CLEVELAND
PHYSICIAN
Academy of Medicine of Cleveland / Northern Ohio Medical Association • July/August 2004
Volume 89 www.amcnoma.org No. 4

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AMC/NOMA President Addresses Case Medical Graduates

Dr. William H. Seitz, Jr., M.D., president of AMC/NOMA, spoke at this year's Case Western Reserve University's School of Medicine commencement on behalf of the Academy of Medicine of Cleveland/Northern Ohio Medical Association. The ceremony was held at Severance Hall on Sunday, May 16.

Keynote speaker was Anthony S. Fauci, M.D., director of the National Institute of Allergy and Infectious Diseases (one of the National Institutes of Health).

According to Richard D. Aach, M.D., associate dean and director of residency and career planning at the School of Medicine, about one-fourth of the 138 graduating students participating in the residency match program this year will be undertaking residencies at University Hospitals of Cleveland or MetroHealth Medical Center in Cleveland. Overall, about 40 percent of the class matched to residencies in Ohio.

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Dr. William H. Seitz, Jr., M.D., *president of AMC/NOMA, spoke at this year's Case Western Reserve University's School of Medicine commencement on behalf of the Academy of Medicine of Cleveland/Northern Ohio Medical Association.*

New *Healthlines* Host Interviews First Guests

New *Healthlines* host **Dr. Ronald Savrin** interviewed his first guest **Dr. Mohan J. Durve,** an assistant clinical professor of pediatrics at both Case and NEOUCOM as well as the AMC/NOMA member allergist, charged with collecting daily pollen and mold spore counts for the area's oldest 24-hour, pollen line.

During the interview, Dr. Durve explained that every weekday morning from May 1st to October 1st he provides pollen and mold spore counts as well as preventative methods to help allergy suffers cope with the sniffling and sneezing brought on by the season. His report is used regularly on local TV and radio stations and is reported in *The Plain Dealer* to help those who suffer from allergies and hay fever take the necessary precautions. Dr. Durve replaces Parrish Garver, M.D., who recently retired his 12-year tenure with the Pollen Line. This season marks the 45th year the hotline has been in existence.

Dr. Mohan Durve *— the AMC/NOMA member that provides the daily pollen and mold counts to the public discusses the AMC/NOMA Pollen Line with* ***Dr. Savrin.***

Dr. Durve informed the *Healthlines* listeners that 40 million people in the U.S. suffer from allergic rhinitis. Left untreated, the problem can cause a more severe case of asthma, chronic ear infections and sinusitis, nasal polyps and an over-

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THE CLEVELAND PHYSICIAN (ISSN# 1084-0982) is published bi-monthly by the Academy of Medicine Cleveland/Northern Ohio Medical Association (AMC/NOMA), 6000 Rockside Woods Blvd., Suite 150, Cleveland, Ohio 44131. Periodicals postage paid at Cleveland, Ohio. POSTMASTER: Send address changes to CLEVELAND PHYSICIAN, 6000 Rockside Woods Blvd., Suite 150, Cleveland, Ohio 44131. Editorial Offices: AMC/NOMA, 6000 Rockside Woods Blvd., Suite 150, Cleveland, Ohio 44131, phone (216) 520-1000. $36 per year. Circulation: 1200.

Opinions expressed by authors are their own, and not necessarily those of the *Cleveland Physician* or The Academy of Medicine of Cleveland/ Northern Ohio Medical Association. *Cleveland Physician* reserves the right to edit all contributions for clarity and length, as well as to reject any material submitted.

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AMC/NOMA President Addresses Case Medical Graduates *(Continued from page 1)*

Dr. Seitz addressed the medical school graduates with the following remarks:

"Twenty-five years ago to the date, I was sitting with my medical school classmates, much as you are today — excited, well-educated and technically prepared to begin my medical career — yet somewhat naïve and anxious about the challenges ahead. I was sad to be leaving the comfortable and nurturing structure of my medical school — the environment that taught me the importance of teamwork.

You have also learned the meaning of teamwork through your long nights studying for exams together, working on your rotations and learning together to become doctors. As individuals, we can only partially take care of our patients, but banded together, we can examine and manage the many aspects of our patients' problems. In medicine, we expect and welcome change. Advances and new information are forthcoming daily. Changes will also occur around you in your lives as physicians, which can affect your ability to care for patients. You will need to embrace these changes and respond to them with the same unity we approach our clinical challenges…as a team. To do so, you must get involved…really involved with the efforts of organized medicine. Branches of organized medicine such as the Academy of Medicine of Cleveland/Northern Ohio Medical Association exist not as a club for mature physicians, but as a network, a resource and an engine of productivity providing a unified voice for all physicians.

At a time when many outside forces impact our profession and can make us seem rudderless, combining all of our resources provides dialogue with our community and representation within our government to ensure effectiveness in carrying out our mission as physicians.

Wherever you wind up, I encourage you to seek out and become involved in your branch of organized medicine. I wish you great success. Congratulations on your accomplishments and thank you for giving me the privilege of addressing you today." ■

New Healthlines Host Interviews First Guests *(Continued from page 1)*

all poor quality of life. He recommended to listeners suffering with this problem to seek medical attention if the condition lasts for more than two or three weeks at a time.

Dr. Savrin's second interview with Dr. Bernard Stulberg, director of the Center for Joint Reconstruction at the Cleveland Orthopedic & Spine Hospital at Cleveland Clinic, discussed total joint replacement. This segment, co-sponsored by Lutheran Hospital and the AMC/NOMA, educated listeners on the topic of total joint replacement: what conditions lead to the procedure, alternatives to the procedure and new techniques in the procedure.

Dr. Stulberg began the interview by defining total joint replacement. He referred to it as using artificial devices to resurface diseased and damaged joints that are beyond repair. He said patients typically seek a physician for treatment when the joint surfaces become so badly damaged that pain and marked stiffness as well as functional limitations become so painful that it's disabling and needs surgical intervention. Dr. Stulberg explained that total joint replacement is being offered to a wider range of patients now because the procedure has become more predictable. He touched on the new techniques for total joint replacement including minimally invasive surgery and computer-assisted surgery. He said minimally invasive surgery is a procedure available to a relatively limited amount of patients that meet criteria for rapid recovery.

Dr. Bernard Stulberg chats with ***Dr. Ronald A. Savrin*** *prior to the taping of the* Healthlines *program.*

Tune into WCLV, 104.9 FM on Monday, Wednesday and Friday every other week at 5:45 p.m. to hear your colleagues. If you'd like to be a future guest on the program please contact Kristi Marusic at (216) 520-1000 ext. 320. ■

AMC/NOMA's Lobby Firm Welcomes Newest Lobbyist

AMC/NOMA's lobbying firm, Towner Policy Group, Ltd., welcomes its newest member, Amanda Sines. She recently joined the firm on May 17, 2004 after serving as an administrative aide to Jeffry Armbruster and Sen. Steve Austria. Prior to that, she served as a page to Sen. Kevin Coughlin, Speakers Larry Householder and Jo Ann Davidson.

Amanda earned her B.A. in Social and Behavioral Science from The Ohio State University. Although Amanda is prohibited to lobby for one year due to the revolving door policy, she will assist Carolyn Towner and Kristy Smith with client reports, attending client meetings and monitoring and attending legislative and rules hearings.

If Amanda's last name sounds familiar, it is because Amanda's father, Ray Sines, is now a Lake County Commissioner who use to work with Carolyn and Kristy when the company was called Sines & Towner Policy Group.

Towner Policy Group, Ltd. is a Columbus-based lobbying firm providing professional representation before the Ohio General Assembly and state administrative agencies for corporations and associations on legislative issues and executive agency issues. Carolyn Towner, Kristy Smith and Amanda Sines represent the physicians of Northeastern Ohio through the AMC/NOMA executive vice-president/CEO and the AMC/NOMA legislative committee and board of directors. ■

Save the Date for the Ohio Supreme Court Candidate Forum

Mark you calendars for **Thursday, August 26 from 3 to 4:30 p.m.** AMC/NOMA, in conjunction with The Center for Health Affairs, is sponsoring a forum to allow members of the medical community to hear directly from the candidates for this year's Ohio Supreme Court races. The event will be held at the Forum Conference Center at One Cleveland on East 9th St. in downtown Cleveland. Candidates for all four of the races have been invited. Participation is expected by all six candidates for the three open seats. ■

We Welcome the Cleveland Clinic Foundation

The Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) is pleased to welcome 1,061 new members from the professional staff of the Cleveland Clinic Foundation.

