Despite physician-patient privilege, subpoenas may require disclosure

By Todd C. Berg, Esq.

The question on some doctors’ minds when it comes to the inviolability of the physician-patient privilege is whether they’re more like psychologists than dentists. In a pair of published opinions — one from early March and one from 2007 — the Michigan Court of Appeals held the attorney general’s investigative subpoenas for patient information couldn’t overcome the psychologist-patient privilege, but could defeat the dentist-patient privilege.

In both cases, the attorney general acted on behalf of the Michigan Department of Community Health, which was investigating the health professionals in question for alleged billing and insurance fraud. (See “Privilege versus subpoenas,” page 13.)

Health care law specialists say doctors have good reason to be concerned because the wording of the physician-patient privilege statute is similar to that of the dentist-patient privilege statute. But the lawyer who represents the Michigan State Medical Society said there’s enough difference between the two statutes that, unless a law specifically requires disclosure, the physician-patient privilege should withstand a subpoena challenge. (See “Three different standards,” page 13.)

Detroit attorney Gregory D. Drutchas of Kitch Drutchas Wagener Valitutti & Sherbrook, who regularly represents health care providers, said the “substantially different” language in the physician and psychologist statutes will likely compel different outcomes when it comes to honoring the respective privileges.

Whereas the psychologist’s

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The Health Lawyers

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ph 248-544-0888  fx 248-544-3111
www.wachler.com
Effective Jan. 1, 2009, the new Leadership Standard 10.03.01.01 provides, in pertinent part, that:

- The hospital has a code of conduct that defines acceptable, disruptive and inappropriate behaviors.
- Leaders create and implement a process for managing disruptive and inappropriate behaviors.
- The hospital has a code of conduct that defines acceptable, disruptive and inappropriate behaviors.
- Leaders create and implement a process for managing disruptive and inappropriate behaviors.
- Writing of malicious, arbitrary, derogatory comments that go beyond the bounds of fair professional conduct.
- Inappropriate expressions of anger such as destruction of property or throwing items.
- Abusive language or behavior directed at the recipient in such a way as to ridicule, humiliate, intimidate, undermine confidence, or belittle.
- Derogatory comments that go beyond difference of opinion that are made to patients or patient's families about caregivers (this is not intended to prohibit comments that deal constructively with the care given).
- Intellectual property rights to the hospital.
- Rights of physicians, the Joint Commission also has recommended physician conduct policies that address concepts that address intimidating physician disruptive behavior; it is not intended to prohibit comments that deal constructively with the care given.
- Intellectual property rights to the hospital.
- Rights of physicians, the Joint Commission also has recommended physician conduct policies that address...
Additional Funding Provisions

The American Recovery and Reinvestment Act of 2009 contains many provisions that provide substantial funding to the health care industry outside of health information technology. For example, there is an increase in general Medicaid funding through raising Federal Medical Assistance Percentages (FMAP) for all states by 6.2 percent. The Act also provides an additional FMAP bump if a state has a relatively large rise in unemployment. Also, the Act provides a ground floor for all states’ FMAP until 2011. It provides that, during that time, a state’s FMAP will not drop below its highest FMAP in any of the years from 2008 to 2011.

Other funding provisions include:

- An additional $1.1 billion for Comparative Effectiveness Research.
- $1.5 billion for construction, renovation, and equipment for community health centers.
- $500 million to train primary health care providers.
- Assistance for medical school expenses for students who agree to practice in underserved communities through the National Health Service Corps.
- $10 billion in funding for National Institutes of Health for new research grants and renovation and construction of buildings, which is one of the Act’s largest provisions.

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Economic stimulus package to have far-reaching impact on health care

The way health care is provided in the United States will be changed by the $787 billion American Recovery and Reinvestment Act of 2009 that is designed to have a substantial and direct effect on the health care industry. Many provisions of the Act, Division A Title XIII and Division B Titles IV, comprise the Health Information Technology for Economic and Clinical Health Act (HITECH Act). These provisions establish the Office of the National Coordinator for Health Information Technology (ONCHIT).

Although the ONCHIT was originally created by President George W. Bush through a 2004 executive order, the HITECH Act codifies the establishment of that office within the Department of Health and Human Services (HHS).

Focus largely on adding electronic users

One of the goals of the ONCHIT is to further develop nationwide health information technology (HIT), which will allow the electronic use and exchange of certified electronic health records (EHR), and will be developed and encouraged through grants to states, thereby funding loans to providers to develop health information technology.

HITECH also is encouraged by Medicare and Medicaid incentives. Importantly, the HITECH Act provides monetary incentives for eligible professionals and hospitals who become meaningful users of EHRs over the next five years.

The Act does not provide an exact definition of meaningful users, but sets forth the following criteria for eligible professionals to be considered a meaningful user: make meaningful use of certified EHR to the satisfaction of the HHS secretary (including the use of electronic prescribing); use certified EHR to report on certain quality measures — if the secretary has set the transition factor that reduces the annual incentive payment calculated as the product of a $2 million base amount plus an annual incentive payment calculated as the product of a $18,000 for the first year of meaningful use of EHR.

The maximum amount of the annual incentives decreases in subsequent years: $12,000, $8,000, $4,000, and $2,000, respectively.

Eligible professionals in a designated health profession eligibility area are also entitled to a 10 percent increase in the annual payments.

Business of Medicine

By Louis C. Sura

Louis C. Sura, a 2003 graduate of Cornell Law School, is an associate at Frank, Hayros, and Nicasco, PLLC. He recently joined the firm after being licensed to practice in Illinois and Ohio. His practice focuses in health care transactions, planning complex commercial litigation, health care law, and the meaningful use of electronic health records (EHR). He can be reached at (248) 952-0400 or lcsura@frankhayros.com.

The Medicare incentives start phasing out if the first year of meaningful use begins after 2013 and the incentive is completely phased out if the first year of meaningful use is after 2014.

These provisions are designed to encourage eligible physicians to adopt EHR sooner rather than later. Regardless, as of 2016, the Medicare incentives expire for all eligible professionals.

In addition to the Medicare payment incentives, the HITECH Act also provides for Medicare payment penalties against qualified physicians who do not become meaningful users of EHR after 2015. Eligible professionals who provide covered professional services in 2015 and following years, but who are not meaningful users, will see a percentage reduction in their Medicare fee for services.

There will be a 1 percent reduction in 2015, 2 percent in 2016, and so on through 2017 and subsequent years. In addition, after 2015, the secretary may determine if less than 75 percent of qualified professionals are meaningful users of EHR, and may impose a penalty equal to 1 percent of the Medicare fee for services.

The secretary also may, however, exempt eligible professionals from the penalty provisions, on a case-by-case basis, because of significant hardships, such as service in a rural area without sufficient Internet access.

Medicare incentives also are available for eligible hospitals that are meaningful users of EHR.

If a hospital demonstrates that it is a meaningful user, then it is eligible for an annual incentive payment calculated as the product of a $2 million base amount plus any possible additional amounts per patient discharge, a Medicare share percentage based on the proportion of in-patient beds, and a transition factor that reduces the annual incentive each year by 25 percent.

