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A new HHS rule means that as of Sept. 23, HIPAA covered entities are required to notify individuals, the media and HHS of certain breaches of protected health information. **See story, page 10**

Physicians: Keep records of medical care you give to your family members

By Suzanne D. Nolan, Esq.

Are you a physician who provides medical care to family members without keeping a formal written medical record of such care?

If so, it is time for you — and every other physician who might consider providing medical care to family members — to think about the type of records that should be kept regarding such care, and how to make those records accessible to other treating physicians.

While providing medical care to and writing prescriptions for family members is a common practice and, for the most part, ethically permissible, physicians should take note that family ties do not negate the legal requirements regarding medical record-keeping.

Further, failure to do so may even place a physician's medical license in jeopardy.

Despite the prevalence of the practice, providing routine medical care to family members is frowned upon even though it may be ethically ap-

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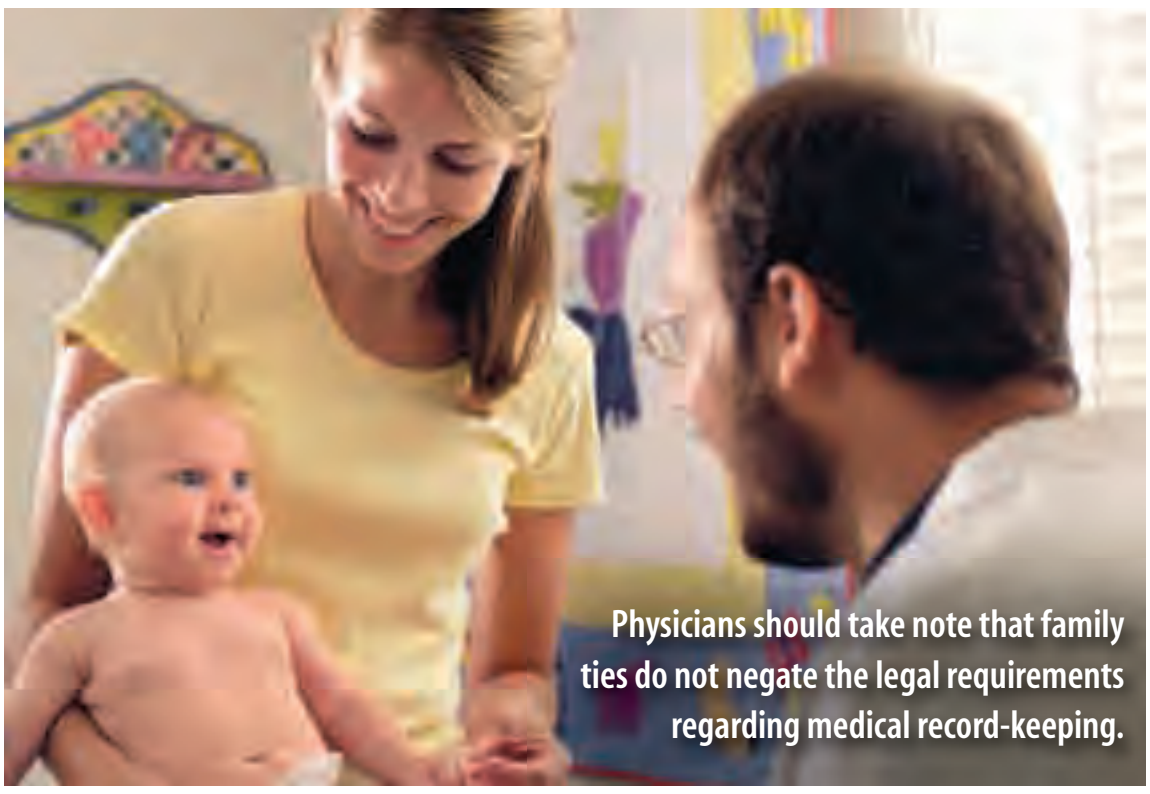

Physicians should take note that family ties do not negate the legal requirements regarding medical record-keeping.

Relocating your medical practice: are REOs the right market for you?

By Kasturi Bagchi

With real estate prices declining and so much vacant office space on the market, now may be the right time to find new space to satisfy the needs of your medical practice.

Even in this buyer's market, however, a deal that is too good to be true probably is.

This old adage rings even more true if you are searching bank inventories of real property, commonly known as Real Estate Owned (REO). However, when you enter the world of REOs as a prospective purchaser, there are two fallacies of which you should be wary.

Bank owned or not?

The first common misconception is that all REOs are actually owned by the bank.

On Web sites and advertisements, the term REO has become synonymous with real estate owned by the bank after an unsuccessful sale at a foreclosure auction where no one bids.

The reality is, it is a regulatory term of art applicable to a broader category of assets. REO stems from the regulatory phrase "Other Real Estate Owned." Under this act, banks are only permitted to hold real estate other than their own bank premises for limited periods of time, and earnings from such other real estate must be reported separately.

Notably, as published in a handbook of the Comptroller of the Currency Administrator of National Banks, "certain troubled loans secured by real estate are considered to be 'in substance foreclosures' and are also treated as other real estate owned."

An "in substance foreclosure situation" is generally characterized by a borrower with little or no equity and the sale of the property being the only source of repayment.

Consequently, a borrower may still be in possession and have legal title to the property, which has been labeled as an REO by the

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The more information you can get up front before you make an offer … will help you avoid the risk of redemption and risks associated with "as-is" sales.

New law aims at achieving parity in coverage for mental illnesses

By Ross A. Hammersley, Esq.

For years, it has become increasingly difficult for American families to obtain health insurance coverage that adequately meets the needs of loved ones afflicted with mental illness or addiction disorders.

Part of this problem has been caused by an imbalance in the availability of health insurance for these diseases.

In response, the Paul Wellstone & Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (Wellstone-Domenici Act) was enacted last fall, seeking to place the health insurance coverage provided to patients with mental illnesses and substance-abuse disorders on par with that of medical and surgical benefits.

The Act takes effect Jan. 1, 2010, so physicians should take note of

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Physicians can play large role in school defibrillator use

Health Care Justice

By Maro E. Bush, Esq.

Maro E. Bush is an associate with Frank, Haron, Weiner and Navarro PLC, where she focuses her practice on federal False Claims Act/qui tam litigation and health care law, including representation of individual physicians, health care professionals and other health care entities in a variety of areas relating to health law and regulations. Contact her at (248) 952-0400 or mbush@fhwnlaw.com.

Each year, 7,000 children and adolescents are affected by sudden cardiac arrest. Of those affected, 500 succumb to sudden cardiac death.

Physicians know that automated external defibrillators (AEDs) are the most crucial tools used to save lives during sudden cardiac arrest (SCA).

In a recent study, researchers found that school-based AED programs provide a high survival rate for both student athletes and older non-students who suffer SCA on school grounds. In the survey involving 1,710 U.S. high schools with AEDs on site, nearly two-thirds of SCA victims survived.

Unfortunately, Michigan schools are not required to have AEDs on site. As a result, many schools lack AED programs. This poses a serious threat to students that have known heart and health conditions that put them at high risk for SCA.

Physicians can play an important role in ensuring their patients have access to AEDs in schools, which not only benefits patients with known heart and health conditions, but, also, potentially other students and non-students suffering from an underlying or undiagnosed condition.

Under the federal Rehabilitation Act of 1973, students diagnosed with a heart condition or other health impairment that puts them at risk for SCA are entitled to have access to an AED at school and on school-related field trips.

However, problems arise when schools are unclear about a student's disability (especially if it is not readily apparent), which can result in reluctance to establish an AED program.

Through creating detailed health plans and AED prescriptions to facilitate a clear understanding of a student's disability and how it should be accommodated, physicians become their patient's most important advocate.

IHPs and Section 504 Plans

Chronic health conditions or disabilities can interfere with students' school participation and achievement. Students with minor conditions may require basic school nursing services such as health care monitoring or medication administration. However, some students need specialized services, which require comprehensive health care plans.

Individualized Healthcare Plans (IHP) and Section 504 Plans (504 Plans) are used to identify a student's disability and corresponding need for reasonable accommodation. Ideally developed as a result of a collaborative effort between the student, family, health care team, and the school/school district, these plans ensure that there is adequate communication about the student's disability and identify the steps that will be taken to accommodate the student.

An IHP is a written document that outlines the student's specific medical needs and may include medical diagnosis, healthcare services required, emergency care plan, field trip plan (if applicable) and other considerations that are integral to safeguarding a student's health and well-being.

Depending on the circumstances and the severity of the student's health condition, IHPs may be written by the student's health care team or the school's nurse. Many organizations, including hospitals, medical centers and professional associations, have created model IHPs for specific conditions.

504 Plans are named after Section 504 of the Rehabilitation Act of 1973, which prohibits discrimination against individuals with disabilities by programs that are recipients of federal funds.

Programs help prevent problems

These Plans outline the student's health concerns, the basis for determination of the disability, how the disability affects a major life activity and the reasonable accommodations that are necessary to ensure the student has the same access to education as children without disabilities.

504 Plans help prevent potential problems or misunderstandings ahead of time. They may be developed as a result of a request by the school or the parents/guardians.

To be protected under Section 504, a student must be found to:

- Have a physical or mental impairment that substantially limits one or more major life activities;
- Have a record of such an impairment; and
- Be regarded as having such an impairment.

The determination of whether a student has a physical or mental impairment that substantially limits a major life activity is made on an individual basis.

Physicians can play an important role in ensuring their patients have access to AEDs in schools, which not only benefits patients with known heart and health conditions, but potentially other students and non-students suffering from an underlying or undiagnosed condition.

The Section 504 regulatory provision defines a physical or mental impairment as any physiological disorder or condition, cosmetic disfigurement, or anatomical loss affecting one or more bodily systems.

Major life activities include functions such as caring for one's self, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working.

Although the format of 504 Plans can vary from school to school, one fact remains constant — the physician is in the best position to define or explain the patient's disability and how it affects or limits activities.