The AMC/NOMA is truly pleased to have the CCF physicians as group members of our organization. We thank CCF for making this choice and hope it will serve to encourage other regional hospitals, groups and health professionals in northern Ohio to follow suit and join the AMC/NOMA. There is strength in numbers — and physicians must stand together to speak with one voice to promote the practice of the highest quality of medicine. ■

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Tellers Committee Members, from left, ***Dr. James Lane, Dr. Ronald Savrin, Dr. Kevin Geraci*** *and* ***Dr. Charles Cassady,*** *count votes for your 2004-2005 Board of Directors.*

AMC/NOMA Legislative Committee Reviews Feasibility of Mandatory Mediation Pilot Program in Northeast Ohio

J.A. Bastulli, M.D., Vice President of Legislative Affairs

Late in 2003, the AMC/NOMA lobbyists, staff and legislative chairman met with Senator Coughlin to discuss legislation that would allow for a pilot project in the Northeastern Ohio counties to provide for an alternative dispute resolution process through the use of mandatory mediation. The AMC/NOMA lobbyists have prepared draft legislation regarding this project.

This envisioned mandatory mediation pilot program would be created for the counties of Ashtabula, Cuyahoga, Geauga, Lake, Lorain, Medina, Portage and Summit to consider the benefits of mediation for any dispute as to the professional negligence of a healthcare professional, hospital, or a healthcare facility. A copy of the mediation panel's decision shall be submitted to the Superintendent of the Department of Insurance for each decision in the counties in the pilot program. The program provides for any action alleging professional negligence in the above referenced counties shall be subject to a mediation process. The mediation panel shall be composed of three voting members from the American Health Lawyers Association Alternative Dispute Resolution Service.

The Ohio rules of evidence shall not apply before the mediation panel. Factual information having a bearing on damages or liability shall be supported by documentary evidence, if possible. The mediation panel may request information on applicable insurance policy limits and may inquire about settlement negotiations, unless a party objects. Statements by the attorneys and the briefs or summaries, and the findings of the mediation panel are admissible in any subsequent court or evidentiary proceeding.

Within 14 days after the mediation hearing, the panel shall make an evaluation and notify the attorney for each party of its evaluation in writing. The evaluation shall include a specific finding on the applicable standard of care. If an award is not unanimous, the evaluation shall so indicate. If the panel determines that a complete action or defense is frivolous as to any party, the panel shall so state as to that party. If the action proceeds to trial, the party who has been determined to have a frivolous action or defense shall post a cash or surety bond, approved by the court for each party against whom the action or defense was determined to be frivolous. If judgment is entered against the party who posted the bond, the bond shall be used to pay all reasonable costs incurred by the other parties and any costs allowed by law or by court rule, including court costs and reasonable attorney fees.

Each party shall file a written acceptance or rejection of the mediation panel's evaluation with the mediation clerk within 28 days after service of the panel's evaluation. The failure to file a written acceptance or rejection within the 28 days constitutes acceptance.

If all the parties accept the mediation panel's evaluation, judgment shall be entered in that amount, which shall include all fees, costs, and interest to the date of judgment. In a case involving multiple parties, judgment shall be entered as to those opposing parties who have accepted the portions of the evaluation that apply to them. Except as otherwise provided in this chapter for multiple parties, if all or part of the evaluation of the mediation panel is rejected, the action shall proceed to trial.

If a party has rejected an evaluation and the action proceeds to trial, that party shall pay the opposing party's actual costs unless the verdict is more favorable to the rejecting party than the mediation evaluation. However, if the opposing party has also rejected the evaluation, that party is entitled to costs only if the verdict is more favorable to that party than the mediation evaluation. A mediation agreement agreed to by all parties shall be binding on all parties to the agreement.

In addition to the proposed mandatory mediation process outlined above, the draft legislation also provides for the ability of a defendant to file an affidavit of noninvolvement and the plaintiff's attorney must file with the complaint an affidavit of merit signed by a healthcare professional who meets the requirements for an expert witness pursuant to section 2339.21 of the Revised Code.

The proposed legislation also provides for the ability of the parties to agree to binding arbitration in these matters in addition to providing for the ability to enter into a settlement agreement if agreed to by all parties.

This mandatory mediation pilot program is still under review by the AMC/NOMA and changes may be made to the legislation. It is also uncertain as to when the legislation may be introduced. Future issues of the *Cleveland Physician* magazine will provide updates on this concept. ■

Join Us for the First Memorial Golf Outing

There is still time to sign up for the first Marissa Rose Biddlestone Memorial Golf Outing commemorating Executive Vice President/CEO Elayne Biddlestone's late daughter. On August 9, 2004 AMC/NOMA members will gather at Canterbury Golf Club to participate in this special fundraiser benefiting the Academy of Medicine Education Foundation (AMEF). Your contributions will assist in expanding educational programs including medical school scholarships as well as implementing new initiatives to assist both physicians and the patients they serve.

Deadline for entry is Friday, July 23, 2004. All foursomes must be finalized by this date as well. For more information regarding this event contact the AMC/NOMA at (216) 520-1000 ext. 309. ■

State House Report

by Carolyn Towner, Kristy Smith, and Amanda Sines

Ohio General Assembly Breaks for Summer

On May 26, 2004, the Ohio General Assembly finished their legislative session and broke for the summer. The Ohio General Assembly will return for a few days of session in September and then won't break again until after the November election. Prior to leaving for their summer break, the legislature sent a number of bills to the Governor for signing.

The following bills passed both the House and the Senate and have been sent to the Governor for signing:

Senate Bill 187, sponsored by Senator Scott Nein (R-Middletown), pertains to deferred annuities. The bill was amended at the request of the Ohio Department of Insurance with language added concerning the time frame, requirements and conditions for the cancellation and renewal of medical malpractice insurance policies. The bill was then amended on May 11, 2004, to provide for an expedited appeals process so that the constitutionality of Senate Bill 281 (124th) can be settled sooner than later. The bill classifies any court order determining the constitutionality of statutory changes brought about by the enactment of Senate Bill 281 of the 124th General Assembly (relating to civil actions for damages arising out of medical malpractice claims) as a final order that may be immediately appealed and affirmed, modified, or reversed.

House Bill 215 establishes an "I'm sorry law"; clarifies the expert witness provisions and requirement; provides for data collection; allows for an affidavit of noninvolvement; and allows the Ohio General Assembly to respectfully request the Ohio Supreme Court to require a plaintiff filing a medical liability claim to include a certificate of expert review as to each defendant. The bill also establishes that the Ohio General Assembly respectfully requests the Ohio Supreme Court to amend the Rules of Civil Procedure to establish an expedited discovery process in medical liability claims to provide for the timely resolution of the disputes.

House Bill 292 provides minimum requirements that are medical in nature for bringing or maintaining an asbestos claim based on a nonmalignant condition or based on lung cancer of an exposed person who is a smoker, or based on a wrongful death of an exposed person. This bill was signed by the Governor on June 3, 2004 and will be effective in 90 days.

House Bill 342 provides the minimum requirements that are medical in nature required for a silicosis claim or a mixed dust disease claim based on a nonmalignant condition, based on lung cancer of an exposed person who is a smoker, or based on wrongful death of an exposed person. This bill was signed by the Governor on June 2, 2004 and will be effective in 90 days.

House Bill 392 permits an individual to make an anatomical gift of all or part of the individual's body by specifying the intent to make an anatomical gift in a space provided in the individual's living will ("declaration" under Ohio law). The bill requires a printed declaration form to include a section, before the form's signature line, specifically designed for an individual to declare the individual's intent to make an anatomical gift.

Senate Bill 43 requires health insurers that issue or require the use of a standardized identification card or an electronic technology for submission and routing of prescription drug claims to issue or require the use of a card or technology containing uniform information. The bill provides for those requirements to take effect one year after the bill's effective date. The bill was amended to also reduce from 10 to two the number of employees life insurance must cover to be considered group life insurance.

The following bills have recently passed the Ohio House of Representatives and are to be referred to a Committee in the Ohio Senate:

House Bill 463, sponsored by State Representative Courtney Combs (R-Hamilton), requires students to be immunized against chicken pox effective during or after the school year beginning in 2006. Exempt from such requirement are the following: students who have had natural chicken pox and present a signed letter from a parent, guardian, or physician to that effect; students whose parent or guardian decline immunizations for their child for such reasons as religious purposes; and students whose physician certifies, in writing, that such immunization against any disease is medically contraindicated is not required to be immunized against that disease.

House Bill 377, sponsored by State Representative Tom Raga (R-Mason), requires the State Board of Pharmacy to establish and maintain a drugs database by electronically collecting and disseminating information to monitor the misuse and diversion of controlled substances and other dangerous drugs the board includes in the database.