The Medicare incentives for eligible hospitals also are limited by phase-out provisions similar to the incentives for eligible professionals. Eligible hospitals that are meaningful users after 2013 may receive incentives payments according to the transition factor as if their first payment year is 2013.

Hospitals that become meaningful EHR users after 2015 are subject to 25 percent reduction in the hospital’s market basket update used to update payments and cost limits for Medicare.

The HITECH Act also encourages the use of EHR by funding additional financial incentives for qualified Medicaid providers. Notably, eligible professionals are not allowed to receive both the Medicare and Medicaid incentives. There is no such restriction on Medicaid hospitals that also are Medicaid providers.

Subsidizing COBRA premiums

The Act also aims to increase the number of individuals with temporary health insurance coverage by providing a 65 percent subsidy for terminated employees’ COBRA premiums. The subsidy provides for former employees to pay 35 percent, and their employers to pay payroll tax credits for the remaining 65 percent of COBRA premium payments.

The COBRA subsidy will last up to nine months and will apply to workers who have been involuntarily terminated between Sept. 1, 2009, and Dec. 31, 2009.

The incentives start March 1, 2009, and is generally available for individuals who have a modified adjusted gross income below $145,000 ($290,000 for joint filers). In addition, a portion of the premium subsidy must be repaid if the individual has a modified adjusted gross income between $125,000 and $145,000 ($250,000 and $290,000 for joint filers).

The scope of the Act is enormous and showcases the importance of the health care industry to our economy. Hopefully, these provisions will provide a big boost for the health care industry and the entire country.
Drug-injury victims now can sue pharmaceutical companies everywhere but in Michigan

By Carol Lundberg

The U.S. Supreme Court’s Wyeth v. Levine decision gives no help at all to Michigan lawyers and clients seeking to sue pharmaceutical companies for injuries caused by drugs approved by the Federal Food and Drug Administration.

That’s because Michigan is the only state that has a law with walls that give vast immunity to drug manufacturers.

And although some plaintiffs attorneys and Democratic lawmakers are pushing to repeal that immunity, there is no sign the Republican majority in the state Senate is backing away from its manufacturers.

Companies for injuries caused by seeking to sue pharmaceutical v. Levine place where its educational activity or students in attendance at a curriculum and normally has a residents must have been ‘candidated’ for qualified tuition and related expenses.' Detroit Medical Center provided by the Detroit Medical Center ly determined that “stipends” pro-

The Supreme Court’s 6-3 opinion states that federal oversight of drug does not prevent state level consumer liability suits. However, in Michigan, people cannot sue if they are injured as the result of using drugs that have passed the FDA’s standards.

Those who file for the status quo say Michigan’s immunity laws will help persuade pharmaceutical companies to invest here. Those who oppose the laws point out that immunity laws are lowering the number of pharmaceutical companies from leaving Michigan, and the laws hurt other industries injured by FDA-approved drugs.

Clients have nowhere to turn As much as he was thrilled by the Supreme Court’s decision, Mark Bernstein, a Farmington Hills lawyer with The Bernstein Law Firm, said he is frustrated by Michigan’s drug-immunity laws.

Bernstein said every week, he turns away dozens of potential clients who claim injury as a result of pharmaceuticals, while his friends and peers in other states are pursuing cases against a long list of drugs, including Accutane, Baycol, Prempro and Paxil.

David Mittelman, of Lansing-based Church Wyble PC, is frustrated as well.

“The state attorney general for the most part has done a good job in Michigan, but with regard to this law, he says Michiganans can go to other states to file a complaint against a drug company,” Mittelman said. “That’s simply not true in most cases. Most judges send it to federal courts, which apply Michigan laws, and kick it out.”

Mittleman said that since Pfister left Michigan in 2008, the pharmaceutical industry in Michigan is nearly nonexistent, as keeping laws that heavily favor the indus-

“Immunity did nothing to keep the companies to move here. Those who oppose the laws point out that those already injured and their survivors.

People are simply not allowed to file in Ohio,” Bernstein said. “It’s not far-fetched, and that’s where they live, they would have a case. They’d be able to file in Ohio,” Bernstein said. “It’s impossible to explain the reason because it’s a complete injustice.”

Changes coming? The Wyeth decision could be the catalyst to change the law. “Wyeth has turned the tide,” said Jill Wheaton, Dykema. “It may result in fewer findings of pre-emptions and may result in legislative changes at the federal and state level. This may cause the Michigan Legislature to look again.”

Wheaton said she disagrees with the Supreme Court’s ruling. She said she thinks drug makers will keep blocking the protection of Michigan residents, “That’s simply not true in most cases. Most judges send it to federal courts, which apply Michigan laws, and kick it out.”

Mittleman said that since Pfister left Michigan in 2008, the pharmaceutical industry in Michigan is nearly nonexistent, as keeping laws that heavily favor the industry while penalizing residents is ‘asinine.’

“The biotech companies are not knocking down the doors to seats in Michigan,” Bernstein said. “The only ones who knocked got run over by Pfizer on its way out.”

Not only the injured suffer as a result of the state laws, Bernstein said, adding that the state is losing out on revenue. If Michigan had participated in just the Vioxx case at the same level of similar size did, the economic effect would have been substantial.

“We would have had 1,650 cases in Michigan. That’s just for Vioxx,” Bernstein said. “The Vioxx settlement that Bernstein’s took only a handful of cases, filed in New Jersey, where Vioxx is manufac-

tured. The state of New Jersey allocated $822 million to continue battling business for the Michigan Legislature to look again.”

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The human toll is harder to cal-

culated, Bernstein said.

“The most troublesome part of this is that you talk to someone from Monroe, and you have to tell them that if they lived 10 miles south of where they live, they would have a case. They’d be able to file in Ohio,” Bernstein said. “It’s impossible to explain the reason because it’s a complete injustice.”

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"The most troublesome part of this is that you talk to someone from Monroe, and you have to tell them that if they lived 10 miles south of where they live, they would have a case."— Mark Bernstein, The Bernstein Law Firm
The Health Insurance Portability and Accountability Act (HIPAA) was enacted by Congress in 1996 and, in part, regulates the use or disclosure of "protected health information," which is data that contains medical information.

The act provides for at least a "reasonable basis" to determine that the information can be used to individually identify a patient and has been treated or maintained in any medium. HIPAA laws apply only to covered health entities, which include health care providers (such as physicians and hospitals), health care plans, and health care clearinghouses. Plans for a federally operated health records centralization service is in the works. The Department of Health and Human Services (HHS), through the division of Health Information Technology, has launched plans to create a nationwide system known as Nationwide Health Information Network (NHIN). However, the program is still in its prototype and trial stage.

Privacy law/HIPAA considerations for physicians and patients

As with any Web-based service, the primary concern of PHR users will undoubtedly be that their private information may be spilled onto the Web, either by hackers, software loopholes or careless usage.

While the Stimulus Bill requires HHS to launch a "national education initiative" to educate patients on privacy laws, physicians need to familiarize themselves on the use of PHR vendors, and keep patients informed of how their information may be used to avoid trouble — whether in the form of HIPAA violations or upset patients.

