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AMCNO Participates in "Start Talking" Kick-Off Event Featuring Lt. Governor Mary Taylor

AMCNO physician leadership and executive staff were on hand for a regional kick-off event for Ohio's new youth drug abuse prevention initiative – "Start Talking" – a campaign which focuses on ways to reduce the likelihood of youth drug use before it even starts. "Start Talking" is inspired by research that shows youth are up to 50 percent less likely to use drugs when parents and adults talk with them about substance use and abuse.

The regional kick-off event was held at Mentor Ridge Middle School where Lt. Governor Mary Taylor was joined by a panel of presenters which included Senator John Eklund, Tracy Plouck, Ohio Mental Health and Addiction Services, Orman Hall, Ohio Department of Drug and Addiction Services and representatives from the school administration and law enforcement.

Presenters stressed the importance of implementing prevention strategies to curb the use of opiates among youth. The campaign features four programs aimed at preventing and reducing drug abuse, including prescription drug abuse, among youth. The "Start Talking" has two main themes – stressing resiliency and self-confidence for young people to make the right decisions and implement prevention strategies to curb the use of opiates. The program encourages physicians, parents, teachers, coaches and

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AMCNO MEDICAL RECORD FACT SHEET NOW AVAILABLE – SEE PAGE 15

Dr. George Topalsky, AMCNO President, discusses the Start Talking program with Lt. Governor Mary Taylor.

The AMCNO to Co-Sponsor Medical Legal Summit with the Cleveland Metropolitan Bar Association

The Academy of Medicine of Cleveland and Northern Ohio, The Cleveland Metropolitan Bar Association and The Academy of Medicine Education Foundation are pleased to co-sponsor a Medical Legal Summit in April 2014. The summit is intended to bring together doctors, lawyers, health care professionals and others who work in allied professions in Northeast Ohio. The AMCNO has attained CME accreditation for the program as well as credits from University Hospitals (UH) for live Clinical Risk Management Education (CRME) credits for those physicians participating in the UH-sponsored Physician Program. We are excited to announce that we have attained Dr. Bill Frist as the keynote speaker on April 11th followed by a continuation of the summit the morning of Saturday, April 12th where there will be sessions offered on topics such as fraud and abuse, cyber liability, tort reform updates, social media usage by physicians and much more. AMCNO members and other healthcare providers are encouraged to attend this informative session. To view a copy of the complete program and registration form see pages 16 and 17 in this issue.

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AMCNO Legislative Update

Ohio Legislators Continue Debate on Legislation to Address Prescription Drug Abuse

The Ohio House has continued to hold hearings and interested party meetings on a number of regulatory prescription drug abuse bills and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) continues to provide our input to the legislature and statewide administrative groups on how to best deal with the issues outlined in these bills without disrupting the patient/physician relationship. We have assured legislators that physicians in Northern Ohio take their role in helping fight the prescription drug abuse problem very seriously and that we understand that physicians need to be engaged on this issue.

In addition, the AMCNO has been working closely with other professional associations to offer a common position statement on the legislation that has been introduced to date and to submit new ideas and solutions for consideration by the legislature. This group of organizations continues to meet with leaders of the Ohio House in order to find common ground on the various prescription drug abuse bills pending in the Ohio House of Representatives. The AMCNO has also made our position known on many of the opioid and prescribing bills as well.

It is clear that there are some legislators on the House Health and Aging Committee who are exasperated with the progress to date in the war against prescription drug abuse and deaths. The AMCNO and the other medical associations have continued to point to the positive momentum to reverse trends as a result of educational efforts of the Governors Cabinet Opiate Action Team (GCOAT); however, some legislators insist that more has to be done to address this issue. The physician organizations continue to advocate for an educational approach to solving the problem, yet some of the legislators continue to press for penalties and more stringent laws.

The AMCNO and the professional associations have been successful in getting some changes made to several of these bills. One bill – HB 314 – has already moved over to the Ohio Senate for additional debate. This bill calls for parental consent when a minor is prescribed a controlled substance. The bill would require medical professionals prescribing a controlled substance to a minor to first receive consent from the child's parent or guardian. Although an exception is given in cases of emergency, prescribers could be fined up to $20,000 for an initial violation and for subsequent violations be fined and issued a minimum six-month suspension of their license. The informed consent mandate requires the prescriber to assess the minor's mental health and substance abuse history, discuss with the patient and his or her parent the risks and dangers of drugs containing opioids, and obtain the signature of the parent on a consent form. The medical associations have questioned some aspects of the bill – in particular the severity of the fines - and the debate will continue in the Senate.

The AMCNO has also been working with other associations and the legislature to address our concerns with House Bill 341 – which as introduced prohibited a controlled substance that is a schedule II drug or contains opioids from being prescribed or dispensed without review of patient information in the State Board of Pharmacy's Ohio Automated Rx Reporting System (OARRS). At the time of its' introduction the AMCNO took an official position of Active Opposition with technical assistance on the bill.

Over the past few weeks, this bill has undergone several changes and four substitute bills have been reviewed by the legislature. The AMCNO and several other medical associations worked together with the legislature to make what we consider to be positive changes to the bill. Some of these changes are included below:

1. If treatment continues for more than 90 days, the prescriber must make a "periodic check" of the patient's OARRS report
2. An OARRS check is required only when prescribing opiate analgesics and benzodiazepines, unless any of the following apply:

- An OARRS report on the patient is unavailable
- The prescriber is treating a hospice or terminally ill patient
- The prescriber is treating cancer
- The prescription is in an amount not beyond seven days
- The prescriber is treating acute pain in a post-operative setting

Based upon these changes the AMCNO has now taken a position of support on HB 341 and we will continue to evaluate and review the other legislation moving through the legislature dealing with prescription drug abuse.

We have also expressed concern with HB 332 which would establish standards and procedures for opioid treatment of chronic, intractable pain resulting from noncancerous conditions and to require that professional disciplinary action be taken for failing to comply with those standards and procedures. There are current Medical Board rules for the treatment of intractable pain which require a thorough evaluation, a diagnosis warranting chronic opioid therapy, an individualized treatment plan, an evaluation by a specialist for the disease process or involved body region, patient informed consent, urine drug screening and addiction medicine consult when indicated. We believe that this Medical Board rule should be examined and a discussion started on what is not working in this rule and then determining a targeted plan for what might be included in legislation going forward.

While the discussion on these bills continues, the AMCNO urges all of our members to adopt and implement the new opioid prescribing guidelines for treating patients with chronic, non-terminal pain. For Ohio-specific resources visit www.opioidprescribing.ohio.gov. The site also has links to OARRS registration. If you have not signed up for OARRS, you may soon be receiving a letter from the Ohio State Medical Board requesting that you do so. Help us by also spreading the word about these safe-prescribing resources to any members of the health care team who are non-AMCNO member prescribers and may not be paying attention to this important issue.

Medicaid Online Sign-Ups Continue – ICDS Launch Set for May 2014

Medicaid Sign-Ups – According to the Office of Health Transformation (OHT) more than 20,300 Ohioans have signed up for Medicaid benefits through a new online tool since it went live. OHT has received over 54,420 Medicaid applications through benefits.ohio.gov, which launched Dec. 9. The agency said 20,338 have been approved, while 3,900 have been denied. The number of applications far exceeds the 17,000 submitted by Jan. 1. Ohioans deemed eligible for Medicaid benefits through the federal exchange were told applications had been forwarded on their behalf to the state for further eligibility determination. These applications, however, were not transferred because of problems with the federal website. Both state and federal officials are continuing to encourage Ohioans who believe they are eligible for Medicaid benefits to apply online through the state's website.

My Care Ohio Update - Dates have been set for Ohioans who are eligible for both Medicare and Medicaid to begin enrolling in the state's Integrated Care Delivery System (ICDS) pilot program. Beginning May 1, residents in Cuyahoga, Lake, Geauga, Medina and Lorain counties will be prompted to choose one of five integrated care plans from Aetna, Buckeye, Molina, CareSoure or UnitedHealthcare. The other 22 counties where dual-enrollees are eligible can begin signing up on June 1 or July 1, according to an updated timeline which has been posted on the OHT's website. The pilot program, which will coordinate care for an estimated 114,000 dual enrollees in the state, is made possible through an agreement with the federal Center for Medicare and Medicaid Service. In December 2012 CMS approved Ohio's plan to create an ICDS.

Enrollees who don't choose a managed care plan by January 2015 will be automatically entered into one. Meanwhile, those who want to opt out and keep their current Medicare Advantage Plan are able to do so, but should know that it won't pay for all their Medicaid Services in the same way a managed care plan would, according to the OHT. Anyone who enrolls through Medicare will be able to choose a MyCare plan beginning next January.