It is important to note that a medical diagnosis, although an important factor, does not automatically entitle a student to receive services under Section 504. Other considerations include teacher recommendations, the student's physical condition and social/cultural background, and adaptive behavior.

In this scenario, the physician once again is the most qualified party to provide information and recommendations and to help facilitate a clear understanding of the situation.

Pending legislation

The Josh Miller HEARTS Act ("Helping Everyone Access Responsive Treatment in Schools") passed in the U.S. House of Representatives and was referred to the Senate Committee on Health, Education, Labor, and Pensions on June 8, 2009. It would establish a federal grant program to help increase the availability of AEDs in elementary and secondary schools across the nation.

An AED is a reasonable accommodation that could save a student's life if he or she goes into SCA. By becoming involved in the process of preparing detailed health care plans and AED prescriptions, physicians can ensure that their patients receive the proper care while attending school.

When a student requires an AED under a 504 Plan, the school district is responsible for purchasing the AED, maintaining it, making it publicly accessible and having staff trained to use it.

By becoming involved in the process of creating detailed IHPs or 504 Plans, physicians can provide their patients, and possibly others, with the life-saving AED programs to which they are entitled.

Making 'meaningful use' of electronic health records: Increase rewards, avoid penalties

By Gary A. Kravitz, Esq.

Many a tree has been sacrificed in written notifications about the incentives and penalties related to electronic health record (EHR) systems, as found in the Health Information Technology for Economic and Clinical Health (HITECH) Act.

Passed as part of the 2009 American Recovery and Reinvestment Act (the Stimulus Bill), HITECH contains incentives in the form of cash payouts to physicians who make "meaningful use" of EHR, and provides for reductions in Medicare and Medicaid payments for those who do not.

The focus on HITECH begs the question: how does a provider qualify for the available incentives, and avoid the potential penalties?

And, more importantly, how do physicians and practices begin implementing EHR systems that comply with HITECH mandates?

Time is of the essence in complying with HITECH, as the cash incentives are meant to encourage physicians to make meaningful use of EHR sooner, rather than later. Failing to make "meaningful use" of EHR by 2014 will result in ineligibility for incentives and a 1 percent penalty on Medicare reimbursements (which will increase over time).

There are similar incentives and penalties on the Medicaid side.

'Meaningful use'

Much of the recent discussion on how to qualify for stimulus incentives has centered on the term "meaningful use."

Taken straight out of the HITECH Act language, this phrase has been the subject of several hearings and commentary.

Time is of the essence in complying with HITECH, as the cash incentives are meant to encourage physicians to make meaningful use of EHR sooner, rather than later. Failing to make "meaningful use" of EHR by 2014 will result in ineligibility for incentives and a 1 percent penalty on Medicare reimbursements.

The HITECH Act contained a general outline as to some of the requirements, and this broad outline has been further clarified in hearings and reports issued by the Health Information Technology Policy Council.

The Council issued its final "Recommendations to National Coordinator for Defining Meaningful Use" in August 2009.

Based on the guidelines in the report, it is expected that in order to meet the threshold, qualifying EHR systems must have the following components: electronic prescribing, certification, interoperability and clinical quality measures.

• **Electronic prescribing:** The HITECH Act clearly states that a critical component to any EHR system is the ability to write prescriptions electronically. It is Congress' belief that e-prescribing will cut down on medical errors, save time for doctors and patients, and cut down on transaction costs.

• **Certification:** A practice must demonstrate that it is using certified EHR technology. This implies that there will be a certification process for each EHR software component or system; however, the Department of Health and Human Services (HHS) has not implemented a certification process yet.

It is important for providers to take note that electronic health records products that have received certification by the independent Certification Commission for Heath Information Technology (CCHIT) will not necessarily be certified for purposes of HITECH compliance.

• **Interoperability:** In plain English, this means the ability to share patient information with other providers, hospitals and governmental agencies.

The Health IT Policy Council's recommendations included specific goals such as the ability to exchange health information (specifically labs, care summary and medication lists) with external clinical entities.

The council also noted the need to ensure adequate privacy and security protections for personal health information (i.e., compliance with HIPAA and data sharing practices in the Nationwide Privacy and Security Framework).

There have already been several articles penned by authors fretting over the perceived privacy issues inherent with the mandatory sharing of patient data using various electronic methods. Therefore, the ability to adequately share information while simultaneously protecting it to the legal limit will be a challenging balancing act.

• **Adoption of Clinical Quality Measures:** In order to have a qualifying EHR system, a provider must report certain quality measures to CMS to demonstrate a goal of improving the quality, safety and efficiency of patient care.

The council recommended reporting on certain medical guideposts, such as percentage of smokers who are offered smoking cessation counseling and percentage of patients with LDL cholesterol under control.

The physician also must track the percent

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Cyber liability insurance to the rescue

New product picks up practice coverage where general liability policies leave off

Business of Medicine

By Suzanne D. Nolan, Esq.

Suzanne D. Nolan's practice at Troy-based Frank, Haron, Weiner & Navarro focuses upon business and intellectual property transactions, including trademark, patent and copyright licensing, e-commerce transactions, and real estate transactions for all types of entities, including healthcare providers. She can be reached at (248) 952-0400 or snolan@fhwnlaw.com.

Cyber liability insurance policies are not written on standard forms, and conditions of and scope of coverage vary significantly from insurer to insurer. . . . As with any insurance policy, the written terms of the policy should be carefully reviewed — preferably by an attorney — to confirm that the policy being purchased will adequately protect your practice from cyber liability risks.

Almost every medical practice has exposure to cyber liability risks. These are risks associated with e-business, the Internet, the security of computer networks and electronic data such as patient health information and financial information and the practice's own electronically-stored business data.

The financial harm and other burdens placed on a practice from breaches of patient privacy, breaches of a computer network's security, or damage to stored data can be severe. However, cyber liability insurance can mitigate the exposure of a practice to such financial harm and help a practice protect its good name.

It is becoming increasingly important for a practice to protect itself from both the risk of disclosing private patient information and the risk of harm to its computer networks.

Increased enforcement begins soon

In the past year, the burden on medical practices to protect the confidentiality of patient health and financial information has grown significantly due to the breach notification requirements of the Health Information Technology for Economic and Clinical Health Act (HITECH), which took effect Sept. 23, 2009; and the Federal Trade Commission's Red Flags Rule, pertaining to detecting and preventing identity theft, enforcement of which is scheduled to begin this November.

At the same time, practices are becoming more dependent on computer networks to access patient records and to bill third-party payers for medical services, with the attendant risk of interruptions to its business operations if computer systems are unavailable or stored data is corrupted.

Practices that operate Web sites are exposed to potential claims that the content of the Web site infringes a third party's copyright or trademark.

Privacy breaches, viruses, business interruption and infringement actions can all expose a practice to the risk of significant financial losses in the form of civil monetary penalties imposed by federal or state governmental agencies, damages in civil lawsuits, lost income due to business interruption, expenses of notifying patients or others of a security breach, or the cost to restore corrupt or lost data.

To protect their reputation and goodwill, most practices implement what they believe are reasonable measures to prevent disclosures of patient information or harm to the practice's computer systems.

However, errors do occur and confidential information can be inadvertently disclosed.

Laptops containing confidential data can be stolen.

Additionally, it is hard to stay one step ahead of the seemingly endless stream of identity thieves and hackers who wish to steal informational assets. In fact, it has been estimated that attacks to computer systems by hackers and identity thieves have increased by 158 percent in the last two years.

Computer systems also are vulnerable to malicious codes (i.e., viruses, trojan horses, logic bombs) picked up through e-mail or Internet browsing.

It is unlikely a practice can ever recover any money from the individuals who created or spread the malicious code, many of whom cannot even be identified or live outside the United States.

Products supplant standard policies

Fortunately, relatively new insurance products generally referred to as "cyber liability" policies are available to protect a practice.

Cyber liability policies provide coverage for losses not covered by a commercial general liability (CGL) policy or a professional liability policy, both of which most practices purchase.

For example, a practice's reputation or goodwill and its informational assets (i.e., electronic data) are classified as intangible assets because they are not physical things.

CGL policies do not cover loss or damage to intangible assets or emotional distress due to breaches of confidentiality, and professional liability policies also typically exclude from coverage any claim arising from violation of patient privacy.

Accordingly, cyber liability insurance policies can fill this insurance gap.

The risk of being subject to a governmental enforcement action under HIPAA is increasing. Enforcement initiatives for HIPAA violations have been greatly expanded by the HITECH Act which authorizes each state attorney general to file suit against a practice on behalf of the residents of its state if the practice has violated HIPAA.

Additionally, no later than Feb. 13, 2012, patients whose privacy has been breached will be able to share in a portion of any civil monetary penalty or monetary settlement collected by the federal Office of Civil Rights (OCR) or the Centers for Medicare and Medicaid (CMS) due to a breach of the HIPAA privacy or security rule.

Civil monetary penalties can range from as little as $100 per violation to as much as $10,000 per violation, and such incentives are expected to lead to an increased reporting of HIPAA violations by individual patients to OCR and CMS.

Additionally, under the Red Flags Rule, patients may be entitled to recover actual damages that they sustain from a practice's violation of the rule. There is a possibility that class action lawsuits could result in massive damages.

Other costs associated with an unauthorized disclosure of protected health information, in addition to civil monetary penalties, include the expenses of notifying patients, of modifying systems and security to prevent future breaches, and legal defense costs.

Further, damages to a practice's network can result in the loss of valuable data or an interruption in business operations.

A cyber liability policy can compensate a practice from loss of business income resulting from an interruption of network operations due to computer viruses and other electronic attacks, and it also can cover the costs of restoring the data.

Cyber liability insurance policies are not written on standard forms, and conditions of and scope of coverage vary significantly from insurer to insurer.

Accordingly, a practice will need to carefully explain its activities, risks, and needs to an insurance agent.