House Bill 365, sponsored by State Representative Steve Buehrer (R–Delta), waives the physician-patient testimonial privilege in probate cases concerning a communication between a deceased client and the deceased client's attorney if the communication is relevant to a dispute between parties who claim through that deceased client, regardless of whether the claims are by testate or intestate succession or by inter vivos transaction. If neither the spouse of a patient nor the executor or administrator of that patient's estate gives consent, testimony or the disclosure of the patient's medical records by a physician, dentist, or other healthcare provider is a permitted use or disclosure of protected health information, and an authorization or opportunity to be heard is not to be required. This provision does not require a mental health professional to disclose psychotherapy notes.

House Bill 257, sponsored by State Representative Patricia Clancy (R–Cincinnati), adds a requirement that all death certificates are required to include, in the medical certification portion of the certificate, a space to indicate, if the deceased individual is female and the manner of death is determined to be a suspicious or violent death, whether any of the following conditions apply to the individual: (1) Not pregnant within the past year; (2) Pregnant at the time of death; (3) Not pregnant, but had been pregnant within forty-two days prior to the time of death; (4) Not pregnant, but had been pregnant within forty-three days

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State House Report

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to one year prior to the time of death; or (5) Unknown whether pregnant within the past year.

House Bill 331, sponsored by State Representative Jean Schmidt (R–Loveland), raises the cap on the amount of benefits healthcare plans may provide for the expense of screening mammography from $85 to 130% of the Medicare reimbursement rate per year. House Bill 331 provides the total benefit for a screening mammography is not to exceed 130% of the Medicare reimbursement rate in Ohio for screening mammography. If there is more than one Medicare reimbursement rate in Ohio for screening mammography or a component of a screening mammography, the reimbursement limit is to be 130% of the lowest Medicare reimbursement rate in Ohio. If a provider, hospital, or other healthcare facility provides a service that is a component of the screening mammography benefit and submits a separate claim for that component, a separate payment is to be made to the provider, hospital, or other healthcare facility in an amount that corresponds to the ratio paid by Medicare in Ohio for that component. A provider, hospital, or other healthcare facility is prohibited from seeking or receiving remuneration in excess of the payment made in accordance with this legislation, except for approved deductibles and copayments

Other bills of interest which are still in a Committee, but have had recent hearings, include the following:

House Bill 238, sponsored by State Representative Larry Flowers (R–Canal Winchester), establishes a Patient's Compensation Fund to pay catastrophic medical malpractice judgments and settlements. The fund is to be used solely to pay amounts in settlements and judgments of medical claims involving qualified providers that are in excess of $250,000. A qualified provider must maintain a minimum amount of medical malpractice insurance and must have coverage of at least $250,000 per occurrence and $750,000 in annual aggregate. The Superintendent of Insurance is to collect a surcharge on qualified providers' malpractice insurance to pay for the fund. "Qualified providers" have to file proof of insurance and must pay the surcharge through their malpractice carrier. The surcharge must be adequate to support the fund, must be a minimum of $100, and will be assessed uniformly on all providers practicing in the same specialty. The bill had a hearing in the House Insurance Committee in May.

House Bill 476, sponsored by State Representative Ron Young (R–Painesville), would establish an alternative form of dispute resolution for medical malpractice claims against physicians. The bill allows a plaintiff to elect to use the alternative form of dispute resolution that allows an expert witness to give an opinion as to whether malpractice was committed or not and, if committed, whether the malpractice resulted in damage to the plaintiff, or that the expert could not give a firm opinion and recommends a review of the records by reviewing physicians. Then the parties can accept the report, request a review of the report, or, in the case of the plaintiff, prosecute a civil action at law. The reviewing physicians would be required to be selected at random from those physicians on a list who specialize in the same branch of medicine as the defendant. If the defendant is found to have not committed malpractice, the plaintiff's attorney is personally liable for the total amount of damages alleged .The bill requires the Superintendent of Insurance to develop a schedule of compensation to be used for the determination of economic and noneconomic compensatory damages in proceedings and in actions involving claims that are heard by a judge without a jury. The bill creates the Disadvantaged Patients Fund consisting of money received from a plaintiff's attorney, interest on awards placed in escrow accounts, proceeds from the sale of books by the State Medical Board to physicians of selected medical malpractice cases for the continued education of physicians in medical malpractice law, and any other money appropriated or donated to the fund to be used only to pay the legal costs of disadvantaged patients. The bill has had two hearings in the House Insurance Committee.

House Joint Resolution 15, sponsored by State Representative Ron Young (R–Painesville), calls for a constitutional amendment to allow the Ohio General Assembly to determine the limits of liability for all non-economic damages and losses in a civil action upon a medical, dental, optometric or chiropractic claim. The limits would be placed upon damages such as pain and suffering, mental anguish, and loss of enjoyment in a claim against a healthcare provider for medical negligence. Economic damages, such as lost earnings, medical care and rehabilitation costs will not be limited. The resolution is modeled after a resolution in Texas which called for an amendment to their state constitution and was recently narrowly passed and enacted. The initiative needs a three-fifths vote in both houses of the Ohio General Assembly and then the issue would be brought to the ballot for a vote. The resolution is in the House Civil and Commercial Law Committee and no hearings have been held.

Senate Bill 80, sponsored by State Senator Steve Stivers (R–Columbus), is the general tort reform legislation and covers the following areas: specific causes of action; statute of repose; trial, liability, damages, and judgements; product liability actions; and other tort provisions. The bill has passed the Ohio Senate, but is still undergoing hearings in the House Judiciary Committee.

Senate Bill 147, sponsored by State Senator Lynn Wachtmann (R–Napoleon), revises the laws regarding the practice of physician assistants, including the establishment of physician-delegated prescriptive authority. As substituted, the bill makes the following changes: lists the drugs physician assistants (PAs) can prescribe and applies the formulary of the advanced practice nurses (APNs) to PAs until a separate one is established; prohibits the PA formulary from being more restrictive than the one for APNs; requires qualifying degrees be obtained from specified accredited programs and extends the time from one to two years for existing PAs with 10 years' experience to obtain prescriptive authority without obtaining a master's degree; and prohibits a PA from performing an abortion and from prescribing any drug or device to perform an abortion and designates violations fourth degree felonies. The bill has been undergoing hearings in the Senate Health, Human Services and Aging Committee.

Copies of these bills may be obtained by going to the State Web site: www.legislature.state.oh.us or a short summary of the bill may be obtained by going to the AMC/NOMA Web site. ■

AMC/NOMA Member Follows up on Bill S1747: Classification of all Contact Lenses as Medical Devices

In the March/April 2004 *Cleveland Physician* issue, ophthalmologist and member Dr. Timothy L. Steinemann, MD, authored an article titled *Decorative Contact Lenses: Medical Devices or Not?* In it, he explained the United States Food and Drug Administration's plans to classify non-corrective decorative lenses as cosmetics — "an article intended, introduced or otherwise applied to a body part for beautifying, promoting attractiveness or altering the appearance." This classification would allow non-corrective decorative contact lenses to be unregulated as medical devices.

While consumers would receive lower costs on the Internet and at various retail outlets on the product, this reclassification is not in the public interest and justifies corrective legislation, Dr. Steinemann explained. This change in legislation would prevent the FDA from conducting safety reviews before the product is sold to the public, prevent the FDA from setting "good manufacturing practices" for manufacturers to follow, prevent the supervision of healthcare professionals in the safety reviews and good practice standard setting as well as prevent prompt reporting of adverse events with the lenses.

Dr. Steinemann believes that further support is needed for S1747 for federal legislation to clarify and classify all contact lenses as medical devices, sanctioned by the FDA and dispensed with prescription by a licensed eye care professional. The impetus for this effort involves many young people with complications following "over-the-counter" sales of "decorative contact lenses."

The measure (HR2218) passed in the U.S. House of Representatives in November 2003. The Senate version (S1747), originally co-sponsored by Ohio's Sen. Mike DeWine and Sen. Edward Kennedy (D-Mass.) is currently being evaluated in committee. There is widespread support for the measure from the American Academy of Ophthalmology, American Optometric Association, Ohio Ophthalmologic Society, The Contact Lenses Association of Ophthalmologists, the Contact Lens Institute, Prevent Blindness America, Prevent Blindness Ohio as well as the Academy of Medicine of Cleveland/Northern Ohio Medical Association and many other industry sponsors including Bausch and Lomb, CIBA Vision/Novartis and Johnson & Johnson/Vistacon.