The Ohio State Board of Pharmacy Can Now Provide Patient Information to Prescribers

The Ohio State Board of Pharmacy has announced that prescribers can now obtain a Practice Insight Report from the Ohio Automated Rx Reporting System (OARRS). This report provides prescribers with easy access to information about their patients including which patients are visiting multiple prescribers and which patients have the highest morphine equivalent doses. In addition the report can provide a list of the drugs most commonly prescribed by the clinician as well as a list of the clinician's patients that have received a prescription for an OARRS reportable drug in the past year.

The Ohio State Board of Pharmacy expects additional information to be added to the Practice Insight Report over the coming months as new sources of data become available.

To access your Practice Insight Report follow these simple steps:

- Step 1: After logging into OARRS, press the "Submit" link in the Requests Menu. This is the same link you press to request a Patient Rx History Report.
- Step 2: In the upper left-hand corner of the request screen, above where you would enter your patient's last name, there is a drop-down box that currently says "Patient." Change this to "Practitioner." After the screen changes, press the "Submit" button. There is no need to enter any additional information; the form is pre-populated.

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AMCNO Legislative Update *(Continued from page 3)*

- Step 3: After your request has been submitted, click "View" from the requests menu. You will now see your "Practitioner" request listed among your normal "Patient" requests. Within a minute or two, your report will be ready for you to review.

The Ohio State Board of Pharmacy has designed this report in order to provide prescribers with additional new information; however, the Board is also aware that physicians would like to be able to access additional information from the OARRS system. As a result, the Board plans to make new sources of data available in the future. Also please note that the Practice Insight Report is run based on the DEA number that you provided on your OARRS registration. If you did not provide this number, or if it is out of date, please contact the Ohio State Board of Pharmacy at **info@ohiopmp.gov** to update your information.

The AMCNO is pleased to see that these reports are now available and in fact the AMCNO made several suggestions about possible OARRS changes in our recent testimony to the legislature and in a joint letter sent to the legislature by the AMCNO and other medical associations. One of our suggestions was for the OARRS program to initiate unsolicited reports for physicians – and the AMCNO believes that the Practice Insight Report now offered by OARRS is a step in the right direction. Some of the other AMCNO suggested enhancements to the OARRS system were as follows:

- Consider avenues to maintain sufficient funding for the OARRS program over time and conduct periodic review of the OARRS performance to ensure efficient operations and identify opportunities for improvement,
- Integrate OARRS data with electronic health records, health information exchanges, and pharmacy dispensing systems to facilitate prescriber and dispenser access, and assist in letting prescribers and pharmacists communicate electronically,
- Encourage the OARRS program to implement the use of physician memos or scorecards to provide physicians that are checking the database with information as to where they match up with their peers and show if they may be an outlier with their prescribing to patients.

The Pharmacy Board encourages OARRS users to provide feedback and suggestions regarding their reports or other system improvements. The AMCNO will continue to advocate for additional changes to the OARRS system. AMCNO members are also encouraged to send their suggestions regarding OARRS improvements to info@ohippmp.gov or send your suggestions to the AMCNO staff at abell@amcno.org and we will forward them to the Board of Pharmacy.

Healthcare Bills Head to the Governor For His Signature

HB 123 – Telehealth Services this legislation which will expand opportunities for medical professionals to provide health care services through remote communication technologies and expand Ohioans' access to care has moved through the legislature. The bill directs the Ohio Department of Medicaid to set a payment schedule for services delivered through interactive audio and video technologies. The AMCNO was disappointed that the bill does not expand the program to all insurers which we believe would bring more consistency to telehealth services and allow for commensurate payments to physicians and hopefully this will be addressed in future legislation. The AMCNO supported the intent of this legislation.

HB 139 – Hospital Admissions – this legislation allows certain advanced practice nurses and physician assistants to admit patients to hospitals in some cases. The bill does not expand the medical professionals' scope of practice and these professionals will still need to have collaborative agreements with physicians and consult with those physicians before admitting patients. After several amendments were made to the bill the AMCNO took a position of support on the legislation.

HB 170 – Drug Overdoses – this bill would ease restrictions on who can administer Naloxone in order to prevent deaths from drug overdoses. Naloxone, a generic form of Narcan, is a non-addictive medication that blocks brain cell receptors activated by opiates and opioids and can restore breathing and consciousness to overdose victims within two to eight minutes. Nine states have removed regulatory barriers on the prescription and administering of this medication, including Illinois, New York and North Carolina, and now Ohio will be added to the list. The AMCNO supported this legislation.

Ohio Receives Low Grades for Tobacco Prevention

Ohio has once again received a failing grade in an annual report that tracks smoking prevention and cessation programs nationally. In the American Lung Association's State of Tobacco Control report Ohio's evaluation marks included F grades in the Tobacco Prevention and Control Program Funding and Cessation Coverage categories and a D grade for cigarette tax. The report, which assigns the grades based on state laws and tobacco-related programs, attributes the poor showing to lack of spending on tobacco prevention and control programs and to a small percentage of residents who've kicked the habit. However, the state was awarded an A grade for its efforts and ability to maintain a smoke-free environment.

According to the American Lung Association, tobacco causes an estimated 18,500 deaths in Ohio annually and costs the state's economy over $9 billion in healthcare costs and lost productivity. In its report, the association called upon Ohio to raise the cigarette tax and then equalize the tax on non-cigarette forms of tobacco with the cigarette tax. It suggests using $50 million of the resulting revenue to fund science-based tobacco prevention and cessation programs. The AMCNO has long advocated for higher tobacco taxes, as well as additional funding for tobacco prevention and we will continue to work in the legislature to address this issue.

Ohio Department of Health (ODH) Director Dr. Ted Wymyslo Steps Down

The Ohio Department of Health Director Dr. Ted Wymyslo has decided to leave ODH at the end of February to return to his private medical practice. As ODH Director, Dr. Wymyslo has worked closely with the state health departments as well as private and public health entities to improve Ohioans' health and wellness. Dr. Wymyslo was active on various issues during his tenure as Director including tobacco use prevention and cessation, infant mortality, opiate abuse, patient centered medical homes, obesity and Medicaid expansion. The AMCNO was pleased to work with Dr. Wymyslo on several of these initiatives including the most recent initiative to address prescription drug abuse issues. The Governor has promoted Department of Health Chief Counsel Lance Himes to Director. Mr. Himes has served as an attorney for the department for 10 years and has been general counsel since October 2011. Prior to joining ODH, he worked as an associate at D. David Altman Co.in Cincinnati. Mr. Himes holds degrees from Wittenberg University and the University of Cincinnati College of Law.

Joint SGR Repeal Bill Moving Through Congress

New joint legislation to repeal Medicare's failed SGR formula is advancing to both chambers of Congress following an agreement announced by the three committees. The agreement was reached by the U.S. House Energy and Commerce Committee, the U.S. House Ways and Means Committee, and the U.S. Senate Finance Committee and the congressional Doctors Caucus which showed bipartisan support for eliminating the flawed SGR program. In addition to repealing the SGR formula, the bill includes automatic positive payment updates of 0.5 percent for five years, a consolidated and restructured Medicare quality reporting program, and transitions to alternative payment models. Congress now has to act before the March 31 deadline, at which point the SGR formula calls for a 24 percent cut to physician payments. The AMCNO will continue to provide information on this issue as the discussion continues. ■