As with any insurance policy, the written terms of the policy should be carefully reviewed — preferably by an attorney — to confirm that the policy being purchased will adequately protect your practice from cyber liability risks.

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FERA gives health care fraud enforcement a boost

The federal False Claims Act (FCA) has long been a key weapon in the government's arsenal to fight health care fraud and abuse.

Now, with the passage of the Fraud Enforcement and Recovery Act of 2009 (FERA), the government will have an even easier time making a case against health care providers accused of defrauding federal health care programs.

One way that FERA expands the scope of the FCA is by removing the "presentment requirement."

Under the previous version of the FCA, a person or entity would be exposed to potential liability only if the allegedly false claim was specifically presented to government. FERA expands the scope of the FCA to claims presented to an agent or contractor acting on behalf of the government.

Language also was added to the definition of "claim" to include "requests or demands for money or property where the government has paid or will pay any portion of the money, regardless of whether the government actually has title to the property at the time of the request or demand."

These revisions will ensure that the FCA can be used to prosecute false claims submitted to state Medicaid programs, as well as to contractors such as Medicare Advantage Plans.

Health Policy

By Andrew B. Wachler, Esq. and Amy K. Fehn, Esq.

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Intent no longer necessary

Another significant amendment to the FCA removes language that was interpreted by the Supreme Court as requiring the government to prove that a defendant had "specific intent" to defraud the government.

Now liability under the FCA may exist as long as the false record or statement is "material to" a false or fraudulent claim. Material is defined broadly as "having a natural tendency to influence, or be capable of influencing, the payment or receipt of money or property."

Perhaps the most significant change that will impact health care providers is the change to the "reverse" false claims provision, i.e., that section of the FCA that extends liability to funds retained, as opposed to false claims submitted, by a person or entity that does not have a right to such funds.

FERA eliminates the requirement of an affirmative act of concealment and extends liability to an individual who "knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government."

FERA also adds a definition of "obligation," which is very broadly defined as "an established duty, whether or not fixed, arising from an express or implied contractual, grantor-grantee, or licensor-licensee relationship, from a fee-based or similar relationship, from statute or regulation, or from the retention of any overpayment."

To avoid liability under the FCA, health care providers and their counsel should carefully analyze statutory and regulatory provisions in which an "obligation" could arise.

For example, a technical violation of the Stark regulations could be construed as an "obligation" to return payments to the government.

Decisions related to repayment of government funds are difficult and should always involve a fact specific analysis and judgment of experienced health care counsel.

Because the FCA defines "knowingly" as including "deliberate ignorance" and "reckless disregard," an effective compliance plan provides significant protection for providers.

However, difficult decisions can arise when compliance activities uncover billing problems that may have been taking place for some time, especially in light of the new broad definition of "obligation."

While we have always recommended that providers conduct compliance audits prospectively, and, at a minimum, retain counsel in order to protect compliance activities through the attorney client and/or work product privilege, the FERA amendments make this decision more important than ever.

Perhaps the most significant change that will impact health care providers is the change to the "reverse" false claims provision, i.e., that section of the FCA that extends liability to funds retained, as opposed to false claims submitted, by a person or entity that does not have a right to such funds.

Whistleblower protection expanded

FERA also includes several amendments that will make it easier for qui tam (i.e., whistleblower) lawsuits to proceed.

Specifically, FERA expands whistleblower protection to government contractors and agents and expands the statute of limitations with regard to government intervention in qui tam lawsuits by allowing the government's complaint to "relate back" to the whistleblower's filing.

In addition, FERA gives the federal government greater flexibility in the discovery process, by allowing the Attorney General to delegate its authority to issue Civil Investigative Demands to other officials.

This will make it easier for federal officials to conduct discovery such as depositions, interrogatories and requests for production. Also, this information can now be shared with whistleblowers making it easier to cure defects in the whistleblower's complaint.

Although most of the amendments to the FCA apply prospectively, the elimination of the "intent" requirement is an exception.

Specifically, the amendments that require a false record or statement to be "material to a false or fraudulent claim" will apply retroactively to all claims pending as of June 7, 2008.

The FERA amendments make it easier for the federal government to prosecute health care providers and entities who violate the FCA.

To minimize risk, health care providers must be aware of their obligations with regard to all health care related statutes and regulations and must have an effective compliance plan in place that will enhance compliance and promptly identify overpayment obligations.

Veterans Aid and Attendance Program matters require special expertise

By Don L. Rosenberg, Esq.

For most veterans, the idea of collecting a pension benefit from the military does not seem like a real possibility unless the veteran suffered a service connected disability.

However, there is the Veterans Aid and Attendance Program (AA), a pension benefit program available to all veterans, and their families. It pays for non-reimbursed home health and medical expenses and the non-reimbursed cost of assisted living, and does not require a service connected disability.

But those who counsel veterans and their families should be aware of companies that are taking advantages of veterans and their surviving spouses.

These companies claim to be providing "educational seminars" to the public. Their motive, however, is to sell some type of financial product such as an annuity and, sometimes, even gold to the family of the veteran. In fact there are companies that use the word "Veterans" and "American" in their company name, which, in reality, are sometimes an assumed name for a financial planning firm.

Over the last several years, individuals have formed various companies stating their main goal is to "help" our veterans, but their true agenda is anything but. Many of these individuals, regardless of their affiliations or background, repeatedly contact assisted living and independent living facilities offering to put on "free informational seminars" educating the general public as to what they may be missing out on.

The fact is, these individuals have surfaced as "financial advisors" and are using their "free informational" presentation, and a confusingly similar name appeared to be linked to a legitimate veterans organization, to market and sell annuities and gold that are unsuitable to the veteran and his or her families.

Not only are these investments not suitable, but they also are not necessary and, in most cases, extremely detrimental to the veteran and his or her families.

These organizations also suggest the veteran give away most of his or her assets without considering any of the tax consequences or devastating Medicaid qualification penalty if his or her health should worsen and he or she would need a nursing home.

Professionals, veterans and their families should understand that it is never necessary to purchase a financial product to qualify for Aid and Attendance benefits. Veterans and their families are encouraged to seek the advice of an accredited veterans and qualified elder law attorney.

Eligibility for the AA Program

In order to be eligible for the AA Program, a veteran must have served 90 days on active duty with at least one day during wartime, and must have been discharged under conditions other than dishonorable. Additionally, the veteran must be "permanently and totally disabled," though the disability need not be service connected.

The specific periods of Wartime Service:

- World War I: April 6, 1917, to Nov. 11, 1918
- World War II: Dec. 7, 1941, to Dec. 31, 1946
- Korean Conflict: June 27, 1950, to Jan. 31, 1955
- Vietnam Era: Aug. 5, 1964 (or Feb. 28, 1961, for veterans who served in country before then) to May 7, 1975
- Gulf War: Aug. 2, 1990 to a to-be-determined date

The current AA monthly pension benefits:

- Veteran and spouse: $1,950
- Veteran: $1,645
- Surviving spouse of a veteran: $1,057

Non-reimbursed medical expenses are generally defined to include the costs associated to health and Medicare insurance premiums, prescriptions drugs, dental and vision care, and expenses related to an assisted living facility, and in-home care aid, and/or adult day care.

Net worth valuation

With the exception of the applicant's home, automobile, traditional household furnishings and personal property, which are treated as noncountable, veterans assets cannot exceed the amount necessary to pay for their medical costs. In other words the asset limit is a formula that calculates the expenses both medical and household and multiplies the shortfall by the veteran's life expectancy.

There is an unwritten asset limit that is commonly referenced and maintains that a single veteran could have $40,000 in assets and a married couple could have $80,000. However, if the veteran is aged and therefore has a shortened life expectancy, then these numbers may be significantly reduced.

Unfortunately, some of the groups in the community advertising that they are helping veterans with eligibility for the program are not considering all the factors when evaluating a veteran's income and assets.

Pre-planning

The Veterans Administration only looks at the applicant's net worth at the time of the actual AA application. At this time, because there is no penalty period for the transfer of assets prior to the time of the application, it is fair to conclude that with proper planning, just about any veteran, and/or his or her spouse, can qualify for a monthly AA pension benefit.

Professionals, veterans and their families should understand that it is never necessary to purchase a financial product to qualify for Aid and Attendance benefits. Veterans and their families are encouraged to seek the advice of an accredited veterans and qualified elder law attorney.

Even though there is no penalty, transferring assets to qualify for this benefit may

See "Veterans," page 15

NPDB: 'I hope you know that this will go down on your permanent record'

Compliance Corner

By Robert S. Iwrey, Esq.

Robert S. Iwrey is a founding partner of The Health Law Partners, P.C., where he focuses his practice on litigation, dispute resolution, contracts, licensure, staff privileges, Medicare, Medicaid, Blue Cross/Blue Shield and other third-party payor audits and appeals. He also provides defense of health care fraud matters, compliance and other health care-related issues. Contact him at (248) 996-8510 or riwrey@thehlp.com.

"I hope you know that this will go down on your permanent record.
Oh yeah?
Well don't get so distressed;
Did I happen to mention that I'm impressed?"

While those lyrics — taken from "Kiss Off" by the Violent Femmes — express the typical teen angst exhibited in much of the 1980s alternative music scene, such frustration/related emotions also are experienced by physicians today when faced with threatened reports to the National Practitioner Data Bank (NPDB).

The effects of a NPDB report can be quite distressing: difficulty obtaining hospital privileges, state licenses, and participation with third-party payors, along with other significant employment-related ramifications.

Once a physician is reported to the NPDB, the report is typically part of the physician's permanent record and can be viewed as akin to having a criminal record that the physician must attempt to explain away in order to save his or her career.

The NPDB is a federal information clearinghouse created pursuant to the Health Care Quality Improvement Act of 1986 (HCQIA) "to collect and release certain information relating to the professional competence and conduct of physicians, dentists and other health care practitioners."

All hospitals are required to access the data bank reports on physicians every two years as part of hospital staff privilege recredentialing.

