also contact the postal inspectors and your local FBI. The FTC also maintains a database of citizen complaints of identity theft and fraud. You should report what has occurred by going to www.consumer.gov/idtheft and complete a Complaint Input Form to have your case included in the database.

Other responses will depend on how you have been victimized.

If your identity is being used to obtain credit or open accounts, you will want to have a "fraud alert" put on your credit accounts with the three credit bureaus. When the criminal attempts to open an account, and the merchant contacts a credit bureau to verify his creditworthiness, the fraud alert will cause you

(Continued on page 17)

Hold on Medicare Payments

A brief hold will be placed on Medicare payments for all claims from September 22 through September 30, 2006. These payment delays are mandated by section 5203 of the Deficit Reduction Act of 2005. No interest will be accrued and no late penalties will be paid to an entity or individual by reason of this one-time hold on payments. In addition, payments will not be staggered and no advance payments will be allowed during this 9-day hold. All claims held during this time will be paid on October 2, 2006. This hold applies only to claims subject to payment. PalmettoGBA will continue to accept and process claims submitted during this time.

Revised 1500 Insurance Claim Form Released

If your practice uses the universal paper claim form known as "the 1500" you may need to contact the insurers and others with whom you do business to check about using a new form. The National Uniform Claim Committee (NUCC) has released a revised version of the 1500 Health Insurance Claim Form that accommodates the reporting of the National Provider Identifier (NPI), an identifier that must be used by all entities covered by the Health Insurance Portability and Accountability Act.

There will be a six-month grace period from Oct. 1, 2006 to March 31, 2007, during which physicians and other health care professionals can use either the current or revised version. The transition will be complete April 1, 2007, when the current form is discontinued. The NUCC strongly recommends contacting health plans prior to submitting a claim on the revised form to ensure that the plans are prepared to accept it.

Visit http://www.nucc.org for the 1500 Reference Instruction Manual, as well as other documents related to the revised form.

Don't Delay NPI Compliance

The countdown has begun; do you have your NPI? Don't risk disruption to your cash flow — get your NPI now! National Provider Identifiers (NPIs) will be required on claims sent on or after May 23, 2007. **Every** healthcare provider needs to get an NPI! Learn more about NPI and how to apply by visiting http://www.cms.hhs.gov/NationalProvIdentStand/ on the CMS Web site. This page also contains a section for Medicare Fee-For-Service (FFS) providers with helpful information on the Medicare NPI implementation. A Countdown Clock is now available on this page to remind health care providers of the number of days left before the compliance date; bookmark this page as new information and resources will continue to be posted. For more information on private industry NPI outreach, visit the Workgroup for Electronic Data Interchange (WEDI) NPI Outreach Initiative Web site at http://www.wedi.org/npioi/index.shtml. ■

Six Rules to Remember for Identity Theft Avoidance

(Continued from page 16)

to be contacted before credit is extended. You may contact the credit bureaus to place a fraud alert: Equifax at www.equifax.com or (800) 525-6285; Experian at www.experian.com or (888) 397-3742; and TransUnion at www.transunion.com or (800) 680-7289.

The criminal may use your identity information to access your existing credit accounts or to open new ones. You must immediately contact each company and warn them of the crime. Also, request the company's fraud dispute forms. Complete and return those forms. Delay in doing either may subject you to some liability for the fraud losses. If the company does not have a fraud dispute form, send them a letter setting forth the facts. You may wish to include a copy of the police report you have filed. You can find more specific information on the steps to be taken at www.consumer.gov/idtheft (the FTC's site) reading "Fair Credit Billing" and "Avoiding Credit and Charge Card Fraud."

Criminals have become very proficient in producing counterfeit bank checks with information stolen from a check of yours. You should contact your bank immediately upon learning that someone is using your checking account. Contact the three check verification companies to report the situation: TeleCheck at (800) 710-9898 or (800) 927-0188; Ceretegy, Inc. at (800) 437-5120 and International Check Services at (800) 631-9656. They will notify merchants not to accept your checks.

If you feel that an ATM or debit card is being used by a criminal, contact the issuing bank.

In each case, document your contacts. When you send a letter, send it certified/return receipt and attach all of these documents to the copy of the letter you retain.

What to Do When Others Try to Make You Pay

Unfortunately, we see too many cases in which the victim is not only victimized in having their credit and good name affected, but also in having attempts made to collect on the criminal's debt. You have rights when this happens.