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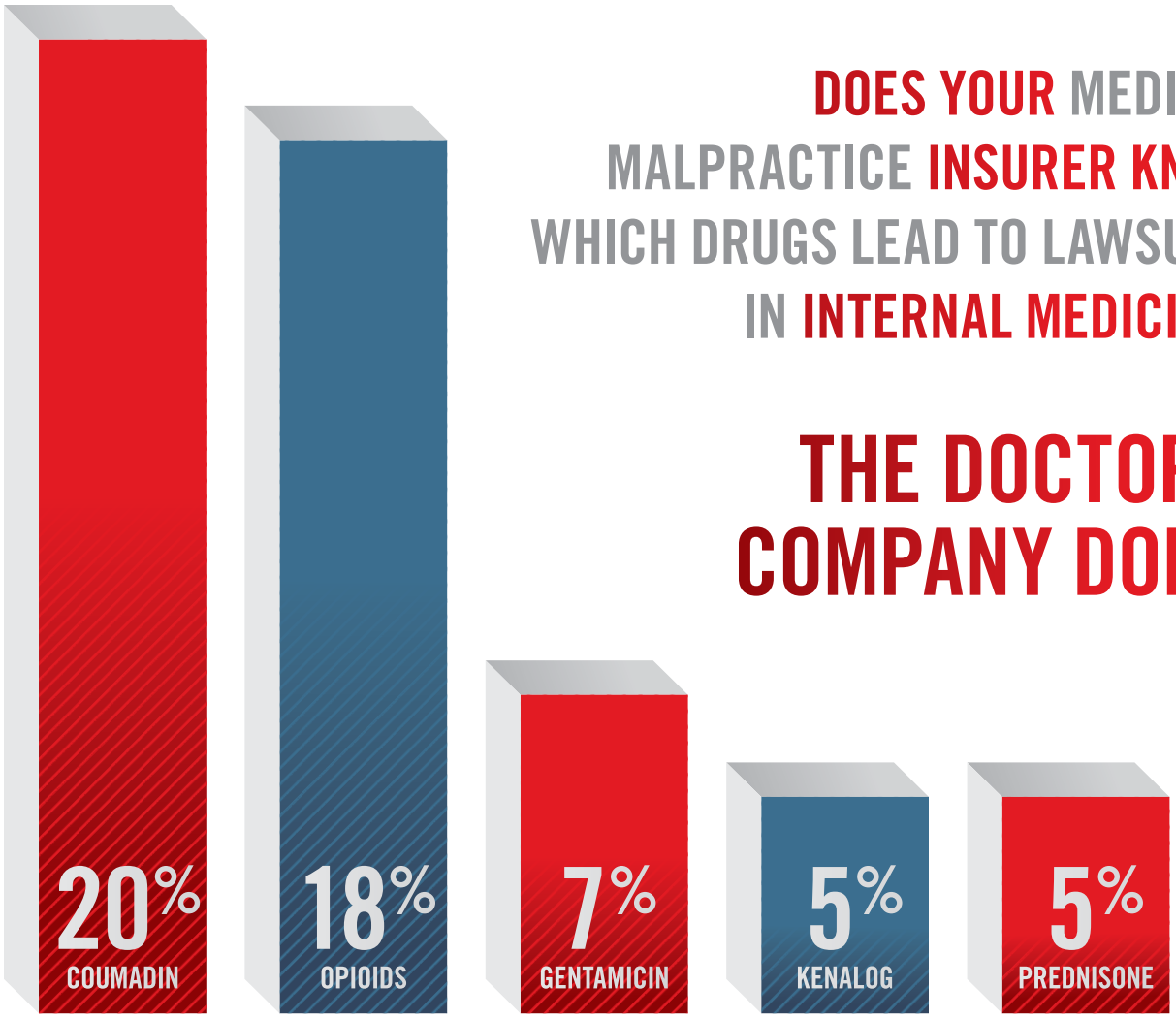

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Emergency Department Opiate Prescribing Guidelines Update

The Ohio Hospital Association (OHA) recently alerted all of their members in the State that the Emergency and Acute Care Facility Opioid and Other Controlled Substances Prescribing Guidelines (ED Guidelines) that were finalized in April, 2012 and adopted and posted in emergency departments by many hospitals across the state should no longer be posted in the emergency department. This alert was sent out by the OHA because the Centers for Medicare and Medicaid Services (CMS) has concluded that posting the ED Guidelines in a hospital facility could create liability for hospitals under the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

TThe ED Guidelines were developed by the multi-disciplinary Professional Education Workgroup (PEW) of Governor Kasich's Cabinet Opiate Action Team (GCOAT) to promote appropriate use of opioids and other controlled substances in emergency departments and urgent care centers. The opiate problem is not unique to Ohio, and several other states began to explore the development of their own emergency department prescribing guidelines, often using Ohio's information as a model. As this issue was discussed in other states, the South Carolina Hospital Association inquired with its regional office of the Center for Medicare and Medicaid Services (CMS Region 4) regarding whether posting guidelines similar to Ohio's could result in violations under EMTALA. EMTALA is a federal law that requires anyone coming to an emergency department to receive an appropriate medical screening to determine whether an emergency medical condition exists, regardless of their insurance status or ability to pay. CMS Region 4 concluded that posting such guidelines in patient waiting rooms or treatment rooms "might be considered to be coercive or intimidating to patients who present to the ED with painful medical conditions, thereby violating both the language and the intent of the EMTALA statute and regulations." Further, CMS Region 4 shared its concern that "some patients with legitimate medical needs and legitimate need for pain control would be unduly coerced to leave the ED before receiving an appropriate medical screening exam." Unfortunately, CMS Region 5 has also concurred with this opinion.

It is recommended that hospitals consider removing the ED Guidelines that may be posted in their emergency departments and consult with hospital legal counsel to decide what course of action to take to educate patients on this important issue while remaining compliant with EMTALA. The OHA also noted that it is important to remember that it is the posting of the ED Guidelines in the emergency department, not the existence of the ED Guidelines, which raises CMS' EMTALA concerns. There was a sample patient handout created along with the ED Guidelines that physicians can use in the ED to communicate with patients about the emergency department's safe prescribing practices. That handout can be provided to patients during the course of that patient's treatment in the emergency department after the patient receives an appropriate screening exam.

While CMS' position is unfortunate, it should not deter emergency room physicians from following the ED Guidelines and having necessary conversations with patients about the risks of opiate use and the need to explore alternative treatments. Physicians should continue to use their independent clinical judgment to treat the unique needs of each patient. ■

FDA issues final guidance on mobile medical apps

Patients now more than ever want immediate answers to their health questions. What they have discovered is that typically there's an app for that—or there is a provider with plans to develop one.

The U.S. Food and Drug Administration (FDA) recently issued final guidance for providers and developers of mobile medical applications (apps), which are software programs that run on mobile communication devices and perform the same functions as traditional medical devices.

The variety and availability of smartphone apps have exploded in recent years as multi-tasking consumers increasingly use their phones to keep up with the latest on news, finance and health. Apple says its iPhone App Store has more than 350,000 apps, and Android, BlackBerry, Windows, and other smartphones account for tens of thousands more. With so many apps on the market, it's no wonder the number of health care related apps has also spiraled.

As a consequence, the FDA intends to exercise enforcement discretion (meaning it will not enforce requirements under the Federal Drug & Cosmetic Act) for the majority of mobile apps as they pose minimal risk to consumers, as long as they comply with all of the other rules imposed by the Federal Trade Commission for mobile apps including containing appropriate privacy policies and disclosures.

This list includes mobile medical apps that:

- Help patients (i.e., users) self-manage their disease or conditions without providing specific treatment or treatment suggestions;
- Provide patients with simple tools to organize and track their health information;
- Provide easy access to information related to patients' health conditions or treatments;
- Help patients document, show, or communicate potential medical conditions to health care providers;
- Automate simple tasks for health care providers;
- Enable patients or providers to interact with Personal Health Record (PHR) or Electronic Health Record (EHR) systems.

The FDA has also already cleared a handful of mobile medical apps used by health care professionals, such as a smartphone-based ultrasound and an application for iPhones and iPads that allow physicians to view medical images and X-rays. These mobile medical apps are included in the category of apps that the FDA does not consider to be a device or require additional regulation as follows:

- Mobile apps that are intended to provide access to electronic "copies" (e.g., e-books, audio books) of medical textbooks or other reference materials with generic text search capabilities;
- Mobile apps that are intended for health care providers to use as educational tools for medical training or to reinforce training previously received;
- Mobile apps that are intended for general patient education and facilitate patient access to commonly used reference information;
- Mobile apps that automate general office operations in a health care setting and are not intended for use in the diagnosis of disease or other conditions, or in the cure, mitigation, treatment, or prevention of disease; and
- Mobile apps that are generic aids or general purpose products.

Rather, the FDA intends to focus its regulatory oversight on a subset of mobile medical apps that present a greater risk to patients if they do not work as intended. Specifically, the FDA is focusing on mobile medical apps that:

- Are intended to be used as an accessory to a regulated medical device – for example, an application that allows a health care professional to make a specific diagnosis by viewing a medical image from a picture archiving and communication system (PACS) on a smartphone or a mobile tablet; or
- Transform a mobile platform into a regulated medical device – for example, an application that turns a smartphone into an electrocardiography (ECG) machine to detect abnormal heart rhythms or determine if a patient is experiencing a heart attack.