State disciplinary actions are required to be reported as well as malpractice insurance payments. Peer review discipline also is required to be reported with some limited exceptions.

Moreover, a hospital must report any physician who resigns while under "investigation" in order to avoid disciplinary action. The term investigation is not defined under the statute.

However, recent case law has broadly defined investigation to include not only fact-finding, but also the ongoing activity of the hospital through the final formal action against the physician.

Thus, the physician may not avoid the permanent mark of a NPDB report by simply resigning once the fact-finding has begun. Rather, absent a carefully negotiated settlement, the physician must proceed throughout the entire process and prevail in order to avoid the potentially devastating report.

Many physicians mistakenly believe that the only types of incidents that are reportable to the NPDB are malpractice actions or hospital incidents that are directly related to quality of care. However, the NPDB guidebook states that a hospital must report any adverse clinical privilege action taken against a physician for unprofessional conduct that has, or could have, an adverse effect on a patient.

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However, the NPDB guidebook states that a hospital must report any adverse clinical privilege action taken against a physician for unprofessional conduct that has, or could have, an adverse effect on a patient.

One scenario that can lead to such a report is an allegation of disruptive behavior.

Prior to the Jan. 1, 2009, requirement by the Joint Commission that hospitals establish disruptive physician policies, many hospitals did not have any policies to assist them when faced with alleged unprofessional conduct of a physician — especially when such conduct was not directly related to quality of care.

Too often, the decision of whether disciplinary action should be taken against a physician, and whether a related report to the NDPB should follow, was dependent upon such factors as whether that physician significantly contributed to the hospital's fiscal bottom line; whether that physician had a special relationship with hospital administration; or whether that physician was affiliated with a particular group of physicians that had a lot of clout with the hospital.

Physicians who did not have such "protections" in place were prone to questionable accusations of disruptive conduct and threatened with a permanent mark on their record in the form of a NPDB report if they did not "conform" their alleged behavior.

Now that hospitals are required to have written disruptive physician policies, bogus allegations and "cherry-picking" enforcement should occur less frequently.

Nonetheless, physicians should still be leery of hospitals using disruptive physician behavior and the threat of a related NPDB report to accomplish a business or political agenda.

The broad interpretation of the duty to report to the NPDB is further amplified by a recent proclamation by Daryl Gray, director of the Division of Practitioner Data Banks, in response to a letter requesting clarification of a NPDB reporting standard.

In a July letter, the NPDB provided guidance on the question of whether "conduct or competence which does not adversely affect patient health or welfare" is reportable.

See "NPDB," page 14

Relocating

Continued from page 1

bank for regulatory purposes.

Because an REO asset can be titled with the bank or a borrower in default, avoid the risk of redemption by the defaulting mortgagor by finding out whom the record owner of the mortgaged property is before you sign any purchase agreement.

If preliminary inquiries through tax bills indicate that the borrower is still of record even though the bank is posturing as the seller, how does the bank plan on conveying title to the REO to a third-party purchaser — you?

When a borrower defaults on a loan, the bank has the right to exercise its remedies, including the right to foreclose on the property and auction it at a sale. In Michigan, every mortgagor has the right to redeem the mortgaged property even after a third-party purchaser bids successfully at the foreclosure sale.

For commercial or industrial properties, a mortgagor has six months from the date of the foreclosure sale to redeem.

In other words, if you received the sheriff's deed for a medical office building at a foreclosure sale on June 1, 2009, the defaulting borrower could still get the property back if it repaid the redemption amount by Dec. 1, 2009.

If a redemption right does exist or could arise in favor of the defaulting mortgagor, you do not want to enter into a purchase agreement that forces you to close prior to the expiration of the redemption period.

Ideally, you can successfully negotiate terms that grant you a due diligence period and a date of closing after the redemption right expires.

Don't expect a fire sale

The second common misconception is that banks are desperate to get rid of inventory.

The reality that has emerged in recent times is that lenders are motivated to reduce their inventory of REO assets to maintain compliance with holding periods and avoid paying carrying costs. However, they still seek to get the highest price possible and are not looking to simply dump real estate cheaply.

These conflicting interests ultimately may compel banks to discount pricing to some degree on REO. In return, however, banks will generally demand an "as-is" sale with no representations or warranties, and perhaps a very limited inspection period.

Regardless of how long of an inspection period you can negotiate with the bank, as a prospective buyer of an REO, you should do as much homework on the condition of the property as you can given the "as-is" nature of these deals.

The more information you can get up front before you make an offer and enter into a purchase agreement will help you avoid the risk of redemption and risks associated with "as-is" sales.

Even before you make an offer, you or your broker should ask the bank or its listing agent for copies of all existing reports, particularly with respect to title, inspections conducted, environmental conditions, insurance claims and operating statements.

The bank may not be willing to release such information until you sign a confidentiality agreement, which would restrict you from sharing the information.

The bank also may not be willing to deliver such information until after a purchase agreement is executed. In the latter case, ideally your purchase agreement will set forth that the due diligence period would not commence until the bank has provided to you such existing reports.

By getting copies of existing reports, you can flush out conditions of the property early while waiting for updated reports to arrive. Also, by obtaining existing reports, you can save money and time by updating the reports instead of starting from scratch.

In addition to existing reports, you or your broker should also inquire if there are any repairs or deferred maintenance that the bank is willing to undertake, and how long the banks take to accept an offer to purchase.

Debunking some of the myths of the REO market will help you form a realistic strategy for the acquisition of such an asset for your medical practice.

The more information you can get up front before you make an offer and enter into a purchase agreement will help you avoid the risk of redemption and risks associated with "as-is" sales.

As with any purchase, the rule of thumb remains: Caveat Emptor!

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Electronic

Continued from page 3

of patients with electronic access to personal health information and to patient-specific educational resources.

Practical Considerations

When adopting an EHR system, a provider may face some human obstacles; even in 2009, some physicians resist using computers in their regular practice.

The focus of HITECH is not just the acquisition of an EHR system, but also in its use and implementation. Therefore, a managing partner of a practice will need to work with physicians to overcome these issues and other concerns, such as the safety, security and compatibility of new software before implementing an EHR system.

Health care practices also must consider how providers will access the system. For example, will providers use desktop PC stations, laptops, or tablets?

There are positives and negatives to each option, including cost, ease of use, and availability. For example, if everything at a large practice must be entered into a desktop PC, the practice might encounter backups while physicians wait for access.

However, careful planning and a thorough review of physician preferences should increase use of the system and avoid additional frustration.

Lastly, a managing physician must consider the vendor that supplies the EHR system. If the practice already has a practice management system, it will be faced with the dilemma of purchasing EHR software from the same vendor, or retaining a new vendor and possibly encountering compatibility problems.

Some companies will not sell their EHR system separately from their practice management system. Thus, a practice may be faced with the expensive prospect of updating their entire system from the ground up.

As noted above, certain vendors already have a proven track record with CCHIT, so it may be wise to consider those vendors for EHR systems. In addition, the larger vendors may have an advantage as they will have the resources to make adjustments to EHR systems as HHS develops its specific goals.

So what does this all mean?

Clearly, increased profits for those companies that make EHR systems and software is one outcome.

But, hopefully, the HITECH Act also will result in better-coordinated patient care, improved access to health information, fewer medication errors, and improved services for treating chronic health issues.

Gary A. Kravitz is an attorney with Frank, Haron, Weiner and Navarro, PLC, where he focuses his practice on health care, real estate, corporate and tax law. He represents health care practitioners on structuring of practices and ancillary services, regulatory compliance, privacy, billing and reimbursement, credentialing and medical staffing, and fraud and abuse matters. Contact him at (248) 952-0400 or gkravitz@fhwnlaw.com.

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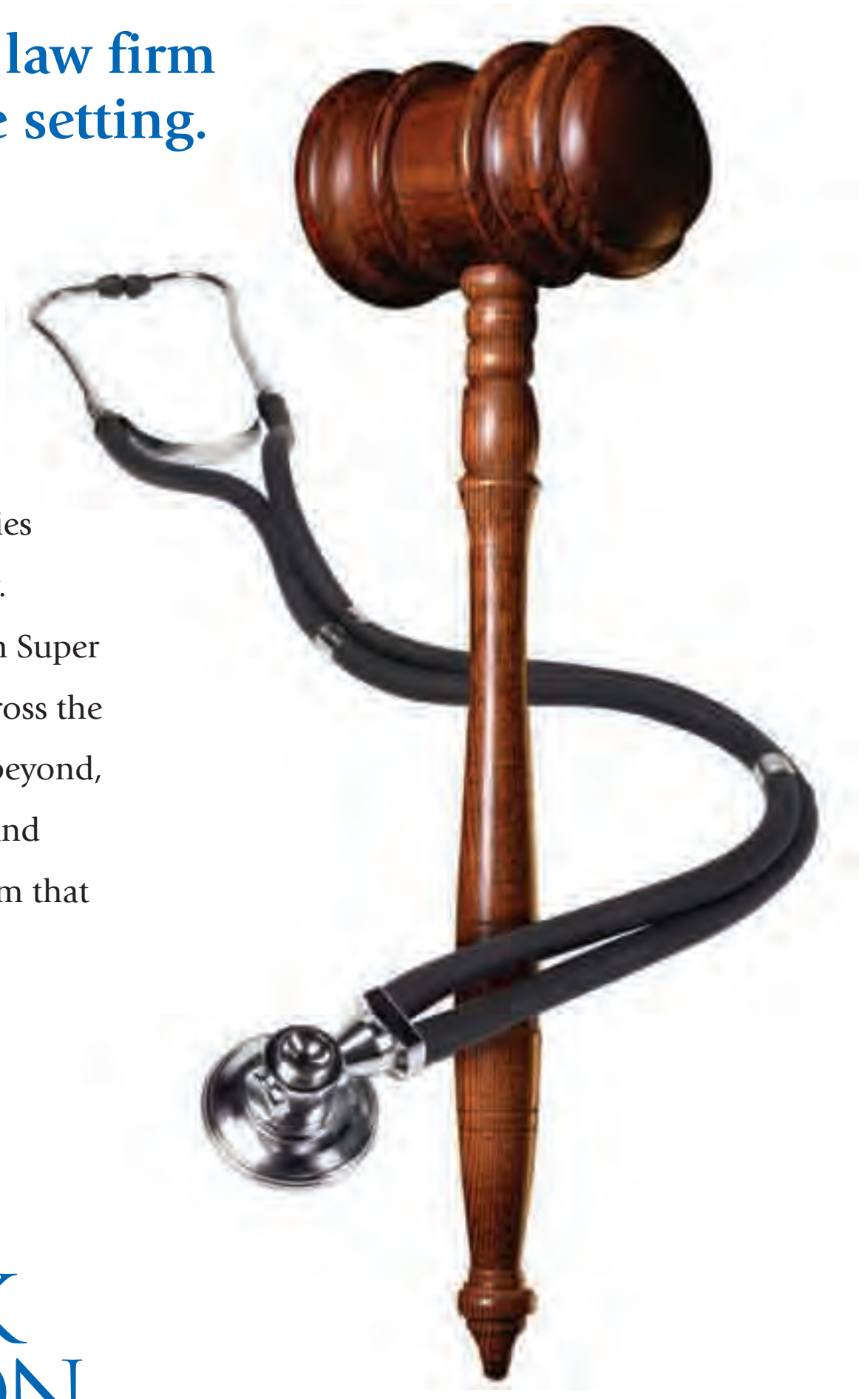