Please visit Prevent Blindness America's advocacy Web site, www.preventblindness.org, for more information on how to support this legislation. ■

Notes from the Ohio Healthcare Task Force April Meeting

Senator George V. Voinovich has formed the Ohio Healthcare Task Force to obtain information from various different groups regarding issues faced by physicians, hospitals and businesses in Ohio relative to healthcare matters. The Senator requested that the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) assign a physician representative to the Ohio Healthcare Task Force. ***Dr. William H. Seitz, Jr.,*** *president of the AMC/NOMA appointed* ***Dr. John A. Bastulli,*** *the AMC/NOMA vice president of Legislative affairs as the AMC/NOMA representative.*

The task force met in Columbus on April 23, 2004. The discussion ranged from providing coverage to the uninsured to assisting physicians with the medical liability crisis at the Federal level. The task force briefly reviewed a document "Expanding Health Insurance Coverage: A Proposal From the American Hospital Association (AHA), and the Catholic Health Association (CHA)" prepared for the two organizations by the Lewin Group. The proposal calls for expansion of coverage for people at the 300 percent poverty level. The group decided to re-evaluate this document at the next meeting.

The task force also discussed the cost of healthcare and technology. There are now electronic medical records in some institutions and physician offices and it does require more expenses — just the coordination of the system alone increases costs. Technology has resulted in patients getting better care but not necessarily getting cheaper care. Patients expect the most up-to-the-minute tests and technology and this drives up costs. The task force discussed the fact that a large portion of the costs in medicine are caused by having more than 75 different reimbursements systems — and how insurance companies increase costs in healthcare as well. Additional comments were made with regard to the need to practice defensive medicine. Physicians tend to practice defensive medicine to protect themselves from liability. If the technology is available, physicians will use it because they want to be sure they cover all their bases. This is a direct result of defensive medicine and the medical liability problem. The way to solve this problem and help reduce costs to the government is to do something about the professional liability crisis.

In response, Senator Voinovich mentioned tort reform legislation continues to stall in the Senate. They are going back to the drawing board to try to get more votes on a bill since he believes this type of legislation would assist the medical profession.

The task force then turned their discussion to the issue of the reduction in paperwork and the need for a uniform claim form and reimbursement schedules. HIPAA was suppose to help with this process and, unfortunately, it has just added more paperwork. It was agreed the HIPAA regulations have created a lot of problems and the Senator asked the group to specifically identify these issues. The HIPAA topic will be evaluated at the next task force meeting in the coming months. ■

AN OPEN LETTER TO MY COLLEAGUES – FROM THE PRESIDENT OF THE AMC/NOMA

Dear Colleague:

How much are you paying for medical liability insurance? Are you seeing more high-risk emergency patients because your colleagues in the community cannot see them? Are you ready to take a stand for medical liability reform? The medical liability crisis continues to permeate the practice of medicine in Northern Ohio. You MUST get involved in this debate — do not sit on the sidelines and let others do this for you.

There will be opposition lining up against us throughout the region. We need a sustained grassroots effort by physicians to fend off the opposition. Physicians must mobilize and join in the battle. The AMC/NOMA has developed patient education/physician advocacy materials to help you provide information to your patients and legislators regarding the medical liability crisis and the importance of maintaining the balance of the Ohio Supreme Court.

- Included as an insert in this issue of the *Cleveland Physician*, AMC/NOMA members will find a brochure prepared by the AMC/NOMA for our members' details the problems with the current system and the solutions for changing it. This can be used for distribution to your patients. The brochure also **outlines the need maintaining the current balance of the Ohio Supreme Court** — and clearly states that the AMC/NOMA, through its political action committee, supports three candidates — **Justices Moyer and O'Donnell and Judge Judith Lanzinger for the Ohio Supreme Court.** The brochure encourages your patients to talk to you, their doctor, about the need to support these candidates to assure access to quality care in Ohio.
- AMC/NOMA members will also receive a mailing in the very near future that will include the brochure as well as a copy of a ***sample letter*** that you can adapt to send to your patients urging their support of medical liability issues and maintaining the balance of the Ohio Supreme Court as well as poster material that you can display in your office. Additionally, the mailing will include an ***informational piece on the three candidates for the Ohio Supreme Court*** who must be elected in order to maintain the balance and fairness in the court, that physicians may utilize in their waiting rooms along with the brochure. It is imperative that the balance of the court remains intact in order to assure fair review of the tort reform laws.

We are counting on your support and ask for a sustained and dedicated effort by all of the physicians in Northeastern Ohio to maintain the tort reform laws and the current balance of the Ohio Supreme Court. If you have any questions on the AMC/NOMA legislative initiatives, please contact the AMC/NOMA staff at (216) 520-1000.

Sincerely,

William H. Seitz, Jr., M.D., President

Tort Reform — The Illusion of HB 215

Richard Ludgin, M.D.
AMC/NOMA Secretary-Treasurer
Chairman, Physician Advocacy Committee

House Bill ("HB") 215 began as a statute establishing a medical screening panel. Where the parties had not already agreed to arbitration, either the plaintiff or defendant, on written request, could cause the matter to be sent to a "Medical Screening Panel." Chaired by an attorney whose role was to be limited to giving legal advice and guidance and to drafting the panel's report, it was to be the three physicians on the panel who would determine all standard of care, cause and damages issues after reviewing all the evidence they might need and calling witnesses and experts to guide them. The decision, while not binding, was admissible in a subsequent court action and the physicians on the panel were subject to being called as witnesses. The solution sought was to discourage the pursuit of medically non-meritorious claims. The AMC/NOMA strongly supported HB 215 when it included the medical screening panel provision.

However, the Medical Screening Panel provision did not survive the first cut. Instead, four other ideas were introduced and recently signed into law. The purpose of this article is to discuss the illusory nature of these gains and to provide the reader with some guidance on how to maximize the new protections afforded.

I. "I'm Sorry."

…[A]ny and all statements, affirmations, gestures or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that are made by a healthcare provider…to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim, and that relate to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of medical care are inadmissible as evidence of an admission of liability or as evidence of an admission against interest.

In the Colorado statute after which 215 was modeled, the physician is also permitted to disclose "fault" without fear of it being used later as an admission of wrongdoing. Due to changes made to HB 215 during the course of the debate on the bill, protection for statements that use the term "fault" or "mistake" were not incorporated in the law.

What is the practical effect of all of this? We are all aware of the JCAHO requirement that patients be informed of unanticipated outcomes of care:

Standard RI.2.90: Patients and, when appropriate, their families are informed about the following:

…Unanticipated outcomes of care, treatment, and services that relate to sentinel events considered reviewable by the Joint Commission.

…The responsible LIP [licensed independent practitioner] or his or her designee informs the patient (and where appropriate his or her family) about those unanticipated outcomes of care, treatment, and services.

None of us chose to practice medicine to engage in an impersonal, adversarial relationship with those whose lives we sought to make better when we chose this career. It is endemic to our collective personality to be forthcoming, even to the point of personal detriment.

While this new law modestly protects our statements from being used against us, please remember statements made today are statements repeated by others. Do not rest assured that if you only make statements of condolence, regret, sympathy, sorrow or apology, they will not be perceived and later remembered as an admission of fault. While the former statements are protected, the latter are not. The "recollection" of a patient or family, provoked by all the emotion of a legal action following an unfortunate result, may well be that the word "fault" was spoken. Then, it is a question of fact —"fault" said or not said — to be decided by a jury. The only situation in which the law, as enacted, will act as an absolute bar is that in which both defendant and plaintiff agree that the healthcare practitioner did not use the word "fault" or any of its direct synonyms when explaining what occurred.

As physicians, we feel "at fault" even when there is no fault. We feel better when we "fess up," even if there is no objective scientific basis to discredit our performance. Do not confuse regret with mistake. Choose your words carefully and be forthcoming and document the content of the conversation. But, do not let this or any other concern keep you from doing the right thing and being the professional you are.

II. Qualifications of Experts

If recognized as an "expert" in Ohio, a witness is then deemed competent to give ***opinion*** testimony. In the absence of expert opinion testimony of deviation from the standard of care, causation and damages, a plaintiff cannot prevail.

HB 215 raises the bar to qualify to give expert testimony and its precise language is worth noting. Remember, that the law still requires the witness have a license to practice medicine and spend at least 75% of his or her professional time in the active practice of medicine.

(A) No person shall be deemed competent to give expert testimony on the liability issues in a medical claim…unless

(3) The person practices in the same or substantially similar specialty as the defendant. The court shall not permit an expert in one medical specialty to testify against a healthcare provider in another medical specialty unless the expert shows both that the expert has substantial familiarity between the specialties.