Physicians should make sure patients understand the benefits and risks of using a PHR vendor. A good place to start might be to instruct patients to carefully read the contractual terms of services and privacy policy of the vendor. Not only does this explain how a patient's information is stored and secured (through use of encryption, firewalls, etc.), it also sets out the limitations of a vendor; for example, if a patient chooses to share access to their PHR with a family member or physician.

Patients should understand fully the levels of authorization that third parties may have to their records, such as "read-only," "write-only" or full unlimited access. Because of the shared nature of PHR systems, physicians should make sure patients are comfortable with restricting/allowing family access to PHI and understand the repercussions. For example, a 16-year-old patient who requests that her pediatrician prescribe her birth control may not want this information available to her parents.

Security umbrella expanded to include business associates

With PHR vendors newly classified as business associates, physicians, as covered entities, must enter into valid business associate contracts with vendors like Google Health and HealthVault.

These contracts must require vendors to implement appropriate administrative and safeguards, among other provisions. In addition to these contracts, under the Stimulus Bill, physicians have their own duty to mitigate damages in the event of a security breach where personal health information is accidentally disseminated.

Specifically, covered entities such as physicians are required to notify both individual affected by the breach. If the covered entity does not have contact information for the affected individual, they may be required to post notice of the breach on its Web site, in newspaper or on television.

For large breaches involving more than 500 residents in a particular area, a "prominent media outlet" must be notified of the breach, as well as the U.S. Department of Health and Human Services. (Note, however, that there is an exception for certain unintentional breaches.)

In addition to avoiding these cumbersome notice requirements, physicians would be well-advised to carefully heed privacy laws in light of the Stimulus Bill new penalties. The penalty for a HIPAA breach is generally $110 for each violation with a cap at $25,000. Under the new rules, penalties can range from $10,000 to $1.5 million per calendar year, depending on the nature of the security breach. These new penalties take effect immediately.

Because the widespread use of EHR and PHR vendors is in its infancy, there are many potential legal and ethical considerations not addressed here. While such technologies provide opportunities to reduce paperwork and costs, physicians should be mindful of the possible liabilities and seek guidance on such issues when appropriate.
Medicare providers and suppliers targeted for prepayment medical review understand the financial burden that review of records poses to payment plans on a medical practice.

Prior to the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (MMA), a provider or supplier subject to non-random prepayment complex medical review remained on this targeted review until it met all Medicare billing requirements and demonstrated an “acceptable error rate.”

The Medicare contractor was given the discretion to determine when the provider or supplier achieved an “acceptable error rate,” resulting in providers and suppliers being subject to lengthy review.

In hearing news for providers and suppliers impacted by medical review that believed no end was in sight, the Centers for Medicare and Medicaid Services (CMS) recently published a final rule addressing termination of non-random prepayment complex medical review. The rule became effective Jan. 1, 2009 (73 Fed. Reg. 55753). See also 42 C.F.R. §421.501 et seq.

The final rule mandates that, in most cases and unless an exception applies, CMS will terminate a provider or supplier from review no later than one year from the initiation of the review, or when the provider’s or supplier’s error rate decreases by 70 percent from the initial error rate.

The final rule implements Section 934 of the MMA, which required CMS to establish termination dates for medical reviews performed by Medicare Administrative Contractors (MACs), or performed by intermediaries and carriers until MACs are in place. CMS will impose the same limitations on medical reviews performed by program safeguard contractors, to ensure that consistent criteria for terminating non-random prepayment review are applied to all providers and suppliers.

Significantly, in addition to the one-year time limit and 70 percent error rate reduction

Medicare contractors focus medical review activities on providers and suppliers they believe pose the greatest risk to the Medicare Trust Funds. Medicare contractors have discretion to determine what constitutes a “sustained or high level of payment error,” but some examples include the following:

- Unusual billing patterns, including inexplicable increases in the volume of claims submitted.
- Billing errors, including a significant billing error rate or errors on claims with a high dollar value.
- Once a Medicare provider or supplier has been chosen for non-random prepayment complex medical review, the provider or supplier must submit medical records to the Medicare contractor for review before payment will be made.

A licensed medical professional will review the medical records to the Medicare contractor for review. The reviewer must use National Coverage Determinations (NCDs) and Local Coverage Decisions (LCDs) to determine whether an item or service is covered and is reasonable and medically necessary.

The Medicare contractor is mandated to consider continuation of the review, if the Medicare contractor suspects possible fraud, then the contractor must conduct another medical review, if it wishes to reinitiate a review. If, at any time during medical review, the Medicare contractor is authorized to extend review can be extended. Specifically, a Medicare contractor is authorized to extend its review under the following circumstances:

- If the provider or supplier fails to respond to requests for medical records.
- If the provider or supplier shifts billing to another inappropriate code.
- If the provider or supplier fails to respond to requests for medical records.

At the conclusion of the one-year timeframe for review, if the Medicare contractor determines that the provider or supplier continues to have a high error rate, the Medicare contractor is mandated to consider the following:

- Referring the provider or supplier to Benefit Integrity Review.
- Continuing educational interventions (without performing further medical review).
- Initiating a post-payment audit.

In some cases, the one-year time limit for non-random prepayment complex medical review can be extended. Specifically, a Medicare contractor is authorized to extend the one-year limit in situations where a provider or supplier takes steps to alter its billing practices to avoid contractor review. For example, the Medicare contractor may extend its review under the following circumstances, among others:

- If a reduced error rate is the result of a reduced number of claims submitted under a specific billing number (i.e., 25 percent or more reduction in claims submitted.)
- If the provider or supplier shifts billing to another inappropriate code.
- If the provider or supplier takes steps to alter its billing practices to avoid contractor review.

Once a Medicare provider or supplier has been terminated from prepayment complex medical review, if it wishes to resume a review, the contractor must conduct another probe review to confirm that there continues to be a high level of payment error.

If this review finds a high level of payment error, the Medicare contractor can re-institute non-random prepayment complex medical review.

What next?

Non-random prepayment complex medical review poses challenges for Medicare providers and suppliers who have been terminated from complex medical review. Providers and suppliers who are subject to non-random prepayment complex medical review must either:

- Continue to submit medical records.
- Submit medical records to the Medicare contractor for review before payment will be made.

The Medicare contractor will impose the same limitations on medical reviews performed by program safeguard contractors, to ensure that consistent criteria for terminating non-random prepayment review are applied to all providers and suppliers.
MICHIGAN MEDICAL LEGISLATION REPORT

Following is a list of bills pending in the Michigan Legislature related to health and health care policy. Detailed information and analysis on this and other pending legislation can be found at www.michiganlegislature.org.

SENIATE BILLS

SB 0026 — Requirements for physicians supervising physician assistants,

(‘A physician who is a sole practitioner or who practices in a group of physicians and treats patients on an outpatient basis shall not supervise more than four physician’s assistants. If a physician in this subsection supervises physician’s assistants at more than one practice site, the physician shall not supervise more than two physician’s assistants by a method other than the physician’s actual physical presence at the practice site.

“The department shall include all of the following in the public awareness campaign developed under this section:

(a) All known effects hookah tobacco use has on an individual’s health.