The Fair Credit Reporting Act sets forth a procedure for you to follow.

First, call the credit bureau and follow-up with a letter that you send certified/return receipt. Tell the bureau what information you consider to be inaccurate. Include copies of any documents you have that support your claim, including a copy of the police report about your situation. It will be easiest if you include a copy of your credit report on which you have circled the items you dispute. You must request a corrections or deletion of the disputed information.

After you have done this, the credit bureau has between 30 and 45 days to investigate your complaint. Part of this procedure involves the credit bureau sending your information to the entity which provided the information you dispute. That entity also must investigate based upon your complaint and report back to the credit bureau.

When the investigation is complete, the credit bureau must report to you with written results. The credit bureau must correct information you dispute unless the investigation shows it to be accurate. They must provide you with a copy of your correct credit report and, at your request, will send notices to all entities that have received your credit report in the last six months of the corrections. If the dispute is not resolved, ask the credit bureau to place a 100-word statement of your dispute in your file.

Second, you must write to any creditor whose information you dispute. Send them copies of the same information you sent to the credit bureau. Again, send your letter certified/return receipt.

For more information, go to www.consumer.gov/idtheft and read "How to Dispute Credit Report Errors" and "Fair Credit Reporting."

Editor's Note: Reprinted with permission. ■

Third Annual AMEF Golf Outing Shines Through the Clouds

Eighty-five golfers braved the occasional drizzle to play at Shaker Heights Country Club on Monday, August 28 for the Academy of Medicine Education Foundation's third annual Marissa Rose Biddlestone Memorial golf outing. Foursomes competed in a shotgun start tournament that raised more than $35,000 for AMEF. The funds will be utilized for medical student scholarships, annual CME seminars and the *Healthblines* radio program.

First, second and third place foursomes were:

1st Place Team
Kevin Geraci, MD; Raymond Scheetz, MD; Bruce Cameron, MD and **Bill Steiner, MD**

2nd Place Team
Matthew Levy, MD, Phil Stickney, MD, Willie Beers and Marc Ullman

3rd Place Team
John Bastulli, MD, Mark Mingione, **Irv Hirsch, MD** and Rick Garcia

Prizes were also awarded for the following:

Closest to the pin – Jim Mackey, Steve Klug, Don Marcello and Andrew Niederst

Longest Drive – Scott Zimmer and Andrew Niederst

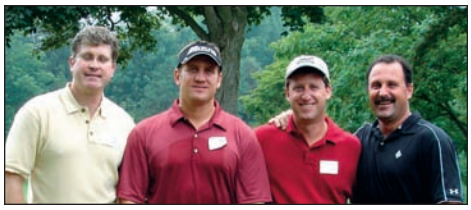
*Third place finishers Rick Garcia, **Irv Hirsch, MD, John Bastulli, MD** and Mark Mingione enjoying the day at Shaker.*

*AMEF Golf Committee members **Richard Fratianne, MD** and **George Leicht, MD,** with Amy McDonald and resident Jeff Claridge.*

*Golf Committee member **Dr. Bill Seitz** (far right) participated in the outing with fellow golfers Warren Hammert, MD, Rick Parker, MD and Jimmy Kleinman.*

*This year's first place foursome **Dr. Raymond Scheetz,** Past President and AMEF board member **Kevin Geraci, MD, Bruce Cameron, MD** and **Bill Steiner, MD.***

A hole-in-one contest sponsor, Mercedes-Benz of Bedford was represented on the links by Jarod Miller, Peter Mapp and Craig Gacom.



*Second place foursome **Phil Stickney, MD,** Wilson Beers, **Matthew Levy, MD** and Marc Ullman having fun on the back nine.*

*Unmistakable on the green in matching hats, the foursome of Tim BrulPort, **Victor Bello, MD,** Rob Zimmerman and Dick Rye.*

Get your clubs ready for next year's event— August 13, 2007 at Mayfield Country Club

Last year's winners from Todd Associates return for more fun: Tim Fitzpatrick, Ned Hyland, Jim Conway and Steve Klug.

Phil Moshier of Sagemark Consulting happily draws the next winner from Elayne Biddlestone during the prize raffle following dinner.

Willie Beers is a proud recipient of a raffle prize.

A special thank you goes to all event and hole sponsors who made the day possible:

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