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Pending Legislation

MICHIGAN MEDICAL LEGISLATION REPORT

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

HOUSE BILLS

HB 4776 – Require prescribers to request information from the Michigan automated prescription system before prescribing and prohibit dispersing under certain circumstances
"Beginning Jan. 1, 2010, a prescriber shall request information from the electronic system as allowed in section 7333a(2)(f) before prescribing a controlled substance included in schedule 3 or 4 to a patient. In addition to any other duty the prescriber has with regard to that patient, the prescriber shall utilize information received from the electronic system under this subsection to determine whether a controlled substance included in schedule 3 or 4 should be prescribed for that patient. Information obtained by the prescriber from the electronic system under this subsection is confidential and is subject to the physician-patient privilege. A prescriber shall mark on the prescription form that he or she has received information from the electronic system as required under this subsection with regard to the patient for which the prescription for a controlled substance included in schedule 3 or 4 is written.
"Beginning Jan. 1, 2010, a pharmacist or dispensing prescriber shall not dispense a controlled substance included in schedule 3 or 4 to a patient unless the prescription form contains the mark of the prescriber that indicates the prescriber has received information from the electronic system as required under subsection (1) with regard to the patient for which the prescription for a controlled substance included in schedule 3 or 4 is written. As used in this section, 'pharmacist' and 'dispensing prescriber' mean those terms as defined in part 177."
Sponsored by: Wayne Schmidt-R
Referred to the Committee on Health Policy

HB 4778 – Require primary care physician to include in patient's medical record a copy of criminal record, if any, and government-issued photo identification; and to require, and prohibit provision of primary care services until obtained.
"A physician under part 170 or part 175 or any person acting under the supervision of that physician shall not provide primary care services to a patient unless all of the requirements of this section are met. This section does not apply to a physician or any person acting under the supervision of a physician who provides emergency or nonprimary care services to a patient.
"A patient who is 16 years of age or older shall present his or her government-issued photo identification to his or her primary care physician upon entering the office or during the check-in process. A physician shall make a copy of the patient's government-issued photo identification and place that copy in the patient's permanent medical record. The physician shall determine at each subsequent visit by the patient whether the identification in the patient's medical record is up-to-date and shall update the record if necessary.
"A patient who has been convicted of a drug offense shall disclose that conviction to a physician who is providing primary care services. A physician shall include in any documentation required of patients during the check-in process a space for the patient to disclose if he or she has been convicted of a drug offense. If a patient discloses a drug offense under this subsection, the physician or any person acting under the supervision of that physician shall not provide primary care services to that patient at any subsequent visit until the patient provides a copy of his or her criminal record. A physician shall make a copy of the patient's criminal record and place that copy in the patient's permanent medical record. The physician shall determine at each subsequent visit by the patient whether the patient's criminal record is up-to-date and shall update the record if necessary."
Sponsored by: James Marleau-R
Referred to the Committee on Health Policy

HB 4937 – Requirements for any physician or other licensee who writes prescriptions to utilize e-prescribing system established under Medicare regulations
"Except as otherwise provided in this section, beginning July 1, 2010, a prescriber shall electronically transmit every prescription for a prescription drug written in this state in a manner that complies with the electronic prescription drug program established for prescribers under the Medicare improvements for patients and providers act of 2008, Public Law 110-275. A prescriber shall offer the patient a written receipt of the information transmitted electronically to the pharmacy. The receipt shall include the patient's name, the dosage and drug prescribed, and the name of the pharmacy where the electronic prescription was sent and shall indicate that the receipt cannot be used as a duplicate order for the same prescription drug. Nothing in this section interferes with the right of a patient to choose a pharmacy or with the prescribing decision at the point of care. If the pharmacy to be used by the patient for whom the prescription is written is not able to receive electronically transmitted prescriptions as provided in this subsection, the prescriber shall write the prescription utilizing electronic prescription technology and do one of the following as directed by the patient:
"(a) Print or otherwise provide the patient with a paper copy of the electronic prescription.
"(b) Transmit the electronic prescription to the pharmacy by facsimile or other means of electronic transmission, if that transmission is otherwise allowed under this act.
"Nothing in this section diminishes or modifies any requirements or protections provided for in the prescription of controlled substances as otherwise established by this act. A prescriber and a pharmacy shall comply with applicable state and federal confidentiality and data security requirements and applicable state record retention and reporting requirements with regard to electronically transmitted prescriptions under this section.
Sponsored by: Kate Segal-D
Referred to the Committee on Health Policy

HB 5043 – License revocation or denial upon conviction of first-, second- or third-degree criminal sexual conduct
"Except as otherwise provided, an individual whose license is limited, suspended, or revoked under this part may apply to his or her board or task force for a reinstatement of a revoked or suspended license or reclassification of a limited license pursuant to section 16247 or 16249.
"Except as otherwise provided, an individual whose registration is suspended or revoked under this part may apply to his or her board for a reinstatement of a suspended or revoked registration pursuant to section 16248.
"A board or task force shall reinstate a license or registration suspended for grounds stated in section 16221(i) upon payment of the installment.
"Except as otherwise provided in this subsection, in case of a revoked license or registration, an applicant shall not apply for reinstatement before the expiration of three years after the effective date of the revocation. In the case of a license or registration that was revoked for a violation of section 16221(b)(vii), a violation of section 16221(c)(iv) consisting of a felony conviction, any other felony conviction involving a controlled substance, or a violation of section 16221(p), an applicant shall not apply for reinstatement before the expiration of five years after the effective date of the revocation. In the case of a license or registration that was revoked for a violation of section 16221(b)(xiii), that revocation is permanent and the licensee or registrant is ineligible for reinstatement. The department shall return an application for reinstatement received before the expiration of the applicable time period under this subsection or if the applicant is ineligible for reinstatement under this subsection.
"The department shall provide an opportunity for a hearing before final rejection of an application for reinstatement.
"Based upon the recommendation of the disciplinary subcommittee for each health profession, the department shall adopt guidelines to establish specific criteria to be met by an applicant for reinstatement under this article or article 7. The criteria may include corrective measures or remedial education as a condition of reinstatement. If a board or task force, in reinstating a license or registration, deviates from the guidelines adopted under this subsection, the board or task force shall state the reason for the deviation on the record."
Sponsored by: Lesia Liss-D
Referred to the Committee on Health Policy

HB 5057 – Require certain physicians to inform patients during second trimester about options regarding cord blood stem cells
"If funding is made available, the department shall promote public awareness and increase knowledge about the statewide network of cord blood stem cell banks, cord blood banking options, and the benefits of cord blood stem cells by developing and disseminating educational materials on the uses and benefits of cord blood stem cells, the viability of cord blood stem cells, information on research results utilizing cord blood stem cells, and any other related materials and information to enable the public to make informed decisions about the utilization of cord blood stem cells. Information shall include, but is not limited to, all of the following:
"(a) An explanation of the differences between public and private cord blood banking.
"(b) Information on the statewide network of cord blood stem cell banks.
"(c) Cord blood options available.
"(d) The medical process and risks involved in the collection of cord blood.
"(e) Medically accepted uses and benefits of cord blood collection and transplantation.
"(f) A statement that due to ongoing research and development there may be future uses and benefits of cord blood collection and transplantation.
"(g) An explanation of any costs to the donor associated with cord blood donation and storage.
"(h) Information on how to request printed materials and how to access other information available on the department's Web site.
"(i) Options for ownership and future use of the donated material.
"(j) An explanation of the storage, maintenance, and viability for transplantation of cord blood stem cells.
"The department, on its Web site, shall make the materials and information gathered and developed under subsection available in printable format to the public and to health care facilities and agencies, cord blood banks, and health care professionals.
"Except as otherwise provided in this section, a health professional who is the primary care provider for a patient who is in her second trimester of pregnancy shall inform the patient of the following options relating to cord blood stem cells after the delivery of her child:
"(a) Discard the cord blood stem cells.
"(b) Donate the cord blood stem cells to a donor bank.
"(c) Store the cord blood stem cells for use by the immediate and extended family members in a cord blood stem cell bank.
"(d) Store the cord blood stem cells for family use through a family or sibling donor banking program that provides free collection, processing, and storage where there is a medical need.
"If the department has developed educational materials under section 2683, the health professional described in subsection 1 shall also provide his or her patient with those materials. A health professional described in subsection 1 meets the notification requirements of this section by providing the information verbally or in writing or by providing the woman with a publication prepared by the department that, as certified by the department, contains all the information required by this section in addition to the information required under section 2683.
"This section does not apply to a health professional and he or she is not required to inform a pregnant patient regarding cord blood stem cell options if providing that information conflicts with the health professional's bona fide religious beliefs.
"A person who acts in good faith pursuant to this section is not subject to civil or criminal liability or professional discipline for those acts."
Sponsored by Paul Scott-R
Referred to the Committee on Health Policy

HB 5284 – A bill to amend 1969 PA 317, entitled "Worker's disability compensation act of 1969," compensation for exposure to secondhand smoke.
" (1) A lung disease or other condition that has been linked to secondhand smoke by credible scientific evidence shall be presumed to have been contributed to, aggravated, or accelerated in a significant manner by employment and is compensable as provided in this act if all of the following conditions are met: (a) The employer permits smoking in the workplace. (b) The affected employee does not smoke and has not been a smoker in the immediately preceding 10 years. (c) The employee was subject to secondhand smoke in the workplace for 1 year or more. (2) The presumption under subsection (1) is removed if the employer provides affirmative evidence of non-work-related causation or specific incidents that establish a cause independent of employment and not merely evidence of a preexisting condition or an abstract medical opinion that employment was not the cause of the disease or condition.
Sponsored by Timothy Bledsoe-D
Referred to the Committee on Regulatory Reform

Legislative Committee Members

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

Contact information for state house representatives can be found at http://house.michigan.gov.