If you have questions about developing your own mobile medical app, including whether it constitutes a device and thus is subject to the FDA's new guidance or what disclosures and other privacy policies are required to be included to ensure compliance with the FTC rules, please contact your legal counsel or the authors of this article:

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Electronic Medical Records and the Emergence of Related Issues in Litigation

By Seamus J. McMahon, Moscarino & Treu, LLP

According to the CDC, in 2012, 72% of office-based physicians used electronic medical record or electronic health record (EMR/EHR) systems. This represented an increase from only 48% of such physicians in 2009. In addition to the CMS related benefits for those providers who use EMR, most believe that the electronic health record increases efficiency, decreases room for error, and, in the end, improves patient care in a way that is difficult to measure. While the use of electronic medical records may have simplified the way in which nurses and physicians document patient care on a day-to-day basis, the emergence of the electronic medical record has caused a corresponding increase in the number of discovery issues for lawyers representing hospitals and physicians after litigation commences in a medical negligence case. The emergence of EMR is changing the way in which lawyers represent healthcare providers, including defending evolving claims related to their creation and alleged destruction or alteration of those records. As a healthcare provider cognizant of the realities of the potential for being involved in a malpractice suit, you not only have to be aware of how your documentation in the EMR is used to promote patient care, but also how it may eventually be used by an attorney representing one of your patients in a malpractice suit against you.

Discovery Issues

With the use of electronic medical records, gone are the days of having the office manager or records custodian pull the patient's file and having him or her run those papers through the copy machine. Before EMR, this could have been considered a complete copy of the patient's medical record and could suffice in response to a general discovery request from a patient's attorney in the context of medical malpractice litigation. Now, in addition to the paper chart, even old-fashioned plaintiffs' lawyers will request production of any information about the patient's medical care that is created or stored in electronic format. As healthcare providers, it is important to consider that the electronically stored patient information goes beyond the words that you type into the computer or dictate at the conclusion of a case. To that end, plaintiffs' attorneys are now not only asking for the content of the medical records created by the healthcare providers, but also audit logs, access reports, email correspondence, telephone logs, and any other information that is generated or stored by a hospital or physician in electronic format. Plaintiffs' attorneys have become more savvy and knowledgeable about how various EMR systems operate and are increasingly learning how to use that information to analyze records produced in discovery and to ultimately use that information to support their theories of liability.

Importantly, Federal Regulations require that all EMRs contain an audit log and that all complying providers maintain an audit log. The audit log tracks information about who accessed the record, when that record was accessed, and what information was entered or changed at any given time. Although the data is primarily used for HIPAA security compliance, it is increasingly becoming the subject of discovery in litigation. Common discovery requests related to electronically stored data include:

Interrogatory No. 1:

Were any of the medical records generated by you, in regard to the care rendered to the decedent prepared using a computer software system for medical records. If so,

(a) State what efforts you have made to retain those records in their original form;

(b) State the method by which the metadata for said records can be retrieved.

Request For Production No. 1:

You are hereby requested to produce a copy of the entire medical chart and billing of the decedent including but not limited to all electronic medical records (EMR) and metadata.

Request for Production No. 2:

With respect to the Electronic Medical Record (EMR) of the decedent, please produce the Audit Trail and/or Audit Access Report which documents all clinical services rendered to the decedent on [x date] and the date, time and identity of each person accessing the record from [x date] to the present.

Request for Production No. 3:

Provide any and all native files of Electronically Stored Information related to decedent including but not limited to any audio recordings, video recording, electronic mails, attachments, text messages, word processing documents, spreadsheets, voicemails and/or digital media.

Request for Production No. 4:

Provide any and all native files of Electronically Stored Information, including but not limited to e-mails, attachments, text messages, word processing documents, spreadsheets, voicemails, digital media, video media, identified, referenced, or relied upon in response to Plaintiff's Interrogatories.

Request for Production No. 5:

Produce a copy of any documents, including electronic data, emails or text records that refer or relate to the decedent.

Based on these common discovery requests, as healthcare providers you must keep in mind the broad scope of what is discoverable in a malpractice case and what information is eventually going to end up in the hands of an attorney who is pursuing claims against you. Once you are involved in litigation and receive these requests, work closely with your counsel to discuss what should and should not immediately be provided. Recent revisions to the state and federal rules of civil procedure will lead to a further increase in the amount of information that can be deemed relevant or reasonably calculated to lead to the discovery of admissible evidence. Because of the novelty of some of these issues, courts across the county have only recently been addressing the discoverability of electronic records and few have addressed it in the context of EMR. *See, e.g., Kipoliongo, et al., v. Tchabo, M.D.*, (May 20, 2011), Vir. Fairfax Cty., No. CL-2010-7881 (granting plaintiff's motion to compel production of EMR audit trail in a fetal death case in which the nurse claimed that she vigilantly monitored the patient's fetal heart monitor but the mother claimed that she had only seen the nurse once or twice during the entire shift); see also *Williams v. Mass. Mut. Life Ins. Co.*, 226 F.R.D. 144, 146 (D. Mass. 2005) (denying motion to appoint computer forensic expert because moving party failed to

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Electronic Medical Records and the Emergence of Related Issues in Litigation *(Continued from page 7)*

present any "credible evidence that Defendants are unwilling to produce computer-generated documents"); *Balboa Threadworks, Inc. v. Stucky,* Case No. 05-1157-JTM-DWB, 2006 WL 763668, at *4 (D. Kan. Mar. 24, 2006) (allowing access to defendants' computer where the defendants' representation that no responsive information existed on computer was contradicted by their production of e-mail created on that computer).

Once They Have the Information, How Will They Use It?

So now that we know what type of information the patients and their lawyers will be looking for after filing a lawsuit, the follow-up question has to be "How will they use the information contained in the EMR as evidence against me to prove their case?"

One of the primary concerns is whether the opposing lawyer will use the information to support a claim related to the records themselves. For example, traditionally, if there were issues with the alteration or destruction of hard copies of medical records, plaintiffs' lawyers would pursue claims related to that conduct, which oftentimes led to an award of punitive damages. The seminal case in Ohio for alteration of medical records is *Moskovitz v. Mt. Sinai Med. Ctr.*, 69 Ohio St.3d 638, 1994 Ohio 324, 635 N.E.2d 331. In *Moskovitz*, the Ohio Supreme Court held that "[a]n intentional alteration, falsification or destruction of medical records by a doctor, to avoid liability for his or her medical negligence, is sufficient to show actual malice, and punitive damages may be awarded whether or not the act of altering, falsifying or destroying records directly causes compensable harm." Id., paragraph one of the syllabus. In *Moskovitz*, the doctor had "whited-out" incriminating entries in his original office chart, added exculpatory language to his previous documentation, made copies of the "revised" chart, and destroyed the original chart. The Ohio Supreme Court found that this conduct supported a separate claim against the doctor, including an award of punitive damages. *Id.; but see Fehrenbach v. O'Malley*, 2011-Ohio-5481 (affirming directed verdict in favor of the healthcare provider on a *Moskovitz* claim when the physician merely added truthful information to the chart).

In the past, forensic document examiners were often retained to test the ink on a patient's chart or to time the entries by analyzing the impressions that the doctor's or nurse's pen made on other pages of the record. With the advent of the EMR, and specifically the audit trail, plaintiffs' attorneys have more information at their fingertips, including who accessed the chart, at what time, and what entries were made or changed. Clinicians should be prepared to explain why a chart was accessed at a particular time or why information was subsequently added or changed in the patient's EMR. One can see how a physician who hits the "delete" button on the computer while subsequently reviewing his patient's medical information could be equated with the physician in *Moskovitz* "whiting out" some unfavorable information from the hard copy of the patient's chart.

The timeline created by the audit trail can also prove to be problematic if the healthcare provider unknowingly provides testimony inconsistent with what is represented on the computerized (and inherently more reliable) audit trail. For example, in an unreported case involving allegations that the hospital personnel delayed diagnosis of a perforated bowel, it was discovered through an audit trail that the attending physician, who denied knowledge of the patient's progressively deteriorating condition, had actually accessed the patient's CT images on multiple occasions during the time of the alleged delay. Contrary to his testimony, the physician had actual contemporaneous knowledge of the patient's decline and the damaging testimony provided by the physician, who had not reviewed the audit trial prior to his deposition, was a critical piece of evidence which was later used against him by the plaintiff's attorney.

In sum, with the increasing use of electronic sources to create and store medical information for patient use, healthcare providers need to be aware of what information can be obtained, who will obtain it, and how it will be used in the event that their care is the subject of a medical negligence claim. If you have any questions about the EMR or how it is used in litigation, consult with your attorney or risk management personnel. ■

AMCNO Board Report

AMCNO Board Adopts Social Media Policy

Over the course of the last few years, social media has proliferated the practice of medicine. There are myriad social media sites, online forums, chat rooms and blogs, as well as Facebook and Twitter that have become part of daily life – both professional and personal. It is critical that physician participation in social media be done with care and with an eye toward the fact that once posted an item is often not anonymous and is easily shared and searchable. Physicians need to be cautious when using social media and remember that your actions online, as well as that of your employees, may negatively impact your practice.