(4) If the person is certified in a specialty, the person must be certified by a board recognized by the [ABMS] or the [ABOS] in a specialty having acknowledged expertise and training directly related to the particular healthcare matter at issue.

As physicians, we know what this language is intended to mean but only when applied to an actual case in a court of law will it take on true meaning. For example, what does an expert have to "show" to satisfy the court that he has "substantial familiarity between the specialties"? All medicine sub-specialists are internists first so do they qualify in all internal medicine cases? Most internists spend time

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Tort Reform
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practicing a part of the medical subspecialties…do they qualify? Will it satisfy the court if a witness merely testifies that he is substantially familiar with the practice of the defendant's specialty and he answers in the affirmative? Note there is no requirement of board certification. Instead, if the witness is board certified then he has the additional burden to show that the specialty of certification is one in which the training and experience result in "substantial familiarity" with the specialty of the person on whose care he is opining.

III. Affidavit of Non-Involvement:

How many times have we heard of defendants named in lawsuits who had no part in the care that is in question ("shotgun pleading")? Over the past several years, professional liability insurers have begun to underwrite — non-renew, raise premiums — based on frequency (being named) as a variable independent from liability. Physicians have been non-renewed when their care was first rate but they were erroneously named in a claim.

Ten years ago, this was not a significant problem because physicians were not penalized when the care they provided was deemed appropriate by their peers…even if it cost the malpractice carrier money in the end. Now, however, when named in a claim or suit is a direct cause of damage to the physician, damages measurable in significant dollars. HB 215 has probably eliminated this cause of action by creating a defined process for a physician to use to self-extricate.

If wrongfully named, a physician may file an "Affidavit of Non-Involvement" *(if mis-identified or otherwise not involved…and could not have caused the alleged malpractice)* with the court. The statute prescribes a procedural timeline during which the plaintiff may contradict the physician's assertions (file motions, submit evidence, call witnesses at a hearing, etc.). If the doctor prevails, the court will dismiss him "otherwise than on the merits," which means he may again be named should evidence inculcating his care be discovered during the course of the litigation. There are penalties assessable against any party who files a false affidavit or pleading or who provides false testimony or who falsely objects to the affidavit. **There are no penalties or costs assessed against a plaintiff or plaintiff's lawyer for incorrectly naming this defendant.** Roughly calculated, this is about a six-month ordeal. It applies to lawsuits and not to claims (ex: 180 day letters).

It is doubtful that this will create an atmosphere of more careful pre-suit identification of defendants to be named. It more than likely will not significantly reduce the number of misidentified defendants. It will, however, make less likely the success of suing a plaintiff and/or his/her attorney for suing a physician who should not have been named.

IV. Collection and Disclosure of Medical Claims Data:

HB 215 contains a list of data elements insurers will be required to report to the Department of Insurance on final disposition (payment of judgment, payment of settlement, no payment on behalf of insured). These include:

1. *name, address, specialty coverage of insured*
2. *insured's policy number*
3. *date of occurrence*
4. *name and address of injured person*
5. *date, amount, and categories (economic, non-economic, punitive) of judgment*
6. *date and amount of settlement*
7. *allocated loss adjustment expenses*
8. *any other information required by the Superintendent of the Department of Insurance*

So, let's call this what it is…data that defines the cost of professional liability on only one side of the equation-the defense. It is interesting to note that there is absolutely no requirement that the plaintiff or their attorney to provide information to this database. There is no requirement that any of the following (a non-exhaustive list) be reported:

1. *ratio of cases pursued to cases screened by plaintiff's counsel*
2. *total cost, by category, incurred in pursuing the claim…for example*
   a. *travel expense by passenger*
   b. *testifying expert expenses by name of expert*
   c. *non-testifying expert expense by name of expert*
   d. *deposition expenses*
   e. *exhibit expenses*

These should be reported for each case along with each case's final disposition.

The data elements listed in the statute only test the cost incurred by insurance companies. Nothing in this "study" attempts to quantify the rationale behind the "contingency fee" arrangement or the costs incurred in "prosecuting these cases." Once again the presumption is that the burden falls on the medical profession to pay this expense. Once again, a state agency is being called to test what the plaintiff's bar has characterized as "overcharging by the insurance companies." Let us not forget that this cost is driven at its outset by a process aimed at enriching the plaintiff's bar that self-righteously proclaims its sole aim is to make whole "victims" of malpractice. We all regret having lost that portion of SB 281 that would have capped contingency fees. The elements missing from this data set strongly suggest an influence preventing the collection of information that will support our next try. If the legislature is truly interested in defining and understanding all financial aspects of professional liability, then perhaps this "other side of the ledger" will likewise be collected.

In short, one more time we are trying to "fix" a system that needs total deconstruction and rebuilding. It is not surprising that representatives of the plaintiff's bar stated they can "live" with these changes — it is essentially business as usual. There will not be equal participation until partisanship gives way to doing what is best for the citizens of Ohio.

(Editor's note: As noted in previous issues of this magazine, there have been other bills passed that contain provisions that could assist physicians with the medical liability crisis, however, it is imperative that the Ohio Supreme Court uphold the tort reform legislation in order for the insurance companies to bring down their rates. The AMC/NOMA is working hard on your behalf and we need your continued support. For information on the AMC/NOMA position on any healthcare related legislation, contact E.R. Biddlestone at (216) 520-1000, ext. 321.) ■

AMC/NOMA Board Votes to Approve Boutique Medicine Policy

The Physician Advocacy Committee (PAC) of the Academy of Medicine of Cleveland/Northern Ohio Medical Association (AMC/NOMA) had been asked to evaluate the issue of special physician-patient contracts for "non-medical services." These special contracts commonly referred to as "retainer practices" or "boutique care" were evaluated and discussed by the members of the committee. These types of practices are set up to provide special additional services including: longer visits, guaranteed availability by phone or pager, counseling for healthy lifestyles and various personalized services – through direct financial relationships with patients.

The PAC review of this matter included information obtained from the American Medical Association (AMA) policy with regard to these practices. The AMA report indicated "although executive health programs, and cash-only practices are not new, the special contracts whereby physicians offer additional special services and amenities to patients who pay additional fees as retainers has received considerable legislative and public interest."

At their April 2004 meeting, the Board of Directors of the AMC/NOMA received the report from the Physician Advocacy Committee and the board voted to adopt the AMA policy with regard to retainer practices as AMC/NOMA policy. The policy reads as follows:

AMC/NOMA RETAINER PRACTICE POLICY – adopted April 2004

Individuals are free to select and supplement insurance for their healthcare on the basis of what appears to them to be an acceptable tradeoff between quality and cost. Retainer contracts, whereby physicians offer special services and amenities (such as longer visits, guaranteed availability by phone or pager, counseling for healthy lifestyles, and various other customized services) to patients who pay additional fees distinct from the cost of medical care, are consistent with pluralism in the delivery and financing of healthcare. However, they also raise ethical concerns that warrant careful attention, particularly if retainer practices become so widespread as to threaten access to care.

1. When entering into a retainer contract, both parties must be clear about the terms of the relationship and must agree to them. Physicians must present the terms of the contract in an honest manner, and must not exert undue pressure on patients to agree to the arrangement. If a physician has knowledge that the patient's healthcare insurance coverage will be compromised by the retainer contract, the information must be discussed with the patient before reaching an agreement on the terms of the retainer contract. Also, patients must be able to opt out of a retainer contract without undue inconvenience or financial penalties.
2. Concern for quality of care the patient receives should be the physician's first consideration. However, it is important that a retainer contract not be promoted as a promise for more or better diagnostic and therapeutic services. Physicians must always ensure that medical care is provided only on the basis of scientific evidence, sound medical judgment, relevant professional guidelines, and concern for economic prudence. Physicians who engage in mixed practices, in which some patients have contracted for special services and amenities and others have not, must be particularly diligent to offer the same standard of diagnostic and therapeutic services to both categories of patients. All patients are entitled to courtesy, respect, dignity, responsiveness, and timely attention to their needs.
3. In accord with medicine's ethical mandate to provide for continuity of care and the ethical imperative that physicians not abandon their patients, physicians converting their traditional practices into retainer practices must facilitate the transfer of their non-participating patients to other physicians, particularly their sickest and most vulnerable ones. If no other physicians are available to care for non-retainer patients in the local community; the physician may be ethically obligated to continue caring for such patients.
4. Physicians who enter into retainer contracts will usually receive reimbursement from their patients' healthcare plans for medical services. Physicians are ethically required to be honest in billing for reimbursement, and must observe relevant laws, rules and contracts. It is desirable that retainer contracts separate clearly special services and amenities from reimbursable medical services. In the absence of such clarification, identification of reimbursable services should be determined on a case-by-case basis.
5. Physicians have a professional obligation to provide care to those in need, regardless of ability to pay, particularly to those in need of urgent care. Physicians who engage in retainer practices should seek specific opportunities to fulfill this obligation.