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Pending Legislation

SENATE BILLS

SB 0423 – Amend the Nonprofit Health Care Corporation Reform Act to include coverage for K-12 school-required vaccines.
"A health care corporation that issues or renews in this state a group or nongroup certificate shall include coverage for immunizations against diseases as specified by the director of the department of community health as necessary for attendance in grades K through 12 in this state.
"Coverage under this section shall not be subject to any dollar limit, co-payment, deductible, or coinsurance provision that does not apply to screening coverage generally.
"This section does not apply to specified disease or accident-only coverage."
Sponsored by: Gilda Jacobs-D
Referred to the Committee on Health Policy

SB 0477 – Amend the Corrections Code of 1953, by adding agreements to have Michigan medical schools provide medical services to prisoners.
"The department shall enter into agreements with one or more medical schools in this state under which health care services would be provided to prisoners by those medical schools.
"The department shall report to the legislature not later than 180 days after the effective date of this section, and annually thereafter, on the status of any agreements entered into under this section. The report shall include an evaluation of the cost and efficiency of health care services delivered under the agreements. Copies of the report shall be delivered to the secretary of the Senate and the clerk of the House of Representatives and to the chairpersons of the standing committees of the Senate and House of Representatives responsible for legislation pertaining to corrections issues."
Sponsored by: Thomas George-R
Referred to the Committee on Judiciary

SB 0499 – Creation of the Employee Accommodation Act
"A health care provider may request reasonable accommodation to avoid providing or participating in a health care service to which the health care provider objects on ethical, moral, or religious grounds.
"A health care provider shall request reasonable accommodation described in subsection (1) in writing. The written request shall be given directly to his or her supervisor and shall include a statement explaining his or her objection and the health care service or services to which he or she specifically objects to providing or participating in under this act.
"A health care provider may request reasonable accommodation under any of the following conditions:
"(a) Upon being offered employment.
"(b) At the time the health care provider adopts an ethical, moral, or religious belief system that conflicts with participation in a health care service.
"(c) Within 24 hours after he or she is asked or has received notice that he or she is scheduled to participate in a health care service to which he or she objects.
"An employer shall retain a health care provider's written request filed under section 5 for the duration of the health care provider's employment. The written request is valid for the duration of the health care provider's employment or until rescinded by the health care provider in writing.
"Within 7 days after receiving a written request pursuant to section 5, an employer shall develop a plan for reasonable accommodation with the health care provider to ensure that the health care provider will not be scheduled or requested to participate in a health care service to which he or she specifically objects.
"An employer shall not ask a prospective employee regarding his or her objection or potential objection to a health care service unless participation in that health care service is a regular or substantial portion of the normal course of duties for the position or staff privileges the prospective employee is seeking.
"An employer shall not refuse employment or staff privileges to a health care provider who is known by the employer to have previously requested or is currently requesting reasonable accommodation under section 5 unless participation in that health care service is a regular or substantial portion of the normal course of duties for that position or staff privileges.
"A medical school or other institution for the education or training of a health care provider shall not refuse admission to an individual or penalize that individual because the individual has filed in writing with the medical school or other institution a request for reasonable accommodation under section 5. ...
"Except as provided in section 9, a health care provider's objection to providing or participating in a health care service as described in section 5 shall not be the basis for one or more of the following:
"(a) Civil liability to another person.
"(b) Criminal action.
"(c) Administrative or licensure action.
"(2) If a health care provider is required by his or her employer to participate in a health care service more than seven days after the health care provider has submitted a written request regarding that health care service, the health care provider is immune from civil liability in an action arising from his or her participation in that health care service.
"A civil action for damages or reinstatement of employment, or both, may be brought against a person, including, but not limited to, a governmental agency, health facility, or other employer, for penalizing or discriminating against a health care provider, including, but not limited to, penalizing or discriminating in hiring, promotion, transfer, a term or condition of employment, licensing, or granting of staff privileges or appointments, solely because that health care provider has submitted a request regarding participating in a health care service under section 5. Civil damages may be awarded equal to the amount of proven damages and attorney fees. A civil action filed under this subsection may include a petition for injunctive relief against a person alleged to have penalized or discriminated against a health care provider as described in this subsection.
"A person who violates this act is responsible for a state civil infraction and may be ordered to pay a fine of not more than $1,000 for each day the violation continues or a fine of not more than $1,000 for each occurrence."
Sponsored by: Roger Kahn-R
Referred to the Committee on Health Policy

SB 0565 – Amend Public Health Code to require promulgation of rules relating to program for allocating leftover medical supplies (PALMS)
"Subject to subsection (2), the department, in consultation with the board, shall promulgate rules and establish procedures necessary to establish, implement, and administer the PALMS. The board shall provide technical assistance to individuals, health facilities and agencies, adult foster care facilities, assisted living facilities, manufacturers, pharmacies, and charitable clinics that participate in the PALMS.
"The department, in consultation with the board, shall promulgate emergency rules under the administrative procedures act of 1969 on or before the expiration of six months after the effective date of this section to establish, implement, and administer the PALMS. The department, in consultation with the board, shall promulgate permanent rules pursuant to the administrative procedures act of 1969 as soon as practical after emergency rules have been promulgated under this subsection. The department and the board shall include all of the following in rules promulgated under this section:
"(a) Eligibility criteria for pharmacies and charitable clinics authorized to receive and dispense donated prescription drugs for the PALMS.
"(b) Eligibility criteria for eligible participants.
"(c) Establishment of a formulary that includes all prescription drugs approved by the federal food and drug administration.
"(d) Standards and procedures for transfer, transportation, acceptance, safe storage, security, and dispensing of donated prescription drugs.
"(e) A process for seeking input from the department in establishing provisions that affect health facilities and agencies, adult foster care facilities, and assisted living facilities.
"(f) A process for seeking input from the department and the department of human services in establishing provisions that affect mental health and substance abuse clients.
"(g) Standards and procedures for inspecting donated prescription drugs to ensure that the prescription drugs meet the requirements of the PALMS and to ensure that, in the professional judgment of the pharmacist, the prescription drugs meet all federal and state standards for product integrity.
"(h) Procedures for the destruction and environmentally sound disposal of prescription drugs or other medications that are donated and that are controlled substances or otherwise ineligible for distribution under the PALMS.
"(i) Procedures for verifying whether the charitable clinic, pharmacy, responsible pharmacist, or other health professionals participating in the PALMS are licensed and in good standing with the applicable licensing board.
"(j) Establishment of standards for acceptance of unused prescription drugs from individuals, health facilities and agencies, adult foster care facilities, and assisted living facilities.
"(k) Any other standards and procedures the department, in consultation with the board, considers appropriate or necessary to establish, implement, and administer the PALMS.
"Pursuant to the rules promulgated and procedures established for the PALMS under this section and section 17775, an individual; a resident of a health facility or agency, adult foster care facility, or assisted living facility; or the representative or guardian of an individual or a resident of a facility may donate unused prescription drugs for dispensing to eligible participants under the PALMS.
"This section and sections 17775 and 17776 do not impair or supersede the provisions regarding the cancer drug repository program established in section 17780. If any provision of this section or section 17775 or 17776 conflicts with a provision of that section with regard to cancer drugs, that section controls."
Sponsored by: Tony Stamas-R
Referred to the Committee on Health Policy

SB 0651 – An individual shall not intentionally engage in or attempt to engage in human cloning. (2) Subsection (1) This subsection does not prohibit scientific research or cell-based therapies not specifically prohibited by that under this subsection. (2) An individual shall not intentionally transport, attempt to transport, or cause to be transported into this state a human embryo created through human cloning. (3) An individual who violates subsection (1) this section is guilty of a felony punishable by imprisonment for not more than 10 years or a fine of not more than $10,000,000 or both. (4) As used in this section, "human cloning" means that term as defined in section 16274 of the public health code, 1978 PA 368, MCL 333.16274.
Sponsored by: Judson Gilbert-R
Referred to the Committee on Health Policy

SB 0681 – Requirement to obtain informed consent before testing for human immunodeficiency virus (HIV); eliminate, and provide option to decline test in writing.