The AMCNO recognizes that this is an important issue for our members, therefore, the AMCNO Board of Directors recently voted to adopt the American Medical Association (AMA) policy statement on professionalism in the use of social media. The AMA policy notes that physicians should weigh a number of considerations when maintaining a presence online.

The AMCNO Board of Directors adopted the American Medical Association policy statement on professionalism in the use of social media as follows:

The Internet has created the ability for medical students and physicians to communicate and share information quickly and to reach millions of people easily. Participating in social networking and other similar Internet opportunities can support physicians' personal expression, enable individual physicians to have a professional presence online, foster collegiality and camaraderie within the profession, provide opportunity to widely disseminate public health messages and other health communication. Social networks, blogs, and other forms of communication online also create new challenges to the patient-physician relationship. Physicians should weigh a number of considerations when maintaining a presence online:

1. Physicians should be cognizant of standards of patient privacy and confidentiality that must be maintained in all environments, including online, and must refrain from posting identifiable patient information online.

2. When using the Internet for social networking, physicians should use privacy settings to safeguard personal information and content to the extent possible, but should realize that privacy settings are not absolute and that once on the Internet, content is likely there permanently. Thus, physicians should routinely monitor their own Internet presence to ensure that the personal and professional information on their own sites and, to the extent possible, content posted about them by others, is accurate and appropriate.

3. If they interact with patients on the Internet, physicians must maintain appropriate boundaries of the patient-physician relationship in accordance with professional ethical guidelines just as they would in any other context.

4. To maintain appropriate professional boundaries physicians should consider separating personal and professional content online.

5. When physicians see content posted by colleagues that appears unprofessional they have a responsibility to bring that content to the attention of the individual, so that he or she can remove it and/or take other appropriate actions. If the behavior significantly violates professional norms and the individual does not take appropriate action to resolve the situation, the physician should report the matter to the appropriate authorities.

6. Physicians must recognize that actions online and content posted may negatively affect their reputations among patients and colleagues, may have consequences for their medical careers (particularly for physicians-in-training and medical students), and can undermine public trust in the medical profession.

AMCNO Past President Dr. Anthony Bacevice Provides Clinisync Clinical Advisory Committee Update

Dr. Anthony Bacevice serves as the AMCNO representative on the Clinisync Clinical Advisory Committee (CAC) and he was present at the AMCNO board meeting to give a report on the activities of the CAC and Clinisync. He noted that the Ohio Health Information Partnership (OHIP) is Ohio's state-designated entity responsible for both Regional Extension Services to physicians for electronic health record adoption and achievement of Meaningful Use under federal guidelines as well as the creation and implementation of a Health Information Exchange (HIE). OHIP has developed the statewide HIE and markets its services under the name of CliniSync.

The OHIP Board of Directors approved formation of a Clinical Advisory Committee (CAC) to guide both strategic and operational activities. The CAC makes recommendations to the OHIP Board on development and operational policy direction and all other committees, except those designated by the Board, report to the CAC.

The CAC provides a stabilizing influence so that organizational concepts and directions are established and maintained with a visionary view. Members of the CAC ensure those most engaged in the program are establishing services to meet business priorities.

Dr. Bacevice outlined the primary goals of CAC– stating that the CAC was established to:

- Advise the Board on operational and strategic improvements
- Review operational direction - current and future
- Establish a Product Roadmap
- Contribute Policy Guidance
- Assist with evaluating HIE development strategies and lessons learned as required for federal-grant evaluation purposes
- Create polices for information exchange and the HIE use

In addition, the CAC provides input to the various CliniSync activities, offers suggestions regarding policies and offers recommendations regarding program evaluation. Some of these activities include: Patient Consent Policy Review, Health Plan Information Connectivity. Data Use and Reciprocal Support Policy (DURSA), Patient Portal Evaluation, Image Sharing, Medication History Integration, Policy Manual Review, and HIE Evaluation Survey. For more information about Clinisync go to www.clinisync.org. ■

Affordable Care Act Update

By David A. Valent, Esq.

Provided herein is a summary of recent developments regarding the implementation of the Affordable Care Act ("ACA") as part of an ongoing series of articles published in this magazine regarding the ACA. The purpose of this article is to provide you with ACA related information impacting you and/or your patients – so you can better be prepared to respond accordingly.

ACA Enrollment Update

On February 12, 2014, the Department of Health and Human Services issued a health insurance market place "enrollment report" identifying the status and progress of those individuals enrolling for health coverage, through the online market places made available by the ACA. This data shows some interesting trends.

First, it should be known that nearly approximately 3.3 million people throughout the United States have now signed up for coverage available as a result of the ACA. Nationally, 25% of individuals signing up are young adults, between the ages of 18 and 34 – presumably some of these individuals were not otherwise previously covered by any insurance. The government touts the increased coverage for this demographic as a positive impact and result of the ACA legislation. Also, the presumption is that these additionally insured individuals will not cause any excessive impact and/or burden on the health care industry, since these individuals are largely healthy, and need less care than the elderly.

As it relates to Ohio, approximately 60,000 individuals have signed up for health plans under the ACA. Only 20% of those individuals however are between the ages of 18 and 34. While Ohio has a smaller portion of younger individuals signing up, it has a larger portion of adults ages 55 to 64, as compared to national statistics. This older demographic represents 38% of those enrolling in Ohio, as compared to the national numbers for this group being at 31% of enrollees.

While there is no assurance that these trends will continue, this early data may be suggestive of the fact that Ohio providers will be seeing an uptick in elderly individuals seeking care, pursuant to ACA issued health plans.

This recent release of data by the Department of Health and Human Services also shows that approximately 58% of Ohioans enrolled have selected silver plans, 18% gold plans, and 3% platinum plans. Only 21% enrolled in bronze plans. Many critics previously speculated that individuals required to obtain health coverage would choose the lowest possible coverage in existence, creating problems for providers with regard to getting paid for necessary services. These numbers perhaps represent an early positive trend to suggest the opposite, in that the minimum plans (bronze) are in large part being avoided.

Delay of ACA Employer Mandate

On February 10, 2014, the Obama administration announced it will delay aspects of the ACA's employer mandate. The mandate generally required businesses with 50 or more "full-time" employees to provide affordable health insurance coverage, or face fines.

The new rule announced changes to these requirements. Relative to midsize businesses, which employ 50 – 99 full-time workers, these companies will have another year to provide health insurance coverage to employees. The employers will not face penalty for failing to provide coverage until 2016.

As for large businesses, with 100 or more full-time employees, these companies will not be subject to the mandate until 2015. The new rule, however, gives these employers more time to ramp up coverage. To avoid fines, large employers only need to offer coverage to 70% of workers in 2015, rather than the previously stated 95%. They will not need to start offering coverage to 95% of workers until 2016.

Further, it should be noted that the rule change does not affect businesses of 50 or less full-time employees, because the ACA does not require them to provide coverage to their employees.

ACA Lawsuit

In January 2014, the Federal Trade Commission filed suit against Kobeni, Inc., over allegedly misleading emails related to the ACA. This appears to be the first known lawsuit filed by the government alleging fraud related to the ACA.

The Defendant, an alleged high volume SPAM emailer, is said to have violated the FTC Act and CAN-SPAM Act. The FTC says that Kobeni sent unsolicited commercial emails, taking advantage of the ACA, to trick recipients into clicking on links that would take them to websites with advertisements for insurance companies. The allegations are further that the emails misinformed consumers that they would be violating federal law if they did not immediately click on the link to enroll in health insurance.

This lawsuit brings light to the fact that there is an immense amount of communication, advertising, and propaganda available regarding the ACA, and its purported implementation and impact. While the allegations in this suit are not yet proven, this suit is certainly a reminder that we must all be vigilant with regard to the source of our information.

It is, in many instances, best to rely directly on the government, and its websites, such as www.healthcare.gov, to obtain the official word with regard to these issues.

The Government, Through the ACA, Stops Providers from Opening Shop

The U.S. Government recently indicated that it intended to place a temporary ban on new home health providers and ambulance suppliers from enrolling as Medicare providers in areas of the country that have found to be at high risk for fraud.

The Center for Medicare and Medicaid Services (CMS) said it would not allow any new home health agencies in Miami, Chicago or Houston. According to the Administrator of CMS "while maintaining patients' access to care, we are putting would be fraudsters on notice that we will find and stop them before they can attempt to bill Medicare, Medicaid, and CHIP."

As a result of the ban, CMS further promised to closely monitor the affected areas, to ensure that adequate access to care is available, based on the number of beneficiaries receiving care and/or needing care in the area. It is touted that this moratorium on health care agencies is invoked under authority granted through the ACA, and its anti-fraud provisions.