The AMC/NOMA Board also reviewed the AMA report which stated that since individuals are free to select and supplement insurance for their healthcare on the basis of what appears to them to be an acceptable tradeoff between quality and cost, retainer fees for special services and amenities appear to be consistent with a system based on pluralistic means of financing and delivery of medical care. However, it is important to note that whether this trend should be promoted is a question that does not have a definitive answer. The above referenced policy is meant to serve as an ethical guideline. If any AMC/NOMA member has a question referable to this policy, please contact E.R. Biddlestone at the AMC/NOMA offices.

(Editor's note: In April 2004, the Office of the Inspector General (OIG) issued a two-page alert with regard to "concierge practices, or boutique practices" — which read in part: "…When participating providers request any other payment for covered services from Medicare patients, they are liable for substantial penalties and exclusions from Medicare and other federal healthcare programs." A representative of the OIG noted that the alert was not intended as an indication of the OIG's position one way or another on concierge care, it merely reiterates the law regarding extra charges.) A copy of the alert may be obtained at www.oig.hhs.gov/fraud/docs/alertsandbulletins/2004/FA033104AssignViolationI.pdf ■

Medicare Web Site Causes Frustration — Prepare for Patient Questions

The Center for Medicare & Medicaid's new Web site launched on Friday, April 30, 2004 to help Medicare beneficiaries sort through information on close to 60,000 drug products and 50,000 pharmacies received negative reviews from seniors. *The Los Angeles Times* reports seniors who are unfamiliar with computers and some patients found that the prices posted on the Web site are not lower than those at local or mail order pharmacies. Families USA, a healthcare watchdog group, says that drug prices for 50 prescription drugs used most frequently by seniors rose 6 percent in 2002 — more than three times the rate of inflation that year.

Drug card sponsors feel some prices on the site were too low or too high and they don't reflect all rebates and discounts under the drug card program.

Health and Human Services spokesperson Bill Pearce encouraged beneficiaries to shop around for the best discounts. He said prices are expected to drop over time as sponsors rework pricing data and compete for customers.

Currently, the government has approved 72 drug cards. Medicare beneficiaries are being encouraged to choose the option that best suits their needs based on their medical conditions and the drugs they take. These beneficiaries will likely turn to you for advice about how to make that decision.

You can print out copies of the enrollment forms for patients from Medicare's Web Site. You can also point patients to the Centers for Medicare & Medicaid Services for help. Beneficiaries can get information on the drug cards available in their area by calling the agency's 1-800-MEDICARE hotline or by logging onto the program's Web site http://www.medicare.gov/default.asp

The Web site also offers background information on the Medicare Prescription Drug Improvement and Modernization Act of 2003. In the meantime, be prepared to answer some of the following patient questions:

Q: When do Medicare drug card discounts begin?

A: June 1, 2004

Q: How many Medicare drug cards can beneficiaries enroll in?

A: Only one card each year.

Q: How much can card issuers charge per year?

A: Card issuers can charge an annual fee of up to $30. Some cards have no fee. Different cards will offer different prices, so beneficiaries should consider their options.

Q: When are discounts applied through retail or mail-order pharmacies?

A: At the time of purchase.

Q: What sort of credit is available to low-income Medicare families using a drug card?

A: A $600-per-year credit.

Q: Can generics save money?

A: The Center for Medicare & Medicaid Services information may suggest a switch to generic or brand-name alternatives to save money. ■

Workers' Compensation Group Rating

Ohio Physicians, as well as all Ohio employers, received quite a shock as they reviewed their monumental increases in workers' compensation premiums over the last year. The Bureau of Workers' Compensation has indicated they no longer have the monetary surplus to continue to offer the level of dividend credits, once as high as 75%. Needless to say, this has created a serious financial impact for physicians across Ohio.

With higher premiums looming, group rating becomes crucial for every business owner. As an advocate of business, The Academy of Medicine in Cleveland/NOMA has partnered with CompManagement, Inc. (CMI) to help you minimize costs through the largest Group Rating Program Administrator in Ohio.

You can take measures to protect your company against the eminent increases in workers' compensation premiums. There is no cost or obligation to receive a group rating review, which will determine if your company is eligible. When you receive solicitations from other group rating plans, do not confuse these requests with quotes from The Academy of Medicine of Cleveland and CompManagement. Information concerning our plan will be on AMC/NOMA or CompManagement letterhead. Should you have any questions concerning your quote, please contact the CMI Group Rating Department at 1-880-825-6755. ■

Stark II Breaks Out Of The Gate

by Amy Leopard Woodhall Walter & Haverfield LLP aleopard@walterhav.com

This article provides general information in summary form with the understanding that it does not constitute individual legal advice. If legal advice is required, the services of competent professional counsel should be sought.

The Centers for Medicare and Medicaid Services (CMS) recently published Phase II of the final Stark Rules on prohibited physician referrals to become effective July 26, 2004. The Phase II rule clarifies how the Stark Law applies to direct and indirect compensation arrangements with referring physicians and physician ownership interests in entities that bill Medicare, providing planning opportunities and challenges for hospitals, physicians, and group practices.

The Stark II Law prohibits a physician referral to an entity for certain "designated health services" covered by Medicare if the referring physician (or an immediate family member) has a financial relationship with the entity, unless an exception applies. Entities cannot bill for services furnished pursuant to a prohibited referral and may be subject to civil monetary penalties and exclusion from Medicare and Medicaid.

Properly structuring physician compensation and ownership has always been an intricate undertaking under the Stark II Law, but the Phase II rule provides greater specificity and predictability. The Phase II rule alleviates many ambiguities in the Stark Law and demonstrates how CMS' administrative interpretation of the statute has evolved.

For example, the Phase II rule expressly implements Congress' intent that traditional group practices may bonus their employees and independent contractor physicians based directly on services they personally perform as well as services that are "incident to" those personally performed services. Medical groups should retain supporting documentation to verify the methods used to calculate productivity bonuses because the Phase II rule allows CMS to obtain that information on request.

For in-office ancillaries furnished at the same street address where physicians routinely provide their full range of services, the Phase II rule provides group practices and solo physicians a choice among three new tests to determine the minimum number of hours per week that the office is open and physicians' availability at the office. If the tests are not met, designated health services that a group practice bills to Medicare must be provided in a space that is owned or leased on a full-time, exclusive basis (i.e., no offsite block leases) before July 26, 2004.

Most "per-click" leases and unit of service and percentage compensation arrangements for services performed by independent contractor physicians can comply with the Stark II conditions if the amount is fair market value for the services actually provided, does not vary during the course of the agreement to account for referrals of designated health services, and is established in sufficient detail in advance. Compensation that is not comparable to similar arrangements where there are no referrals continues to be problematic, but Phase II establishes fair market value safe harbors intended to be conclusive for hourly compensation.

Physician recruitment arrangements involving hospitals and group practices have been narrowed due to a perceived potential for abuse and may need to be restructured or meet another exception. This area is ripe for comment and further study by CMS due to the new requirement that only actual incremental costs attributable to the recruited physician be recognized for hospital guarantees.

The Phase II rule retains the indirect compensation analysis and exception established in Phase I to cover many indirect financial relationships between the entity billing Medicare and the referring physician. The Phase II rule further clarifies and streamlines many legitimate transactions, potentially invigorating the long dormant enforcement by CMS and reinvigorating private parties seeking remedies as a qui tam relator.

Now is a good time to review physician compensation arrangements to identify how they may be affected, restructure them if necessary, and establish compliance documentation. Most Stark exceptions will continue to require a written agreement unless the physician is an employee. Several Stark exceptions still require compliance with the anti-kickback statute and Medicare claims submission, necessitating internal compliance documentation. Entities that bill Medicare should retain information on physician ownership and compensation arrangements, including the name and UPIN number and the nature of the financial relationship, and must provide that information to CMS and the HHS Office of Inspector General OIG within thirty (30) days of receiving such a request. Prudence also dictates that physician compensation be carefully structured and documented to comply with express conditions in the final rule.