Except as otherwise provided in subsections (12) and (13), a physician who orders an HIV test or a health facility that performs an HIV test shall provide counseling appropriate to the test subject both before and after the test is administered. (2) Except as otherwise provided in this part, a physician, or an individual to whom the physician has delegated authority to perform a selected act, task, or function under section 16215, shall not may order an HIV test for the purpose of diagnosing HIV infection without first receiving the written, informed consent of the test subject. For purposes of this section, written, informed consent consists of a signed writing executed by the test subject or the legally authorized representative of the test subject that includes, at a minimum, all of the following:(a) An explanation of the test including, but not limited to, the purpose of the test, the potential uses and limitations of the test, and the meaning of test results.(b) An explanation of the rights of the test subject including, but not limited to, all of the following:(i) The right to withdraw consent to the test at any time before the administration of the test. (ii) The right under this part to confidentiality of the test results. (iii) The right under this part to consent to and participate in the test on an anonymous basis. (c) The person or class of persons to whom the test results may be disclosed under this part. Unless the HIV test is declined in writing under this section, the test subject's consent to general medical care is considered consent to an HIV test. (3) Beginning July 28, 1989 October 1, 2009, a physician or an individual to whom the physician has delegated authority to perform a selected act, task, or function under section 16215 who orders an HIV test shall distribute to each test subject a pamphlet regarding the HIV test on a form provided by the department. The epartment shall develop the pamphlet, which shall include all of the following: (a) The purpose and nature of the test. (b) The consequences of both taking and not taking the test. (c) The meaning of the test results. (d) Other information considered necessary or relevant by the department. (e) A model consent form for the signed writing required under subsection (2) test subject to use if he or she wishes to decline the HIV test in writing. The department shall include in the model consent form all of the information required under subsection (2)(a), (b), and (c). following: (i) An explanation of the test including, but not limited to, the purpose of the test, the potential uses and limitations of the test, and the meaning of test results. ..."
Sponsored by: Thomas George-R
Referred to the Committee on Health Policy

BILLS PASSED

SB 0528 – Prohibiting reuse of single-use medical devices under certain circumstances and prescription of remedies for violation.
Sponsored by: Bill Hardiman-R
Passed in Senate (35-0)
Status: Referred to the Committee on Health Policy

HBS 4763-69 – HEALTH, Children
Create short title and allow for promulgation of rules for Children's Safe Products Act.
Sponsored by Judy Nerat-D
Passed in House (63-44)
Status: Referred to Committee on Health Policy

HB 4899 – HEALTH, Diseases
Require department to create and update list of reportable diseases at least annually
Sponsored by Kate Segal-D
Passed in House (106-2)
Status: Referred to Committee on Health Policy

HB 4900 – HEALTH, Local Health Departments
Penalties for violation of a local health department regulation or order of a local health officer.
Sponsored by Tim Moore-R
Passed in House (104-4)
Status: Referred to Committee on Health Policy

See "Pending Legislation," page 14

CMS changes rules regarding use of 'consignment closets'

The Centers for Medicare & Medicaid Services (CMS) recently issued a change request to amend the Medicare Program Integrity Manual. It would prohibit the use of certain "consignment closet" and "stock and bill" arrangements used by durable medical equipment, prosthetics, orthotics, and supplies (DMEPOS) suppliers.

Specifically, DMEPOS suppliers will no longer be able to maintain an inventory at a health professional's office and bill Medicare beneficiaries for the supplies distributed by health professionals from the inventory.

While the change request does not impact the use of consignment closets in hospitals, the anti-kickback concerns remain the same.

Inventory must be limited

DMEPOS suppliers will still be permitted to maintain an inventory at a health care professional's office, but only under the following limited circumstances:

- The title to the DMEPOS is transferred to the health care professional at the time the DMEPOS is furnished to the beneficiary;
- The health care professional bills the patient for the DMEPOS supplies using the health care professional's own enrolled DMEPOS number;
- Services related to the fitting or use of the DMEPOS are performed by individuals being paid by the health care professional and not by any other DMEPOS supplier; and
- The beneficiary should be directed back to the health care professional for any questions or problems regarding the DMEPOS.

The National Supplier Clearinghouse Medicare Administrative Contractor (NSC-MAC) has been charged with verifying that two or more DMEPOS suppliers are not located at the same practice location.

A separate practice location is defined as a location with a separate entrance and a separate post office address.

According to the change request, the reason for this change was that most consignment closets or stock and bill arrangements were not in compliance with the DMEPOS supplier standards set forth in 42 CFR §424.57.

Although CMS did not indicate which standards were problematic, it is likely that DMEPOS suppliers utilizing consignment closets were determined in some instances not to meet requirements to "enroll separate locations it uses to furnish Medicare covered DMEPOS" or the requirement that it "fills orders, fabricates, or fits items from its own inventory. …"

The Office of the Inspector General (OIG) for the Department of Health and Human Services (HHS) has also long been concerned about the use of consignment closets.

Specifically, the OIG has expressed concern that DMEPOS suppliers were using payments for consignment closets and associated services as a vehicle to compensate physicians for access to the supplier's patient base.

For example, rent that is less than fair market value or payment for "management services" to physician offices that does not serve a legitimate business purpose have been cited by the OIG as potential anti-kickback violations in Advisory Opinions, Special Fraud Alerts and the DMEPOS Supplier Compliance Guidance.

Even if arrangements meet the current requirements, there may still be fraud and abuse concerns associated with the use of consignment closets.

For example, to the extent that DME companies offer "discounts" on supplies to physicians, such discounts should be appropriately reported to Medicare.

Arrangements between DMEPOS suppliers and health care providers also should be carefully analyzed to determine whether they could be construed as being a prohibited "contractual joint venture" that would violate the anti-kickback statute.

The OIG has identified certain characteristics that it considers to be "suspect" and potentially indicating an arrangement that would violate the anti-kickback statute.

Suspect arrangements

Some of these suspect characteristics that might be applicable to an arrangement between a DMEPOS Supplier and a health professional include:

- The health professional expands into a new health care service, i.e., DMEPOS, which is intended to predominately serve the health care professional's existing patients with no effort to expand the business to a new customer base.
- The health professional enters into the venture with a DMEPOS supplier who would otherwise be its direct competitor.
- The health professional makes little or no financial investment, with its sole contribution to the venture being access to its patient base.
- The DMEPOS supplier operates the venture and contributes the financial investment.
- The health professional's remuneration is tied to the volume or value of patient referrals from the health professional's patient base.

All of these factors are illustrative of a suspect contractual arrangement, but no one factor is considered determinative.

While the change request does not impact the use of consignment closets in hospitals, the anti-kickback concerns remain the same.

Providers who currently utilize consignment closets or stock and bill arrangements in any setting should have these arrangements reviewed by health care counsel for compliance with the new requirements, as well as the DMEPOS certification standards, the anti-kickback statute and the Stark regulations.

Health Policy

By Amy K. Fehn, Esq. and Jennifer Ferro, Esq.

FEHN

FERRO

Amy K. Fehn and Jennifer Ferro are health care attorneys at Wachler & Associates, P.C. Fehn is a former registered nurse who has been counseling health care providers for the past 11 years on regulatory and compliance matters such as HIPAA, Stark, fraud and abuse, and the defense of RAC and other Medicare and third-party payor audits. Ferro practices in all areas of health care law and devotes a substantial portion of her practice to representing providers in the Medicare and other third-party payor audit appeals processes. Contact them at (248) 544-0888 or afehn@wachler.com andjcolagiovanni@wachler.com.

New HIPAA breach notification rule in effect

As of Sept. 23, HIPAA covered entities are required to notify individuals, the media and HHS of certain breaches of protected health information (PHI).

Business associates causing such breaches are required to notify the covered entity of such breaches. The Office for Civil Rights will not impose sanctions for breaches occurring prior to Feb. 22, 2010, essentially giving covered entities six months to comply.

The Department of Health and Human Services (HHS) published the interim final rule Aug. 24, 2009, which was required by the American Recovery and Reinvestment Act of 2008 (ARRA), and amends the Health Insurance Portability and Accountability Act (HIPAA) Privacy Rule.

Breach notification is required when there is: an acquisition, access, use, or disclosure in violation of the HIPAA Privacy Rule, of PHI that was unsecured, when an exception does not apply, and it compromises the security or privacy of such information.

Considerations in breach notification

- **Step 1:** Determine if the use or disclosure was in violation of the HIPAA Privacy Rule. If there was no violation, then no notice is required.
- **Step 2:** Determine if the PHI was "unsecured," a PHI that was not secured through the use of a technology or methodology that renders the PHI unusable, unreadable, or indecipherable to unauthorized individuals, per HHS guidance.

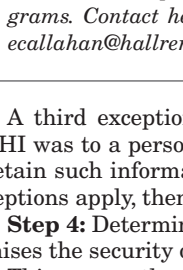
HHS guidance has identified encryption and destruction. In other words, no notice is required if the PHI was encrypted or destroyed per HHS guidance.

- **Step 3:** Determine if an exception applies. One exception is if it was an unintentional acquisition, access, or use of PHI by workforce member or other person under authority of a covered entity (or business associate), if in good faith, within scope of authority, and the PHI not further used or disclosed.

Another exception is if it was an inadvertent disclosure of PHI by person authorized to access PHI to another such person at the same covered entity, business associate, or organized health care arrangement, and the PHI not further used or disclosed.

Privacy Matters

By Elizabeth Callahan-Morris, Esq.



Elizabeth Callahan-Morris is an attorney with Hall, Render, Killian, Heath & Lyman, P.C. She focuses her practice in the areas of corporate compliance, patient care issues, HIPAA and regulatory law. She advises hospitals and other health care organizations on all aspects of compliance programs. Contact her at (248) 740-7505 or ecallahan@hallrender.com.

A third exception is if the disclosure of PHI was to a person not reasonably able to retain such information. If any of these exceptions apply, then no notice is required.

Step 4: Determine if the breach "compromises the security or privacy" of the PHI.

This means the covered entity must determine whether it "poses a significant risk of financial, reputational, or other harm to the individual," per a risk assessment. Note that if the PHI had no identifiers (none of the 16 direct identifiers per limited data set rule, no dates of birth and no ZIP codes), then it automatically does not "compromise the security or privacy" of the PHI.