Indeed, this development is noteworthy as it highlights the strength of power the ACA provides to the government relative to the rendering of health care services. The ACA indeed gives CMS the authority to impose moratoriums on new providers, in certain sectors and regions.

For further information regarding ACA and/or issues that may be specific to your practice, please do not hesitate to contact David A. Valent, Esq. at Reminger Co., L.P.A.: dvalent@reminger.com, 101 Prospect Avenue, West, Suite 1400, Cleveland, Ohio 44115. ■

The Academy of Medicine of Cleveland & Northern Ohio *Healthlines* Program

For more than 40 years, the Academy's *Healthlines* program has provided valuable medical information and the insight of our member physicians to the public. Listed below are the participating physicians, along with their respective topics that were recorded in 2013.

Thank you to the following interviewees who interviewed on *Healthlines* in 2013:

Dr. Lawrence Kent – *Patient Satisfaction Surveys*

Dr. William Seitz – *(Computer) Generated 3-D Guided Deformity Correction in the Wrist and Forearm*

Dr. George Topalsky – *Shingles Vaccine*

Dr. Brian Appleby – *New Treatments for Alzheimer's Disease*

Dr. James Merlino – *How to Get Physicians Involved in the Patient Experience*

Dr. Kenneth Woodside – *Kidney Transplants for Patients with Well-Controlled HIV*

Dr. Julie Sterbank – *The AMCNO Pollen Line 2013*

Dr. Anthony Post – *New Treatments for Hepatitis C*

Drs. Hans Luders & Jonathan Miller – *Multiple Hippocampal Transection for Epilepsy Patients*

Dr. David Frid – *How to Spot Bogus Health Claims*

Dr. Stewart Tepper – *New Approaches for Treating Migraine Headaches*

Dr. Meagan Costedio – *Removing a Colon and Non-Invasive Colorectal Surgery*

Dr. Roseanna Lechner – *Basics of Back Pain*

Dr. Charis Eng – *Genetic Mutations Associated with Cowden Syndrome*

Dr. Donald Ford – *Choosing Wisely for Better Health*

Dr. George Kikano – Using Telemedicine for Patient Care

Dr. Sumita Khatri – *Treating Adult Asthma*

Dr. Benjamin Walter – *Braingate: Movement Disorders*

Dr. Michael Benninger – *Cleveland Clinic Voice Center*

Dr. Raed Dweik – *Detecting Heart Failure Using Breath Tests*

Dr. John Santa – *Choosing Wisely Initiative*

Dr. Max Wiznitzer – *Multiple Steps in Diagnosing Kids with ADHD*

Dr. Mikkael Sekeres – *Redefining Cancer Care in a New Age*

Dr. Moises Auron – *Bloodless Surgery*

Dr. Sree Battu – *Four Ways to Improve Breast Cancer Rehabilitation*

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) award-winning *Healthlines* program is now housed on the Academy of Medicine Foundation (AMEF) website (www.amefonline.org) and available for the public and the medical community on demand via an audio stream. The *Healthlines* program continues to be produced and edited by the WCLV studios and professional staff, along with the assistance of the *Healthlines* host, Dr. Anthony Bacevice, Jr. Promotional advertising spots run on WCLV FM, WCPN FM, and Q104 highlighting the *Healthlines* program and directing listeners to the AMEF website. *Healthlines* is an excellent way for our members to provide information to the general public on timely, medically-related topics. It also provides you, our members, with the opportunity to get your name out in the community – truly a member benefit. For more information on the *Healthlines* program, please contact the AMCNO at 216-520-1000. ■

AMCNO Participates in "Start Talking" Kick-Off Event Featuring Lt. Governor Mary Taylor *(Continued from page 1)*

other adults to talk openly to children about drugs. The plan is to engage adults in the community to interact with young people and talk about the dangers of drug use.

Lt. Governor Mary Taylor stated that Governor Kasich has focused on the opiate abuse issue and he has been working with the medical community and others to establish new guidelines for physicians to utilize in the emergency room and in their practice. The Governor has now launched the "Start Talking" initiative in order to focus on preventing and reducing drug abuse in youth. She thanked Governor Kasich for recognizing this important issue and encouraged everyone in the State to get behind this initiative in order to help young people make the right decisions.

Dr. George Topalsky, AMCNO President, (left) and Dr. Robert Hobbs, AMCNO Board member, (right) discuss the Start Talking program with Senator John Eklund (center).

The AMCNO supports any effort that will eliminate opiate abuse and we plan to work with the state agencies to promote the program to the Northern Ohio community and to our members. The AMCNO was integrally involved in the Governor's Cabinet Opiate Action Team (GCOAT) in the development of the opioid prescribing guidelines and recent statistics mentioned during the event show that the health care community has already made strides to address this problem with a 41% decline in the number of Ohioans exposed to high doses of prescription opiates. However, there is more that can be done to address this issue and the AMCNO plans to continue to work with the Governor and the state agencies to promote the prescribing guidelines for physicians as well as the "Start Talking" initiative. To learn more about the "Start Talking" campaign, visit **www.StartTalking.Ohio.Gov.** ■

AMCNO Wine Tasting

Attendees at the annual AMCNO Wine Tasting event held Sunday, February 16th at La Cave du Vin in Cleveland Heights took a break from the cold winter weather to enjoy fine wine, good food and each other's company. AMCNO members and their spouses/guests were treated to six wines. If you were not able to join us this year – watch for the "save the date" for next year – as we will do this event again! ■

AMCNO Pollen Counts Kick Off Allergy Season

The AMCNO welcomes back
Allergists Robert W. Hostoffer, D.O.
Theodore H. Sher, M.D.
Haig Tcheurekdjian, M.D.
Allergy/Immunology Associates Inc.

Providing Daily Pollen Counts
And Preventative Methods
April 1, 2014 – October 1, 2014

(216) 520-1050 or www.amcno.org/pollen

AMCNO Physician Leadership Meets with Congressman David Joyce

The AMCNO was pleased to meet with Congressman David Joyce and his staff to discuss key issues of interest to the AMCNO and physicians. Rep. Joyce received an overview of the AMCNO activities and the issues currently under review by the organization.

In response to questions from the AMCNO concerning future changes to the Medicare Sustainable Growth Rate (SGR), Rep. Joyce noted that there are many individuals working on this issue and they want to do something about it now if possible. Rep. Joyce is aware that something has to be done now to address this issue.

Rep. Joyce is of the opinion that there is still work to be done to explain the Affordable Care Act (ACA) in order to outline how it works and what needs to be done to meet the goals of the legislation. The House just passed legislation requiring the administration to notify Americans if their information has been compromised on the health care exchanges and the measure won the support of 67 Democrats. Rep. Joyce noted that Americans have a right to know if their personal, private information has been compromised due to the health care law and this bill will require that the website be made more secure and if there is a breach then those that have signed up must be notified within 48 hours that there has been a breach. He noted that Ohioans receiving health care coverage on the new exchanges are required to submit a lot of personal information and with all of the ongoing maintenance and problems that have occurred with the site, there can be no guarantee that their information is secure and this bill addresses some of these concerns.

AMCNO representatives mentioned that physicians are very concerned about the impending physician shortage and the AMCNO stressed the importance of getting adequate funding for the training of new physicians. The AMCNO urged Rep. Joyce to review the graduate medical education issue and funding for same since it is imperative that the United States have the ability to train qualified physicians in the future.

Dr. John Bastulli AMCNO Vice President of Legislative Affairs (left) and Dr. George Topalsky, AMCNO President, (right) spend a moment with Rep. David Joyce.

AMCNO representatives also asked for Rep. Joyce's input on a bill that was recently introduced by Reps. Matsui (CA) and Johnson (OH) to create a federal definition of telehealth. AMCNO representatives noted that this has been a topic of discussion in the Ohio legislature and in meetings with the State Medical Board of Ohio. The bill just introduced in Congress known as the Telehealth Modernization Act of 2013 will encourage health care providers to utilize innovative technologies to provide greater and more efficient patient care. The bill has been referred to the House Energy and Commerce Committee which has jurisdiction over health care and technology issues. Telehealth is a major contributing factor to increased health care quality, convenience and lower costs. However, there are currently 50 separate sets of rules as to what type of care can be provided. This often leaves both providers and patients in a state of uncertainty. This Act will provide guidance to states as they look to utilize telehealth technologies in the safest, most secure manner possible. The legislation is based on the landmark telehealth legislation that passed in California and is designed to incentivize more states to expeditiously adopt more favorable telehealth policies.