STARK PHASE II HIGHLIGHTS:

- Specialty Hospital Ownership Moratorium
- Streamlined Academic Medical Center Exception for Teaching Hospitals
- Community-wide Health Information Systems
- Installment Payments for Isolated Transactions
- Professional Courtesy Arrangements
- OB Malpractice Subsidies
- Physician Retention Payments
- Revised Recruitment Package Requirements
- Charitable Contributions from Physicians
- Fair Market Value Safe Harbors
- Termination without Cause
- Inadvertent or Temporary Noncompliance

Amy Leopard Woodhall is a partner at Walter & Haverfield LLP advising healthcare clients on strategic corporate and regulatory issues, reimbursement matters, compliance and government investigations. She is the Chair of the Health Law Committee of the Ohio State Bar Association and teaches health law as an Adjunct Associate Professor at Case Western Reserve University. ■

IN BRIEF

Ohio Chamber of Commerce Endorses Moyer, O'Donnell and Lanzinger

Ohio Chamber of Commerce announces endorsement of three candidates for Ohio Supreme Court. The political action committee of the Ohio Chamber of Commerce announced its endorsement of Chief Justice Moyer for election to a fourth term, and for the election of appointed Justice Terrence O'Donnell and Appellate Judge Judith Lanzinger.

The Chamber is of the opinion that the elections of these three judges will secure for all Ohioans a fair and balanced Supreme Court. As noted in previous AMC/NOMA publications, Justice O'Donnell faces opposition in the fall election from Appellate Judge William O'Neill, while Judge Nancy Fuerst of Cuyahoga County Common Pleas Court opposes Judge Lanzinger.

The November 2 election marks only the fourth time in the last 54 years that a majority of the seven-member court will be chosen at one time. Four seats on the court also were filled in the general elections of 1950, 1964, and 1970.

Note: The AMC/NOMA political action committee — NOMPAC has already announced its endorsement of Chief Justice Moyer and the election of appointed Justice Terrence O'Donnell and Appellate Judge Judith Lanzinger.

Medical Malpractice Payouts are on the Rise

The Physician Insurers Association of America's latest report indicates that about 8% of all claims payments in medical liability lawsuits today exceed $1 million. That is double the percentage of claims of a million dollars or more made in 1978. The report also noted that the average payment climbed to $328,000, an increase from $200,000 in 1996. Only 25% of all malpractice claims last year included an indemnity payment for insurers and only 1% of the 8,000 cases studied by the PIAA resulted in a verdict for the plaintiff against a doctor. PIAA spokesman are of the opinion that these statistics show that the cost of insurance for doctors cannot be limited until Congress imposes caps on noneconomic damages in malpractice lawsuits.

Senators Asking for a Change in the Sustainable Growth Rate Formula

Physician payments are likely to decline by 40% from 2005 to 2014 unless Congress or the CMS acts to change the formula Medicare uses to calculate annual adjustments. That's the prediction made in a letter sent to CMS Administrator Mark McClellan by Senate Finance Committee Chairman Charles Grassley (R-Iowa) and ranking member Max Baucus (D-Mont.). Under the SGR, physician rates are adjusted up or down annually to meet an established target for spending on physician services. Last year's Medicare reform law gave physicians a 1.5% payment increase in 2004 and 2005, averting a scheduled decrease for those years under the SGR. The General Accounting Office has said that without changes to the SGR, it is likely that physicians will experience annual pay cuts of about 5% for seven consecutive years starting in 2006.

Medical Malpractice Insurance Update: The Doctors' Company, GE MedicalPro, OHIC and OHIC's parent company, MLMIC, All Downgraded

The Academy of Medicine/Northern Ohio Medical Association (AMC/NOMA) was recently notified by the Premium Group that A.M. Best downgraded a number of medical malpractice insurance companies including:

- The Doctors' Company (based in Napa, CA) downgraded to "B++" Very Good, from "A-" Excellent. This rating is still considered "secure" according to A.M. Best.
- GE Medical Protective downgraded to "A-" Excellent from "A" Excellent and the A.M. Best outlook is stable. A.M. Best confirmed the financial rating of "A" Excellent, with a stable outlook, of parent company GE Employers Reinsurance.
- OHIC Insurance Company was downgraded to "C++" Marginal from "B" Fair and parent company MLMIC to "B-" Fair from "B" Fair. ■

PATIENT WELLNESS

Managing Normal Pressure Hydrocephalus in the Elderly

Mark Luciano, M.D., Ph.D., Head, Section of Pediatric and Congenital Neurosurgery, The Cleveland Clinic

Normal pressure hydrocephalus (NPH) is an adult form of chronic hydrocephalus which, when left untreated, results in progressive neurological deterioration in elderly patients. While occurring in only a minority of the large number of elderly patients with slowing gait and cognition, diagnosis is key, as failure to identify and treat NPH results in definitive decrease in the quality of life of this elderly population.

Enlarged cerebral ventricles and relatively normal ICP seen in NPH are actually similar to that seen in any chronic hydrocephalus. Although definition of NPH is typically limited to the adult or elderly patient, NPH may be best considered and termed "adult chronic hydrocephalus."

The precise pathogenesis of NPH is unknown. Ventricular expansions requires an imbalance between the expanding force vectors in the cerebral ventricles and those opposing in the brain parenchyma. Increased resistance of CSF resorption results in an increased force within the ventricle. Exact etiology and location of this resistance is often not known and may often vary among individuals.

The clinical diagnosis of NPH is based upon the triad of symptoms:

- gait imbalance – typically shuffling or apraxic in nature
- cognitive dysfunction – considered to be a subcortical dementia, as compared to Alzheimer's dementia which is cortical
- urinary incontinence – though the least specific, incontinence can significantly be improved with shunting

The hallmark of NPH is enlarged cerebral ventricles. While there is no precise criteria for degrees of enlargement, especially in the elderly population where progressive thinning results in some ventricular enlargement, an Evans Index (ventricular width on axial CT or MRI at the level of the foramen of Monro per brain width at that same level) of >0.3 is indicative of hydrocephalus (Figure 1A).

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Distinguishing hydrocephalus from ventriculomegaly, which is "ex vacuo" due to cerebral atrophy, is the most frequent concern. While an increase in hemispheric sulcal and subarachnoid fluid space commensurate with ventricular expansion may suggest gyral thinning due to atrophy, this interpretation may exclude some patients with NPH. Sulcal enlargement, especially focal, can be seen in NPH and may decrease with (S)CSF shunting. In addition, the presence of cortical atrophy does not eliminate the possibility of hydrocephalus (Figure 1B). Other general signs of hydrocephalus such as gyral effacement against the skull and transependymal edema are more often seen with acute hydrocephalus and are not reliably observed in the chronic form (Figure 1C).

Medical treatment has not traditionally been successful in the treatment of hydrocephalus or for NPH. CSF shunting through an implanted catheter and valve system has been the mainstay in the treatment of hydrocephalus for the last four decades. Identifying patients with NPH who might benefit from surgical treatment can be facilitated through special testing such as lumbar catheter drainage trials and functional testing, often performed in a 2-3 day in-hospital stay. And while shunting has remained the same in principle, improvements in the method of implantation and the systems utilized, which result in better outcomes and fewer complications. Most recently, neuroendoscopic third ventriculostomy, a surgical treatment not requiring an implant, has been used in limited cases, especially for NPH of the obstructive type.

Following shunting, an improvement in gait is the most frequently experienced, or most outwardly identifiable, outcome. Patients also report improvement in cognition, memory and alertness. Urological incontinence often significantly improves with shunting. The reported rate of clinical improvement in gait, cognition and urinary incontinence can vary from 25% to 90%. Over 90% of Cleveland Clinic patients have reported improvement by three months after shunting.

Key to ensuring a successful outcome is continuing medical and surgical follow-up, especially to maintain the shunt or to adjust drainage over time. With improvements in patient screening, surgical techniques, shunt devices and patient follow-up, more patients can be helped with an acceptable risk-benefit ratio.