(b) All known health risks associated with the use of a hookah to smoke hookah tobacco, including the importance of cleaning and sanitizing the hookah after each use.

(c) All pertinent federal, state, or local laws, rules, ordinances, regulations, guidelines, and other legal pronouncements regarding the sale, taxation, storage, or handling of hookah tobacco, including the prohibition on the sale of tobacco products to minors.

(d) Any other information the department considers appropriate.”

Sponsored by: Tony Stamas-R
Status: Referred to the Committee on Health Policy

SB 0047 — Amend the Public Health Code to require the Department of Community Health to operate a Website with a consumer information on prescription drugs; and require the DCH to establish and maintain a toll-free telephone number for information on prescription drug programs available in the state.

“The department shall create and operate a prescription drug Web site to educate consumers about the presence of certain prescription drug products and to provide links to other helpful Web sites including, but not limited to, those Web sites that may assist and educate consumers on the availability of public and private programs that, in compliance with federal and state rules and regulations, offer access to discounted or free prescription drugs.

“The department shall include all of the following on the prescription drug Web site:

(a) The 150 most commonly prescribed brand name products as reported in the state’s medical assistance program.

(b) If not included under subdivision (a), the most commonly prescribed brand name drug products used for the treatment of all major illnesses and diseases, as determined by the department.

(c) If available, prescription drug equivalents for the brand name drug products included under subdivisions (a) and (b).

(3) The usual and customary price for each drug product included under subdivisions (a), (b), and (c).

The price information on the Web site shall be prominently displayed in a clear and understandable manner.

(i) If available, the generic equivalent drug product for each brand name drug product.

(ii) The price attributable to each brand name and generic equivalent drug product.

(iii) The dosage, the number of doses and doses strength, upon which the posted price is based.

(h) The name, street, address, and city or other identifiable location of the pharmacy at which the listed drug product may be purchased at a posted price.

(i) A minimum of five links to other Web sites as described in subsection (1).

SB 0118 — Public awareness campaign about the risks of hookah tobacco use

...“the department shall develop and disseminate a public awareness campaign about the health risks associated with and legal requirements related to hookah tobacco use. The department shall include all of the following in the public awareness campaign developed under this section:

(a) All known effects hookah tobacco use has on an individual’s health.

(b) All known health risks associated with the use of a hookah to smoke hookah tobacco, including the importance of cleaning and sanitizing the hookah after each use.

(c) All pertinent federal, state, or local laws, rules, ordinances, regulations, guidelines, and other legal pronouncements regarding the sale, taxation, storage, or handling of hookah tobacco, including the prohibition on the sale of tobacco products to minors.

(d) Any other information the department considers appropriate.”

Sponsored by: Jim Clark Coleman-D
Status: Referred to the Committee on Economic Development and Regulatory Reform

SB 0147 — Partial-birth abortion ban act.

“Except as related in subsection (4), a physician, an individual performing an act, task, or function under the delegatory authority of a physician, or any individual who is not a physician or not otherwise legally authorized to perform an abortion who knowingly performs a partial-birth abortion and a fetus is killed as a necessary action for the purpose of performing the abortion for a violation of this section, shall be guilty of a felony punishable by imprisonment for not more than two years or a fine of not more than $50,000, or both.

(4) It is not a violation of this part if the physician’s reasonable medical judgment a partial-birth abortion is necessary to save the life of a mother whose life is endangered by a physical, physiological, or physical injury.

(5) The spouse of the mother at the time of the partial birth abortion or other parent of the mother if the mother had not attained the age of 18 at the time of the partial-birth abortion may file a civil action against the physician or individual described in subsection (3) for a violation of this section unless the pregnancy is a result of the plaintiff’s criminal conduct or the plaintiff consented to the partial-birth abortion.”

Sponsored by: Cameron Brown-R
Status: Referred to Committee on Health Policy

SB 0182 — Establish a procedure for donating medication to a repository for distribution to medically indigent.

“The board shall establish, implement, and administer a statewide unused prescription drug repository program consistent with public health and safety laws to which unused prescription drugs, other than controlled substances, may be transferred from a health facility or agency, an adult foster care facility, an assisted living facility, or a pharmacy or a charitable clinic that elects to participate in the program. The program is created to distribute unused prescription drugs, other than controlled substances, to the medically indigent.

Subject to subsection (11), the board shall promulgate rules and establish procedures necessary to establish, implement, and administer the program. The board shall provide technical assistance to health facilities and agencies, adult foster care facilities, assisted living facilities, manufacturers, pharmacies, and charitable clinics that elect to participate in the program.

Participation in the program by a health facility or agency, adult foster care facility, assisted living facility, manufacturer, pharmacy, or charitable clinic is voluntary. Nothing in this section requires any health facility or agency, adult foster care facility, assisted living facility, manufacturer, pharmacy, or charitable clinic to participate in the program.

Pharmacies, health professionals, and charitable clinics shall use the following criteria in accepting and dispensing unused prescription drugs for use in the program:

(a) Only prescription drugs in their original sealed unit dose packaging or unused injectables shall be accepted and dispensed under this program.

(b) The packaging shall be opened.

(c) Expired prescription drugs shall not be accepted.

(d) A prescription drug shall not be accepted or dispensed if the person accepting or dispensing the drug has reason to believe that the drug is adulterated.

(e) Controlled substances shall not be accepted.

(f) Subject to the limitations prescribed in this subsection, unused prescription drugs dispensed for purposes of a medical assistance program or drug donation program may be accepted and dispensed under this program.

(g) Any additional criteria established in rules promulgated under this section.

Sponsored by Dennis O’Howski-D
Status: Referred to Committee on Health Policy

SB 0350 — Regulate insurance, health and medical benefit plan carriers offering incentives to physicians or other health care professionals for prescribing certain medications.

“A carrier or any person acting on a carrier’s behalf shall not do any of the following:

(a) Pay a physician or other health care professional to prescribe a specific drug or type of drug.

(b) Pay a physician, pharmacist, or other health care professional to switch a stable patient from one drug to another specific drug or type of drug.

(c) Provide financial incentives to a physician or other health care professional to prescribe a specific drug or type of drug.

(d) Provide a cash bonus or other reward to a physician or other health care professional for compliance with medical

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Contact information for state senators can be found at http://www.michigan.gov.

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Cite this page as 5 M.L.R. 8
Pending Legislation

Continued

benefit plan guidelines regarding drugs to be used.

(a) Withhold a portion of a physician’s or other health care professional’s compensation or financially penalize a physician or other health care professional in some other way for failure to comply with specific medication use mandates.

(b) Provide incentives or other inducements to a physician or other health care professional to prescribe a specific drug or type of drug.

(c) Engage in any other activity that may be viewed as a kickback for prescribing a specific drug or type of drug.

“On or before Feb. 1, May 1, Aug. 1, and Nov. 1 every year, a carrier shall report all of the following to the attorney general for the immediately preceding quarter:

(a) Any payments, financial incentives, or other inducements to physicians or other health care professionals that may be viewed as an inducement to a physician or other health care professional to prescribe a specific drug or type of drug or to switch a stable patient from one drug to another specific drug or type of drug.