Drs. Bastulli and Topalsky asked Rep. Joyce to continue to utilize the AMCNO physician leadership and staff as a resource in the future and to contact us when he has questions on health care related issues or other matters in particular on the topics discussed during the meeting such as SGR reform, telehealth, GME funding and implementation of the ACA. Rep. Joyce thanked the AMCNO and he plans to continue to meet with us in the future. ■

Medical Records Fact Sheet
New Fees Effective January 2014

Retention of Medical Records

Medical considerations are the key basis for deciding how long to retain medical records. Rules relating to the maintenance of patient records are to be found in the American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics. Current Opinion **7.05.** Under Ohio Law (R.C. §**4731.22 (B)(18)**), violations of the AMA ethical rules can result in disciplinary action by the Ohio State Medical Board. Most states, including Ohio, do not have a general state law that requires records be kept for a minimum length of time. Ohio Revised Code §**2913.40 (D)** mandates the retention of records associated with Medicaid for a period of at least six (6) years after reimbursement for the claim is received by the physician. It is recommended that records relating to a Medicare patient be kept for at least six (6) years after the physician received payment for the service. Medicare's Conditions of Participation requires five (5) year retention. Managed care contracts should be consulted to see if they provide any specified period of retention of medical records. In all cases, medical records should be kept for the length of time of the statute of limitations for medical malpractice claims. Under Ohio Law an action for medical malpractice must be brought within one year after the cause of action "accrues" (R.C. §**2305.113**). However, there are various exceptions or special rules. For example, the statute of limitations in wrongful death cases is two years after the date of death. In the case of a minor, the statute of limitations does not begin to run until the minor has reached his or her 18th birthday. The statute can be "tolled" or otherwise extended in other situations, and the date on which a cause of action "accrues" can vary. As a practical matter, all of this makes it difficult to define the Ohio statute of limitations with absolute certainty. If you are discarding or destroying old records, patients should be given the opportunity to claim the records or have them sent to another physician. The AMCNO recommends that physicians keep medical records indefinitely, if feasible.

Update on Charging for Copies of Medical Records

A physician who treated a patient should not refuse for any reason to make records of that patient promptly available on request to another physician presently treating the patient, or, except in limited circumstances, refuse to make them available to the patient or a patient's representative (not an insurer). A written request signed by the patient or by what the law refers to, as a "personal representative or authorized person" is required. Ohio Revised Code §**3701.742** obligates a physician to permit a patient or a patient's representative to examine a copy of all of the medical record. An exception arises when a physician who has treated the patient determines for clearly stated treatment reasons that disclosure of the requested record is likely to have an adverse effect on the patient, in which case the physician is to provide the record to a physician chosen by the patient. Medical records should not be withheld because of an unpaid bill for medical services. Ohio law establishes the maximum fees that may be charged by health care provider or medical records company that receives a request for a copy of a patient's medical record. Ohio law provides for certain limited situations in which copies of records must be provided without charge, for example, where the records are necessary to support a claim by the patient for Social Security disability benefits. EFFECTIVE JANUARY 2014, the maximum fees that may be charged, are as set forth below.

(1) The following maximum fee applies when the request comes from a patient or the patient's representative.

a) No records search fee is allowed;

b) ***For data recorded on paper or electronically****:* $3.02 per page for the first ten pages; $0.63 per page for pages 11 through 50; $0.26 per page for pages 51 and higher
For data resulting from an X-ray, MRI, or CAT scan recorded on paper or film: $2.07 per page

c) Actual cost of postage may also be charged

(2) The following maximum applies when the request comes from a person or entity other than a patient or patient's representative.

a) A $18.61 records search fee is allowed;

b) ***For data recorded on paper or electronically*****:** $1.22 per page for the first ten pages; $0.63 per page for pages 11 through 50: $0.26 per page for pages 51 and higher
For data resulting from an X-ray, MRI, or CAT scan recorded on paper or film**:** $2.07 per page

c) The actual cost of postage may also be charged

Ohio Law requires the Director of Health to adjust the fee schedule annually, with the adjustment to be not later than January 31st of each calendar year, to reflect an increase or decrease in the Consumer Price Index over the previous 12-month period. If you have any questions regarding this fact sheet or other practice management issues, please contact the AMCNO at (216) 520-1000 ext. 102.

Medical/Legal Summit

April 11 & 12, 2014

April 11 – 1.5 CME credits
April 12 – 4.00 CME credits
Risk Management Credit - The AMCNO has obtained approval from University Hospitals (UH) for four hours of Clinical Risk Management Education (CRME) credit for those physicians participating in the UH Sponsored Physician Program . The Doctors Company is offering a 3% discount to their members that attend the Medical/Legal Summit. This discount cannot be combined with additional discounts offered for TDC educational conferences/seminars.

Chair: Matt Donnelly, Deputy Chief Legal Officer, Cleveland Clinic

Vice-Chair: Michael Anderson, MD, Chief Medical Officer, University Hospitals

The Summit is intended to bring together doctors, lawyers, health care professionals and others who work in allied professions for education, lively discussion and opportunities to socialize.

Schedule at a Glance

HEALTH LAW UPDATE (optional session)

FRIDAY, APRIL 11, 2014 - 12:30 - 3:45 PM *CLE credits /no CME available for this optional session)*
State and Federal Update 12:30-1 PM, Fraud & Abuse Basics 1:05– 1:50 PM, Strategies for hospital-physician arrangements 1:05 - 2:30 PM, Introduction to HIPAA, 1:50– 2:30 PM, A Deep Dive into Health Care Contracting 2:40 – 3:45 PM, Professional licensure, medical staff and credentialing issues 2:40-3:45 PM

MEDICAL/LEGAL SUMMIT 2014

FRIDAY, APRIL 11, 2014 **1.5** *CME credits, CLE credits*
4:00 PM – 5:30 PM

Plenary Address and Q&A Session

Keynote Speaker

William H. Frist, M.D., is a nationally recognized heart and lung transplant surgeon, former U.S. Senate Majority Leader, and Chairman of the Executive Council of Cressey and Company. Senator Frist represented Tennessee in the U.S. Senate for 12 years where he served on both the Health and Finance committees. He is currently Adjunct Professor of Cardiac Surgery at Vanderbilt University and Clinical Professor of Surgery at Meharry Medical College. He is also Co-Chair of the Health Project at the Bipartisan Policy Center. His board service includes the Robert Wood Johnson Foundation, the Kaiser Family Foundation, and the Center for Strategic and International Studies. Senator Frist is one of only two individuals to rank in the top ten of each of the five inaugural Modern Healthcare Magazine annual surveys of the most powerful people in healthcare in the United States.

5:30 PM Reception

SATURDAY, APRIL 12, 2014 *4.0 CME credits, CLE credits 4.0*

7:00 AM - 8:00 AM Continental Breakfast

8:00 AM - 8:15 AM Welcome & Introductions

8:15 AM - 9:15 AM **Debate on Tort Reform**
Moderator: Kim Bixenstine, Esq., University Hospitals
Presenters: Professor Max Mehlman, Case Western University School of Law; Brian Atchinson, President & CEO, Physician Insurers Association of America (PIAA)

9:15 AM - 10:15 AM **Social Media's Effects on Physicians and Lawyers**
Presenters: Sara Rorer, Esq., Taft, Stettinius & Hollister; David Marburger, Esq. , Baker Hostetler

10:15 AM - 10:30 AM Break

10:30 AM - 11:30 AM **Breakout Options Session 1:**

- **The Use of OARRS When Prescribing Narcotic Prescriptions**
  Moderator - Judge David Matia, Cuyahoga County Drug Court
  Presenters: Thomas P. Gilson, M.D., Medical Examiner of Cuyahoga County; Representative Robert Sprague, Ohio House of Representatives; Aaron Haslam, Executive Director of the Ohio State Medical Board; Ohio Pharmacy Board Representative (invited)

- **Fraud and Abuse and other Regulatory Issues Facing Physicians**
  Moderator - Stephen Sozio, Esq., Jones Day
  Presenter Steven Dettelbach, U.S. Attorney's Office (invited)

11:30 AM - 11:45 AM Break

11:45 AM - 12:45 PM **Breakout Options Session 2:**

- **Cyber Liability**
  Moderator: Mike Tobin, Public Information Officer, U.S. Attorney's office
  Presenters: Hospital system IT representative (invited); FBI representative (invited)

- **Issues involving Drug and Device Manufacturers**
  Moderator: Edward Taber, Esq., Tucker Ellis
  Presenters: Chris Coburn, Vice President, Innovation, Partners HealthCare; Professor Gwendolyn Majette, Cleveland Marshall College of Law; PhARMA Representative (invited)