For more information, please contact Mark Luciano, M.D., Ph.D., at (216) 444-5747. ■

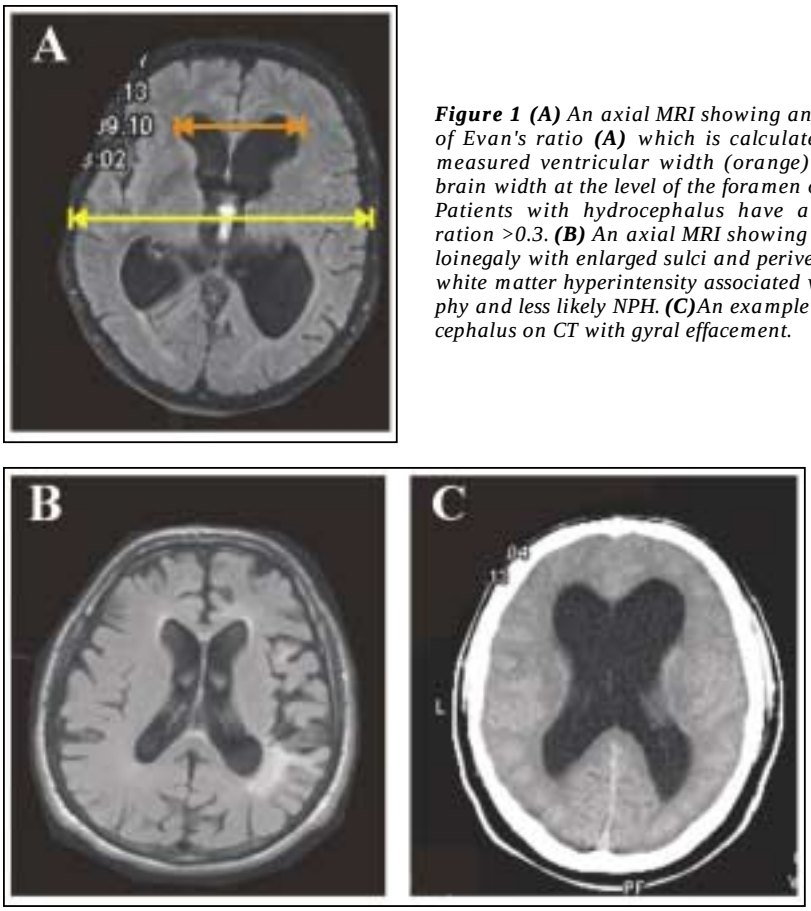
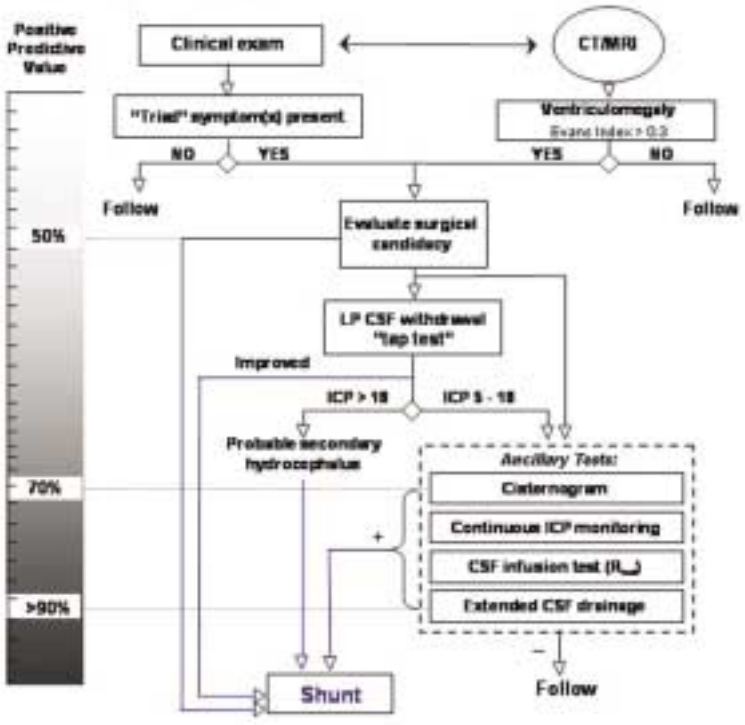


Figure 1 (A) *An axial MRI showing an example of Evan's ratio* ***(A)*** *which is calculated as the measured ventricular width (orange) over the brain width at the level of the foramen of Monro. Patients with hydrocephalus have an Evan's ration >0.3.* ***(B)*** *An axial MRI showing ventriculoinegaly with enlarged sulci and periventricular white matter hyperintensity associated with atrophy and less likely NPH.* ***(C)*****An example of hydrocephalus on CT with gyral effacement.**

Management of Normal Pressure Hydrocephalus



Representative Earl Martin responds to questions from members of the legislative committee. From l to r – ***Dr. Ronald L. Price, Dr. John A. Bastulli,*** *Representative Martin, Carolyn Towner, AMC/NOMA lobbyist;* ***Dr. Richard Ludgin*** *and Dr. Satish Maha.*

House Representative Earl Martin attended the AMC/NOMA legislative committee meeting in June 2004. Rep. Martin wants to get to know the physicians in the community. He is in his first term and was appointed to fill the term of former Representative Jeff Manning. He serves on various committees. Among those important to physicians are the Health and Family Services Committee and the House Insurance Committee, in which he is the vice chair. His district encompasses Avon Lake, Avon, North Ridgeville, most of Elyria as well as Columbia, Eaton and Carlisle Townships.

As a businessman, he's concerned if Ohio continues to lose doctors — how is government going to lure businesses to the state? He's also concerned about the overall impact on the community and how this ultimately affects residents and patients alike. He agrees we need to stop what is happening in society today with regard to frivolous lawsuits. He feels everyone in Ohio is paying the price for these suits with higher premiums and increased costs.

Rep. Martin indicated he would be willing to work with the AMC/NOMA in the future on healthcare related legislation. ■

Voter's Guide 2004

The AMC/NOMA is currently updating a voting guide of issues and candidates for the upcoming election on Tuesday, November 2, 2004 is an election year for members of the Ohio House of Representatives, one-half of the Ohio Senators (odd numbered districts), all Congress persons, all Statewide office holders, four Supreme Court Justice seats and the presidency.

This publication will be available to physician members only. More information will be posted in the September/October issue of the *Cleveland Physician.* ■

Medical Liability crisis continues – AMC/NOMA is at the forefront providing information to the public and physicians

The AMC/NOMA has been working hard to bring this issue to the public and raise awareness regarding the seriousness of the crisis we face.

Healthlines, the Academy's radio program on WCLV 104.9 FM, will air a two part series on the medical liability issue this fall — topics will include pending legislative issues, the Ohio Constitution, and the upcoming legislative races. Healthlines airs on Mondays Wednesdays & Fridays every other week at 5:45 pm. ■

AMC/NOMA educating public on the medical liability crisis

Both the AMC/NOMA president, **William H. Seitz, Jr., M.D.** and the AMC/NOMA Vice President of Legislative Affairs, **Dr. John Bastulli** were guests on the radio program "Healthcare Cost Crisis" with Alan Thompson on WERE 1300-AM on the matter of the medical liability crisis across northeastern Ohio. Dr. Bastulli addressed several factors relating to how this situation developed, why it is worsening and the Academy's sustained grassroots efforts with regard to the medical liability crisis. Dr. Bastulli emphasized the need to maintain the current balance in the Ohio Supreme Court as a means to alleviate the burden of rising medical malpractice premiums. (see page 8).

Detailed information on medical liability can be found on our Web site at www.amcnoma.org or by calling the Academy at (216) 520-1000, extension 321. ■

EYE ON THE STATEHOUSE @ www.amcnoma.org
AMC/NOMA members can access our Legislation Action Center to:
- Monitor progress of House & Senate bills
- Contact legislators by mail, e-mail, fax or telephone on issues that are of importance to you ■

Fundraisers held in NE Ohio by physician leadership for Justice O'Donnell and Chief Justice Moyer

A fundraiser was held in support of Justice Terrence O'Donnell at the home of Dr. John Clough on Wednesday, June 2nd. Another fundraiser was held in support of Chief Justice Thomas Moyer at the home of Dr. John Bastulli on Monday, June 28th. Both events were well-attended by AMC/NOMA leadership and members. Both Justice O'Donnell and Chief Justice Moyer briefly addressed those gathered with regard to their judicial philosophy, as well as thanking the attendees for their support. ■

Dr. Richard Ludgin *greets Justice Terrence O'Donnell at the June 2nd fundraiser.*

Justice O'Donnell chats with Mr. Philip Moshier of Sagemark Consulting and AMC/NOMA president ***Dr. William H. Seitz, Jr.***

Chief Justice Moyer talks to AMC/NOMA member ***Dr. William Bohl.***

Justice O'Donnell talks about his judicial philosophy with AMC/NOMA past president ***Dr. Kevin T. Geraci.***

From l to r – ***Dr. John A. Bastulli,*** *Justice O'Donnell and* ***Dr. John Clough*** *at the June 2nd fundraiser.*

In addition to the physicians attending the fundraiser, two state legislators were also in attendance. From l to r – Chief Justice Moyer, AMC/NOMA President, ***Dr. William H. Seitz, Jr.;*** *Representatives James P. Trakas and Tom Patton.*