(b) Any other information the attorney general requires.

Sponsored by: Bruce Patterson
Status: Referred to Committee on Health Policy

HBB 4808 — Development of an acuity system and staffing plan for nurses.

“A hospital shall submit to the [Department of Community Health] a staffing plan as provided under this section.

Each hospital is responsible for the development and implementation of a written staffing plan that provides sufficient, appropriately qualified nurses to meet the individualized needs of its patients. Each hospital shall develop an assessment tool that evaluates the actual patient acuity levels and nursing care requirements for each unit during each shift. The hospital shall use the assessment tool to make adjustments to the staffing plan as needed to ensure safe patient care.

*In assist in the development of a staffing plan, the hospital shall establish a staffing committee for that unit.

*The staffing committee shall be considered a part of the nurse’s regularly scheduled workweek.

*Hospital shall not retaliate against a nurse who participates on the staffing committee.

“The staffing committee shall establish a staffing strategy for that unit if the patients’ needs within that unit for a shift exceed the required minimum direct care registered professional nurse-to-patient ratios set forth therein.

*Within two years after the effective date of this section, each hospital shall have established and implemented an acuity system for addressing fluctuations in actual patient needs.

See "Pending Legislation," page 10
acuity levels and nursing care requirements
required increasing staff levels above
the minimums set. The assessment tool shall be
used annually to review the accuracy of the
acuity system established under this
subsection.

“The hospital shall post the hospital’s staffing
plan for each unit in a conspicuous place
within that unit for public review. Upon
request, the hospital shall provide copies of the
staffing plan that are filed with the [Department of
Community Health] to the public.”

Sponsored by: Lesia Liss-D
Status: Resigned to Committee on Health
Policy.

HB 4012 – Laundring of surgical or work
clothes exposed to blood or other
infectious material; require facilities to comply
with governing bloodborne infectious
diseases and to not allow employees to launder at
home.

“A health facility or agency in which invasive
surgical procedures are performed and in which
the employees are exposed to blood or other
potentially infectious material or
routinely required to enter restricted operating
areas shall comply with the following requirements
of R 325.7011 of the Michigan administrative
code. A health facility or agency shall determine
whether it is necessary to require employees or
require an employee who participates in
invasive surgical procedures, has exposure to
blood or other potentially infectious material, or
enters a restricted operating area to take his or
her work clothes home for laundering.”

Sponsored by: Lesia Liss-D

HB 4172 – Influenza vaccine strategic plan;
Require hospitals to establish a plan to
inform and provide elderly persons with the
vaccine.

“Beginning Oct. 1, 2009, a hospital shall
establish a strategic plan for managing its supply
doing it the influenza vaccine. The plan shall be
consistent with guidelines or recommendations
issued by the federal centers for disease control
and prevention. The plan shall be on a form provided by the department
for immunization practices of the federal centers for
disease control and prevention.

During the influenza season, if the hospital
has the influenza vaccine available and supply
is consistent with the hospital’s strategic plan,
the hospital shall inform each person 65 years
of age or older who is admitted to the hospital
for a period of 24 hours or more that the
influenza vaccine is available and offer
to provide the vaccine to those persons for whom
the vaccine is not contraindicative. If that
person consents to be vaccinated against
influenza and a physician, nurse, pharmacist, or
other independent practicing licensed health
professional determines that there is not a
relative or absolute contraindication to giving
the vaccine, the health care professional shall
administer the pneumococcal vaccine on a previous
occasion, received the vaccine, or refused the vaccine
and the vaccine was not contraindicated because a
contraindication rendered the administration of the
vaccine inadvisable.”

Sponsored by: Robert Jones D

HB 4121 – Partial-birth abortion ban act.

“Except as provided in subsection (4), a
physician, an individual performing an act, task,
or function under the delegatory authority of a
physician, or any other individual who is not a
physician or not otherwise legally authorized to
perform an abortion who knowingly performs a
partial-birth abortion and kills a human fetus is
guilty of a felony punishable by imprisonment
for not more than two years or a fine of not
more than $500,000, or both.

(4) It is not a violation ... if in the physician’s
reasonable medical judgment a partial-birth abortion
is necessary to save the life of a
mother whose life is endangered by a
physical disorder, physical illness, or
physical injury.

The documentation of the vaccination required
under this section may be in the form of a
written note included in the patient’s medical
record indicating that he or she had received the
vaccine on a prior occasion, received the
vaccine, or refused the vaccine or that the
vaccine was not administered because a
contraindication rendered the administration of
the vaccine inadvisable.

Sponsored by: Robert Jones D

HB 4140 – To expand the special volunteer
license for retired physicians to include
chiropractors.

An individual who is retired from the active
practice of medicine, osteopathic medicine and
surgery, podiatric medicine and surgery,
chiropractic, or dentistry and who wishes to
donate his or her expertise for the medical,
chiropractic, or dental care and treatment of
indigent and needy individuals in this state or
for the medical, chiropractic, or dental care and
treatment of individuals in medically
underserved areas of this state may obtain a
special volunteer license to engage in the
practice of medicine, osteopathic medicine and
surgery, podiatric medicine and surgery,
chiropractic, or dentistry by submitting an
application to the board pursuant to this
section.

An application for a special volunteer license
shall be on a form provided by the department
and shall include each of the following:
(a) Documentation that the individual has been previously licensed to engage in the
practice of medicine, osteopathic medicine and
surgery, podiatric medicine and surgery,
chiropractic, or dentistry in this state and
that his or her license was in good standing
prior to the expiration of his or her license.

(b) Acknowledgment and documentation that the applicant will not receive any payment or
compensation, either direct or indirect, or have the expectation of any payment or
compensation, for any medical, chiropractic,
or dental care services provided under the
special volunteer license.

(c) If the applicant has been out of practice for three or more years, documentation that,
during the three years immediately preceding the application, he or she had attended at
least two-thirds of the continuing education courses or programs required under part 170,
175, 180, 164, or 166 for the renewal of his or her license.

Sponsored by: Dave Hildenbrand

HB 4339 – Health facilities and hospitals to
inform and provide elderly persons with the
pneumococcal vaccine.

“Beginning Oct. 1, 2009, a hospital shall
establish a strategic plan for managing its supply
of the pneumococcal vaccine. The plan shall be
consistent with guidelines or recommendations
issued by the federal centers for disease control
and prevention. During the pneumococcal season,
if the hospital has the vaccines available and supply
is consistent with the hospital’s strategic plan,
the hospital shall inform each person 65 years
of age or older who is admitted to the hospital
for a period of 24 hours or more that the
pneumococcal vaccine is available and offer
to provide the vaccine to those persons for whom
the vaccine is not contraindicative. If that
person consents to be vaccinated against
pneumonia and a physician, nurse, pharmacist, or
other independent practicing licensed health
care professional determines that there is not a
relative or absolute contraindication to giving
the vaccine, the health care professional shall
administer the pneumococcal vaccine on a previous
occasion, received the vaccine, or refused the vaccine
and the vaccine was not contraindicated because a
contraindication rendered the administration of the
vaccine inadvisable.