2014 MEDICAL/LEGAL SUMMIT
REGISTRATION FORM

Medical/Legal Summit

☐ $75 AMCNO members, and other healthcare providers
☐ $125 Non-Members
☐ $15 Medical Students and Residents

Please choose one breakout option from each session

Breakout Options Session 1:
10:30 AM - 11:30 AM

☐ *The Use of OARRS When Prescribing Narcotic Prescriptions*
☐ *Fraud and Abuse and other Regulatory Issues Facing Physicians*

Breakout Options Session 2:
11:45 AM - 12:45 PM

☐ *Cyber Liability*
☐ *Issues involving Drug and Device Manufacturers*

Please return your registration to the AMCNO

Name _____

Address _____

City _____ State _____ Zip _____ Phone _____ E-mail: _____

Credit Card No. _____ Exp. Date _____ Seccurity Code _____

Signature _____

To Register:
by phone/fax or mail to: **AMCNO**
6100 Oak Tree Blvd., Ste. 440
Independence, OH 44131
Phone: 216-520-1000 FAX: 216-520-0999
to register online go to www.amcno.org
Make check payable to the AMCNO
(all fax reservations must include a credit card number, expiration date, and signature)

Event Location:
Global Center for Health Innovation
11 St Clair Ave NE
Cleveland, OH 44114

amcno
THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO

CMBA
CLEVELAND METROPOLITAN BAR ASSOCIATION

AMEF
Academy of Medicine Education Foundation

This activity was planned and implemented in accordance with the Essential Areas and Policies of the Ohio State Medical Association (OSMA) through the joint sponsorship of St. Vincent Charity Medical Center and The Academy of Medicine of Cleveland & Northern Ohio (AMCNO). St. Vincent Charity Medical Center is accredited by the Ohio State Medical Association (OSMA) to provide continuing medical education for physicians. St. Vincent Charity Medical Center designates this live activity for a maximum of 5.5 *AMA PRA Category 1 Credits™*. Physicians should claim only the credit commensurate with the extent of their participation in the activity.

The AMCNO has obtained approval from University Hospitals (UH) for four hours of Clinical Risk Management Education (CRME) credit for those physicians participating in the UH Sponsored Physician Program

Professional Practice Gap: To be determined
signed into law the Patient Protection and Affordable Care Act (PPACA). This legislation is considered one of the most significant pieces of legislation since the establishment of Medicare and Medicaid in 1965. The new law will significantly transform the U.S. healthcare delivery system and the practice of medicine. In addition to the Act, other issues are also reshaping the practice of medicine. They include a changing physician workforce, a shift from private practice to large group practice and significant regulatory changes affecting physicians. This program will give a medical-legal overview of the challenges and changes in health care delivery and their impact on the practice of medicine.

Global Desired Learning Outcomes: At the completion of the session, participants should be able to:

- Explain the physician's role in avoiding the inappropriate disclosure and use of protected health information,
- Identify the risks and legal ramifications of the use of social media by physicians,
- Identify criminal and civil actions and settlements involving physicians and the impact on hospital-physician relationships,
- Describe effective avenues for communication between government and the medical community in the wake of increased regulations and rules,
- Discuss physician interactions with drug and device companies and the ethics of interactions between pharmaceutical companies and physicians in relation to current laws,
- Cite legislative and regulatory initiatives that affect the practice of medicine and understand how these initiatives impact the prescribing of opiates to patients,
- Recognize the issues related to medical malpractice and tort reform, and the different options for addressing medical malpractice cases.

SAVE THE DATE

The Academy of Medicine of Cleveland & Northern Ohio

invites you to attend our

2014 Annual Meeting

Friday, April 25, 2014

Wyndham Cleveland at PlayhouseSquare
1260 Euclid Ave, Cleveland, OH 44115
6 p.m. Reception • 7 p.m. Dinner
Black Tie Optional

Presentation of 50 Year Awardees
and Academy of Medicine Education
Foundation (AMEF) Scholarships
to medical students from
Case School of Medicine,
Cleveland Clinic Lerner College of Medicine,
Northeast Ohio Medical University and
Ohio University

AMCNO 2014 HONOREES

William H. Seitz, Jr., M.D.
John. H. Budd, M.D.
Distinguished Membership Award

Michael R. Anderson, M.D.
Charles L. Hudson MD
Distinguished Service Award

Gregory A. Nemunaitis, M.D.
Clinician of the Year Award

Albert L. Waldo, M.D.
Special Honors Award

Laura J. David, M.D.
Outstanding Service Award

Dan Paoletti
Special Recognition

George M. Moscarino, J.D.
AMCNO Presidential Citation Award

Please join us in congratulating our medical scholarship recipients and awardees on April 25, 2014.

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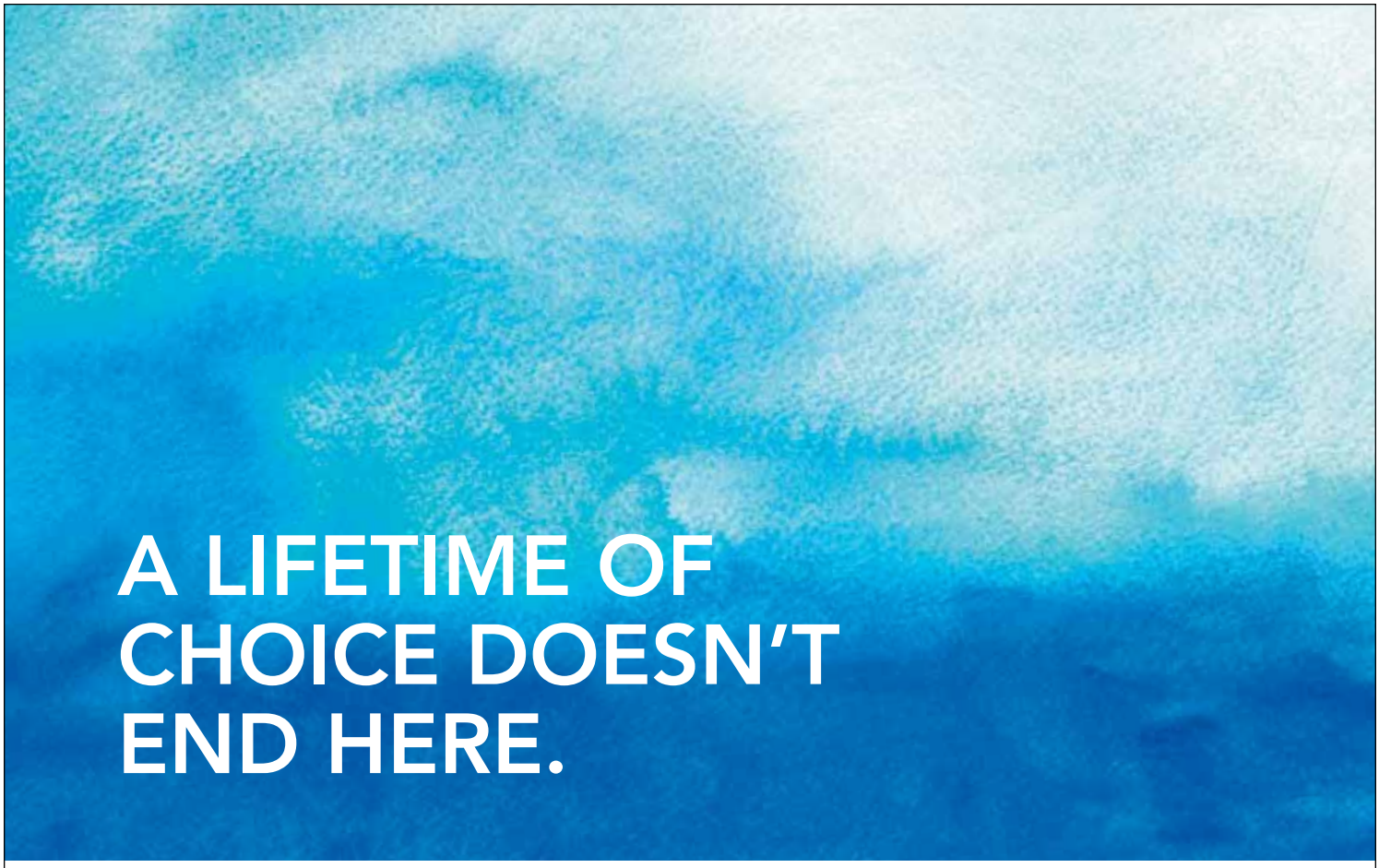
‡ Offer available on prescriptions Monday through Friday at select Giant Eagle Pharmacy locations.



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