Sponsored by: Robert Jones D

HB 4580 – Revise prohibition on redispensing
a pharmaceutical to allow pharmacists to
charge a reasonable fee for patients who
refuse prescription drugs.

This section does not require a pharmacist to
redispense drug products in a customized
medication package from the pharmacy
previously licensed to engage in the
practice of medicine, osteopathic medicine and
surgery, podiatric medicine and surgery,
chiropractic, or dentistry under this section.

Sponsored by: Bill Caul-R
Status: Pending bill filed March 5, 2009.
Writing the right

The following suggestions will go a long way toward avoiding third-party infringement claims:

1. The practice’s written agreement with the Web developer should require the developer to assign or license all rights in the content to the practice. Specific language must be used in the written agreement to convey the copyright.

2. The Web developer should execute the appropriate assignment or license to transfer rights in the content.

3. The written agreement should require the Web developer to represent and warrant that its employees created all of the content on the site as work for hire, or if the developer is an individual, that she or he did. If a third party (such as a photographer) created some of the content, the Web developer should be required to disclose in writing the name of the third party and describe the content acquired from the third party.

4. The Web developer should provide the practice with a copy of any assignment or license agreement from the third party who owns the copyright and the practice should keep copies of any assignment or licenses with its permanent records.

5. The practice should require the Web developer to indemnify it against any third-party infringement claims based on use of content supplied by the developer. The indemnification provision should be broad written so that it includes the attorney fees of the practice.

6. If the Web developer goes out of business or is financially distressed, the indemnification provision may be of little practical value. Therefore, the practice should take care in selecting the developer.

7. The Web developer should license the software code to the practice. (Because the same code is used repeatedly by a developer, any license to use the software code is generally a nonexclusive license.)

8. The practice should make sure that any of its physicians or employees who provide content for the site either own the content or have express permission to use it.

9. The practice should consider purchasing a cyber liability insurance policy to cover the damages for and the cost of defending against claims of copyright infringement arising from content posted on the practice’s Web site.

10. The practice should protect the content on its Web site by registering its copyright in the content by filing an application with the U.S. Copyright Office. By doing this before any infringement occurs by anyone else, the practice has the ability to collect statutory damages in the event of a violation of copyright.

Preserving intellectual property rights

Copyright protection is one key to a successful practice Web site

Physician practices frequently use Web sites as marketing tools to attract new patients and to enhance the level of services provided to their existing patients.

The use of a Web site allows a practice to broadly advertise and help introduce prospective patients to the practice’s healthcare professionals and services.

However, the benefits of a practice Web site can be negated if the practice becomes embroiled in litigation over the use of copyrighted content.

A copyright protects the practice’s ownership of the content on its site by preventing third parties from, among other things, copying or displaying content owned by the practice. At the same time, a practice has to make sure that it respects the intellectual property rights of others and does not reproduce or display copyrighted content owned by anyone else.

Generally, Web site content consists of a collection of individual creative works, such as photographs or illustrations, audio clips, video clips, text and code. In addition to the individual copyright in each of these works, a copyright also exists in the combination of individual works and the manner of their arrangement on the site.

Content ownership varies

Most practices utilize the services of Web developers to create a Web site. Typically, the developer selects the content to be used and writes the computer code for the Web site.

Although the Web developer may create some of the content of the Web site, the Web developer also uses content created by third parties, either by hiring them to specially create content or by purchasing or licensing content already created by the third parties.

For example, the Web developer may arrange to have a photographer take photos of the practice’s physicians or facility, or the developer may purchase and use general “clip art”-type images to personalize the site and make it more attractive to prospective patients. The practice’s physicians may even “clip art”-type images to personalize the site and make it more attractive to prospective patients.

It is important to note that the owner of a copyrightable work is initially the person who creates the work. Therefore, unless there is a written agreement in place to the contrary, the Web developer hired by the practice to create the content and code for the Web site, and not the practice, will own or control the copyright in the content and code created.

A practice has the right to use these works on the site only if the practice either owns the works, or has duly licensed the works. In order for the practice to have the exclusive right to use the content, the Web developer must assign or exclusively license the content to the practice. Otherwise, the practice will not be able to prevent the Web developer from using the content on other Web sites, or prevent third parties from copyrighting the contents of the practice’s site.

For example, if a practice uses a logo, the logo may be the most important image on the Web site and a valuable marketing tool. Therefore, unless the practice owns the logo, the Web developer who created it could sell the rights to use the logo to other developers.

If a Web developer (or any other person) supplying content/usage content that has been developed by a third party, the supplier must have the consent of the third party to use this content. For example, a physician in a cardiology practice may post cholesterol-management articles obtained from a medical association on her practice Web site. Even if the physician attributes the articles to the association, it is not enough to avoid a potential copyright violation — instead, the physician should contact the association and obtain permission to use the content.

Physician practices increasingly are using the Internet as a source of revenue. Legal advice is earned by selling or licensing images protected by copyright. Instead of fighting infringement, a copyright owner pays significant fees to hire a specialized company to do such monitoring.

Steps save headaches and money

Accordingly, when an infringing use of content is discovered, the owner wants to recover the cost of monitoring, the license fee that the owner would have earned, and legal expenses. Copyright owners often demand (under threat of filing suit for copyright infringement) several times the amount that it would have cost a practice or Web developer to initially license the content.

Such an approach puts the practice in the difficult position of capitulating to the demands of the copyright owner, or paying even more fees and the threat of legal action.

Thus, it is generally cost-effective for a practice to properly license content prior to using it.

In many cases, a practice may have innovative and useful content provided by a Web developer in the belief, usually based on the developer’s representations, that the developer owned the content and had duly authorized the practice to use the content.

It is a common misconception that because the practice relied on such representations, it will not be liable for copyright infringement. In fact, copyright law can impose liability on anyone who, among other things, copies or publicly displays content without the permission of the copyright owner.

A practice can protect itself by making sure it owns the content of its Web site or has duly licensed such content.

Copyright law is a complex area of the law, and there are many other issues not addressed in this article. If a practice is uncertain about whether it has the right to use any content, the practice should consult a qualified intellectual property attorney to make sure its Web site remains an asset — and not a liability.
**Medicare**

Continued from page 3

could slow the process of compensation for her clients.

“The lawyers who represent these insurers don’t want [their clients] to get fined,” MacKenzie said. But she doesn’t want anyone to panic.

“Their responsibility begins and ends with notifying Medicare. That’s all they have to do,” she added. “They don’t have to worry about whether Medicare gets paid. They won’t really be able to talk to Medicare because of HIPAA laws. They just have to get Medicare on notice when a claimant is Medicare eligible.”

The purpose of the change is to ensure that all parties comply with the Medicare Secondary Payer statute. She has heard rumblings that some defendant attorneys are saying they’ll pay Medicare directly.

“There are some who think that’s necessary, and are suggesting that they’ll make the check out to my firm, to my client, and to Medicare,” MacKenzie said. “That’s not going to work. Even if we could figure out whom to send the check to for endorsement, it still has to come back to us for endorsement. Medicare is already four months behind on final demand letters. Sometimes we can’t even get someone from Medicare on the phone. How in the world would we manage sending checks out there? It’s never going to happen.”

Though most plaintiff attorneys already were notifying Medicare, and were ensuring that their clients paid Medicare to satisfy liens against their settlements, some were not, said personal-injury attorney Mark J. Bernstein of The Bernstein Law Firm in Farmington Hills.

“The big picture is that Medicare is sick of being covered,” he said. “They’ve tried to say if there is any other type of insurance, Medicare should be the secondary insurance. And that’s the law, and most every- one follows it. The problems are that when there are multiple liens, everyone starts paying the bills, and it can take years to sort it out. It’s a nightmare to untangle that mess.”

He said that it appears CMS is trying to avoid the mess by getting lawyers on both sides of a case to figure out early what liens will need to be paid. But he’s not hopeful that adding more rules about Medicare will be helpful.

“Handling liens is nothing new, but navigating them has become more complex every year. It holds up disbursement and frustrates the clients who are just trying to pay the rent,” Bernstein said. “We’ll wait and see if this helps, but if the part is any indication of the future, it will only make it more complicated.”

He said he worries that because insurance liens are complex and often misunderstood, the law fails to take into account how slow the process of sorting out primary and secondary insurance payers is. It’s difficult enough now, Bernstein said.

“The law requires Medicare to be reimbursed 60 days after a settlement,” he said. “But it can take months for Medicare to get final recovery demand letters to us. That slows the process.”

Even worse is when clients don’t want to tell them that they’re Medicare eligible.

“Medicare is such a nightmare,” he said, “some clients try to avoid it altogether and don’t tell you.”

The new Medicare notification procedure requirement will come up most often in cases in which there is an injury involving an elderly person, and the injured person is Medicare eligible, said Jules B. Olsman of Olsman Mueller.

“There are some cases that are pretty clear. If you have a slip-and-fall that causes a hip fracture, everyone knows how much the medical bills are and how they got paid and who is entitled to compensation and repayment,” Olsman said.

It gets stickier though, when a client has multiple health issues.

“Let’s say a person enters a nursing care facility with congestive heart failure, and that patient is being treated for that. But then, while in the [facility] that patient falls or is dropped and fractures a hip,” he said.

“The case is only about the hip fracture, but when Medicare sends the final demand letter, everything they paid is going to be in there. We have to sort out what they’ve entitled to as a result of the injury, but not the other treatment,” Olsman said.

“The set-aside amount and pay- ment will remain the responsibili- ty of the plaintiff’s attorney, he said, as it has been. A federal court late last year found that Paul J. Harris, a West Virginia attorney, was responsible to ensure that CMS was compensated after Harris’ client fell from a ladder and sued the ladder retailer.

“The client was awarded $25,000. Harris had notified CMS that his client was Medicare eligible, but did not pay CMS the $11,367 Medicare claimed it was owed. Olsman said.

“Even worse is when the mon- ey anymore, and the court said Harris should have paid on behalf of the client,” Olsman said.

The CMS change will require de- fendant attorneys to become involved with communicating with Medicare early in the process, he said.

“One way to look at this is the government wants to make sure they’re not being ignored and they’re getting the last dollar,” he said. “If you threaten the insur- ance industry with penalties, the government will get compliance.”

If you would like to comment on this story, please contact Carol Lundberg at (248) 465-6105 or carol.lundberg@mliawah.com.

“**The lawyers who represent these insurers don’t want [their clients] to get fined.**”


“The lawyers who represent these insurers don’t want [their clients] to get fined.”


Privilege

Continued from page 1

privilege is relatively absolute in providing preservation, the physician-patient privilege prohibits disclosure of medical records except as otherwise provided by law," he said.

That’s significant, said Grand Rapids attorney Richard E. Hillery II of Miller Johnson, because the Court of Appeals in the 2007 case ruled on one particular language in the dentist-privilege statute to conclude the attorney general’s investigative subpoena warranted disclosure. According to the statute, MCL 333.1646(1), the dentist is prohibited from disclosing privileged information "[e]xcept as otherwise permitted or required under the health insurer portability and accountability act of 1996 (HIPAA)."

Hillery said in an e-mail the Court of Appeals “has recognized that the Legislature “has afforded special treatment and protection to medical records,” but those same protections haven’t been given to other medical records, such as dental and physician records.

Detroit attorney Daniel J. Schulte of Kerr Russell & Weber PLC, who represents the Michigan State Medical Society, cautioned against assuming it was a foregone conclusion that the physician-patient privilege will prevail in an investigatory subpoena.

He acknowledged the physician-patient and the dentist-patient privilege statutes shared some similar language, but, he said, where they differed was critical.

The dentist privilege disclosure is allowed where HIPAA permits or requires it, Schulte said, but the physician privilege contains no such language.

“Any view,” he said, “the ‘except as otherwise provided by law’ language in the physician-patient privilege statute means the privilege cannot be overcome by an attorney general investigative subpoena unless a separate federal or state statute requires disclosure.

That rule out HIPAA, Schulte added, because HIPAA doesn’t ever require disclosure; it only permits disclosure under certain circumstances.

Lake Orion attorney Allen M. Wolf of The Wolf Law Firm, PLLC, who represented the dentist in the 2007 Court of Appeals case, disagreed with Schulte’s HIPAA argument.

He said in an e-mail the physician-patient privilege “would follow the same HIPAA analysis used to overcome” the dentist-patient privilege in his client’s case.

In the 2007 opinion, the Court of Appeals said HIPAA permitted disclosure of the subpoenaed dental-patient information because a health care provider, such as a dentist, “may disclose protected health information to a health oversight agency for oversight activities.”

The court said the DCH was an oversight agency and the seeking oversight agency and the seeking investigative subpoena by the attorney general investigative subpoena was a separate federal or state statute requires disclosure.

The Court of Appeals has recognized that the Legislature “has afforded special treatment and protection to mental health records,” but those same protections haven’t been given to other medical records, such as dental and physician records.

— Richard E. Hillery II, Miller Johnson

Whereas the psychologist’s privilege is relatively absolute in prohibiting disclosure, the physician-patient privilege prohibits disclosure “[e]xcept as otherwise provided by law.”

— Gregory D. Drutsch, Kling, Blackwell, Valviti & Sherbrook

Termination

Continued from page 7

providers and suppliers as a result of inter-rupted cash flow.

Inevitably, a provider or supplier faces a problem, but definitively one a Medicare provider or supplier is aware that it has been placed on a non-random prepayment complex medical review, the Medicare provider or supplier must take an honest, hard look at its documentation and coding practices and look for areas for improvement.

For example, the provider or supplier should consider the following:

• Are the services the provider rendered documented to establish medical necessity, taking into consideration applicable Medicare National Coverage Determinations, Local Cover-age Determinations, and policies?

• Are claims appropriately cod-ed? For example, with respect to evalua-tion and management services, are all codes billed at a level 4 or level 5?

As further noted herein, unusual billing patterns and billing errors related to high-dollar values are red flags for Medicare reviewers. It may be beneficial to engage the services of an independent auditor to review a sampling of medical records and identify areas for improvement.

In addition, a qualified health care attor-ney or consultant can as-sist your organiza-tion to review its documentation and coding prac-tices for compliance with Medicare policy. It may be advantageous for providers and suppli-ers to incorporate the suggestions of the independent auditor, health care attorney or consultant to potentially avoid future claim denials.

Importantly, although it is advisable that a Medicare provider or supplier subject non-random prepayment complex review analysis its documentation for compliance with Medicare policy, and initiate corrections as appropriate, the Medicare provider or supplier must be cognizant that it not replace one improper billing practice with any other improper billing practice.

As further noted herein, if a provider or supplier engages in improper claims or billing-related activi-ties in an ef-fort to avoid review, the Medicare contractor is authorized to extend the timeframe for review.

The provider or supplier also may find it advantageous to meet with the Medical Di-rector of the Medicare con-tractor reviewing its records as part of the non-random prepayment complex medical review. This meeting will engage the provider or supplier with an opportunity to gain an understanding of its situation, understand the specific areas identified as deficiencies, and understand the medical review process. A meeting also gives the provider or supplier an opportunity to explain its practices and any poten-tial legitimate payment method anomalies (e.g., a home care physician with numer-ous high-level evaluation and management codes, due to the high proportion of home care patients with numerous comorbidities).

Furthermore, the Medicare provider or supplier must be cognizant that they should experi-ence claim denials as a result of the review, appeal rights through the Medicare appeals process apply. Accordingly, the provider or supplier should have an opportunity to track claim denials and appeal deadlines. An experienced health care attorney can assist your organization to successfully appeal claim denials, by utilizing various strategies including drafting a position paper, employing an expert consultant/witness, arguing the merits of the underlying claim and employ-ing legal defense.

Three different standards

• Physician-patient privilege (MCL 333.1646(1): “Except as otherwise provided by law, a person so licensed or allowed to use that title under the laws of this state or any other state is entitled to use that title under the laws of this state.”

• Psychologist-patient privilege (MCL 600.2157): “Except as otherwise provided by law, a person so licensed or allowed to use that title under the laws of this state or any other state is entitled to use that title under the laws of this state.”
Changes included in stimulus law

By Correy E. Stephenson

In addition to making changes to COBRA and the tax laws, the American Recovery and Reinvestment Act of 2009 also includes changes to the Health Insurance Portability and Accountability Act (HIPAA).

Here is a look at the major changes:

- Increased notification requirements
  - Covered entities are now required to notify affected individuals when a privacy breach occurs. Jackson Lewis, who coordinates the firm’s HIPAA and workplace privacy practice, said Barack Obama didn’t indicate they were part of his health care policy plans, said Rachel Cutler, a partner in the Health Law Group at Jackson Lewis in Philadelphia who is an expert on health and wellness plan compliance.
  - As a result, covered entities must now "update their policies and procedures and refrain employees from inappropriate practices.

The biggest changes involve new requirements for breach notification. The changes vary based on the type of covered entity and the specific nature of the breach, with some taking immediate effect and others not going into effect until 2011.

In addition, states are being asked to update their policies and procedures and enforce protections and HIPAA and workplace privacy compliance.

"The changes will have a big impact on business associates [already] had obligations through contractual agreements but now must comply with the state requirements," she added. In addition, individuals also have greater rights to access, request, and inspect their protected health information is being used.

- State attorneys general actions
  - Lazzarotti said he was surprised by the increased level of enforcement. State attorneys general to bring a civil action for violations of HIPAA privacy and security provisions of HIPAA and seek damages for violations of HIPAA.

- Greater fines and penalties
  - Covered entities that violate HIPAA are now subject to up to $1.5 million per violation penalty for each intentional violation. The maximum annual penalties of up to $1.5 million per violation have now been tightened.

- State attorneys general actions
  - Lazzarotti said he was surprised by the increased level of enforcement. State attorneys general to bring a civil action for violations of HIPAA privacy and security provisions of HIPAA and seek damages for violations of HIPAA.
As health care costs continue to skyrocket, it is not uncommon for Medicare claims to be denied either because they are not covered under the program, or because they are found to be excluded from coverage as not reasonable and necessary.

In today’s economy, it is especially important for health care providers to ensure that they will be compensated for services provided, medicare beneficiaries from liability purposes. The basic purpose of this section is to protect Medicare beneficiaries from liability purposes? The basic purpose of this section is to protect Medicare beneficiaries from liability purposes.

Liability Provision applies only to assigned physicians or suppliers. When a Medicare claim is denied, the provider is liable for payment if the service or item is not covered by Medicare. This means that the provider is liable for payment if the service or item is not covered by Medicare.

The Limitation of Liability Provision, certain home care agencies, community mental health centers. Although not technically included within the definition of a “provider,” the Limitation of Liability Provision also applies to physicians and suppliers, so long as the services or items in question were not medically necessary and reasonable for the purpose of reference, the term “provider” also includes physicians and suppliers.

When does a provider have knowledge for limitation of liability purposes? Providers receive numerous advisories and updates regarding Medicare coverage on a continual basis and are expected to be aware of which medical services are likely to be denied by Medicare.

Also, a previous denial notice to a provider for a service or item furnished in a particular situation is taken as evidence that the limitation on Medicare coverage was known. Thus, unless sufficient documentation accompanies a claim for Medicare reimbursement and states that the beneficiary was notified that the services at issue would likely be denied, Medicare takes the position that the provider is liable for payment for such denied services.

In a situation where services are provided to a beneficiary, Medicare will likely consider not medically necessary, the provider must inform the beneficiary of that possibility to avoid being liable for the costs. The notification must be in writing and must be provided to the beneficiary before the service is provided.

The notice must specifically state that Medicare will probably deny the claim and that the patient bears responsibility for the cost of the service. To the contrary, must be accepted by Medicare for limitation of liability purposes. The Department of Health and Human Services has directed that such notices are not to be considered acceptable evidence of payment is possible.

Sometimes, providers will give their patients generic notices or waivers which state that the denial of payment is possible. This is not sufficient to avoid the beneficiary’s liability for services provided.

Medicare was created in 1965 as an amendment to the Social Security program. Medicare provides health insurance to people 65 and older, and to certain other qualifying individuals under that age. The overall purpose of Medicare is to provide payment for “basic” health care costs.

Components of Effective Advanced Beneficiary Notices

To be effective, an Advanced Beneficiary Notice (ABN) must meet the following requirements:

- It must be on an approved form (CMS-R-131-G).
- It must be given in writing advance of furnishing the service or item in question.
- It must include the patient’s name, dates and description of the service or item, and the reasons why the service or item may not be considered reasonable and necessary.
- It must be signed and dated by the patient, indicating that the patient assumes financial responsibility for the service if payment is denied as being not medically reasonable and necessary for reasons indicated on the ABN.

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The law firm of
WACHLER & ASSOCIATES, PC
Specializing in Medicare, Medicaid and Third Party Payor Audits and Appeals:

• Over the past 20 years, WACHLER & ASSOCIATES, PC has successfully represented thousands of providers and suppliers in their appeals of Medicare [including the recent Recovery Audit Contractor (RAC)], Medicaid, BCBSM, Delta Dental, and other third party payor audits.

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