If it is determined that the breach did not compromise the security or privacy of the PHI, then no notice is required.

In cases where notification is not required, covered entities should still consider notification as a way to mitigate any harmful effect of a wrongful use or disclosure under the existing HIPAA Privacy Rule on "mitigation."

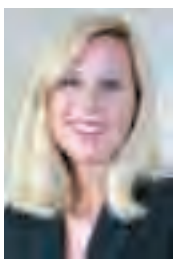
In general, if notification is not required under HIPAA, then notification also is not

See "HIPAA," page 14

Physicians can choose to opt out of Medicare participation

Health Policy

By Abby Pendleton, Esq. and Jessica L. Gustafson, Esq.


PENDLETON


GUSTAFSON

Abby Pendleton and Jessica L. Gustafson are partners with the health care law firm of The Health Law Partners, P.C. They specialize in a number of areas, including but not limited to, Recovery Audit Contractor (RAC), Medicare, Medicaid and other payor audit appeals, healthcare regulatory matters, compliance matters, reimbursement and contracting matters, transactional and corporate matters, and licensing, staff privilege and payor de-participation matters. Contact them at (248) 996-8510 or apendleton@thehlp.com and jgustafson@thehlp.com.

To participate or not to participate: that is the question.

As Medicare providers begin to experience decreased reimbursement for certain Medicare procedures, and some providers become overwhelmed by the volume of laws, regulations and policies governing the program, some physicians are beginning to question the value of continued Medicare participation.

Physicians have choices when it comes to Medicare participation: they can participate with Medicare; they can become a non-participating provider; and they can opt-out of the Medicare program.

Option 1: To participate

The vast majority of physicians participate with Medicare. In fact, more than 97 percent of Michigan physicians and other practitioners participate with Medicare.

The Centers for Medicare and Medicaid Services (CMS) strives to incent providers to participate (PAR) by:

- Offering a 5 percent higher Medicare approved amount for services provided compared with the approved amount for non-PAR physicians;
- Offering directories of PAR physicians to beneficiaries; and
- Offering to PAR physicians faster claims-processing times, and a toll-free number for claims-related questions.

To become a PAR provider with Medicare, providers must complete a CMS-855 Medicare enrollment application and obtain a National Provider Identifier (NPI) number from the National Plan and Provider Enumeration System (NPPES).

PAR physicians agree to accept assignment on all Medicare claims and agree to accept Medicare's allowed charge as payment in full for all covered services.

Once a claim is submitted, Medicare will provide 80 percent of its allowed charge directly to the billing physician; the physician must collect the 20 percent patient co-payment. A PAR physician cannot bill a patient an amount in excess of the Medicare allowed charge.

Option 2: Not to participate

A physician also may choose not to participate with Medicare — that is, become a "non-PAR" physician.

There are a couple differences between being a PAR physician and a non-PAR physician. Medicare approved amounts for services provided by non-PAR physicians are 5 percent lower than for PAR physicians, but non-PAR physicians may charge more than the Medicare approved amount.

In fact, the limiting charges for non-PAR physician services are set at 115 percent of the Medicare approved amount for non-PAR physician services.

A non-PAR physician may choose whether to accept assignment on a claim-by-claim basis.

Importantly, a physician cannot opt out of the Medicare program for some beneficiaries but not others, or for some practice locations, but not others.

Option 3: The opt-out option

Provided that certain requirements are met, physicians may choose to opt-out of the Medicare program entirely and provide services to Medicare beneficiaries through private contracts. To opt-out of the Medicare program, the following procedures must be followed:

- Even if a physician never has enrolled in the Medicare program before, he or she still must provide a NPI number to the Medicare Carrier (which in Michigan is Wisconsin Physician Services, or WPS), so that the carrier may record internally that the physician has opted-out of Medicare.
- If a physician chooses to opt out, he or she must enter into a private contract with each Medicare beneficiary to whom he or she furnishes covered services. An opt-out physician is not required to use a private contract for an item or service that is excluded from Medicare.

Among other requirements, private contracts between an opt-out physician and Medicare beneficiaries must indicate the effective date and expiration date of the opt-out period.

The contracts also must indicate that the beneficiary agrees to give up Medicare payment for Medicare-covered services, accepts full responsibility for payment, and agrees to pay the physician his charges (irrespective of Medicare limits that would apply if the physician had not opted out).

Specific requirements for Provider Contracts can be found in the Medicare Benefit Policy Manual, Chapter 15, Section 40.8.

A sample private contract is available from the American Medical Association's Web site at www.ama-assn.org/.

- Within 10 days of the date an opt-out physician enters into his first private contract with a Medicare beneficiary, the physician must file an affidavit with the Medicare Carrier, which indicates that the physician has opted out of Medicare.

Among other requirements, the affidavit must indicate that the provider will not submit any claim to Medicare for covered items and services provided to Medicare beneficiaries during the two-year period after the affidavit's effective date.

Additionally, the affidavit must indicate that the physician agrees not to receive any Medicare payments during this time period.

The specific requirements governing Opt Out Affidavits can be found in the Medicare Benefit Policy Manual, Chapter 15, Section 40.9.

A sample affidavit is available from the American Medical Association's Web site.

Note that there is one main exception to an opt-out physician receiving reimbursement from the Medicare program: In an emergency situation, a physician may treat a Medicare beneficiary in need of emergency services, even if the physician does not have a private contract with the beneficiary, and the physician may bill Medicare for the treatment provided.

The provider may not charge more than the Medicare limiting charge for such services, and must submit the claim to Medicare on the beneficiary's behalf.

The timing of when a physician may opt out of the Medicare program depends upon whether that physician is a PAR physician or non-PAR physician.

PAR physicians must file the requisite opt out affidavit with the Medicare Carrier at least 30 days before the first day of the next quarter; the effective date of the opt out period will be the first day of the quarter. Non-PAR physicians may opt out at any time by filing the required affidavit.

Importantly, a physician cannot opt out of the Medicare program for some beneficiaries but not others, or for some practice locations, but not others.

According to WPS' Web site, "[A] provider cannot choose to 'opt out' of Medicare for some Medicare beneficiaries but not others, or for some services but not others. The 'opt out' status applies to all items or services the provider furnishes to Medicare beneficiaries regardless of the location where they are furnished. Therefore, it applies to all of a provider's Medicare numbers."

Hospitals may be liable if doctors violated statute

Negligence claim against doctors approved in child abuse reporting case

Michigan Court of Appeals

By Edward Wesoloski, Esq.

The estate of a child whose foster father beat him to death can sue the doctors who examined the child before the beating for having "reasonable cause to suspect child abuse or neglect" and failing to report that suspicion to state officials, the Michigan Court of Appeals has ruled in a 2-1 decision.

The estate may sue the doctors in negligence under MCL 722.633(1), the Child Protection Act's civil remedy provision, the majority held.

A medical-malpractice suit is not required for claims that the doctors violated their duty to report suspected abuse under MCL 722.623 to the Department of Human Services (DHS).

Judge Peter D. O'Connell, who dissented in *Lee v. Detroit Medical Center, et al.* (Lawyers Weekly No. 07-70652, 18 pages), predicted that doctors, fearful of frivolous lawsuits and lacking the "protections inherent in a medical-malpractice cause of action," will file a report every time a child presents with a bump or a bruise.

O'Connell's prediction may well become reality.

"The court has essentially left doctors with no choice. They have to report everything" to avoid liability under the act, said Jennifer A. Engelhardt, of Giarmarco, Mullins & Horton, P.C., who represented one of the doctors in *Lee* on appeal.

In *Lee*, the 3-year-old child was placed with foster parents in April 2002. He was well-nourished but had eczema, a skin condition, and other problems.

By January 2003, the child was losing weight. His family doctor referred him to Children's Hospital to assess the child's "failure to thrive."

The child's foster mother took him to the Children's Hospital emergency room for a second opinion on why he was not growing and because he had tremors.

Drs. Vince Truong and Jayshree Rao examined the child.

Truong noted that the child's "skin had 'multiple bruising suggesting [a] history of abuse.'" Truong later testified that he observed both old and new bruises. He said he did not suspect abuse. The foster mother seemed caring and concerned, and his findings were consistent with the history she gave.

Rao "signed off" on Truong's report, but later testified that the report was incorrect. The report should have noted "marks or scars" on the child but not bruises, she said.

Neither doctor filed a report with the DHS.

About two months later, the child's foster father beat him to death and confessed to the crime.

The plaintiff, the child's older sister, filed a negligence claim against Truong, Rao, Children's Hospital, the Detroit Medical Center and other defendants.

The doctors argued that the plaintiff was required to sue for medical malpractice to establish a claim under the act. The institutional defendants argued that the act did not provide for vicarious liability.

Wayne County Circuit Court Judge Warfield Moore, Jr. granted the doctors summary disposition but refused to dismiss the vicarious liability claims.

The Court of Appeals reinstated the estate's case against the doctors and affirmed Moore's vicarious liability ruling.

Same standard for all

The majority rejected defense arguments that, because reporting decisions are made during medical treatment and involve the exercise of medical judgment, the claim sounds in medical malpractice.

Under MCL 722.623, the standard for triggering the duty to report is "reasonable cause to suspect child abuse or neglect."

"The standard is the same for everyone, whether they are a physician, a licensed social worker, a teacher or a member of the clergy," said Heather A. Jefferson, an appellate attorney with Southfield Fieger, Fieger, Kenney, Johnson and Giroux, P.C., who represented the child's estate on appeal.

" If the Legislature intended to have a different standard for 'reasonable cause to suspect,' the Legislature could have drafted that distinction within the statute. It didn't."

— Heather A. Jefferson, Fieger, Fieger, Kenney, Johnson and Giroux, P.C.

"If the Legislature intended to have a different standard for 'reasonable cause to suspect,' the Legislature could have drafted that distinction within the statute. It didn't," she said.

Court of Appeals Judge Donald S. Owens, writing for the majority, noted the lack of differing standards and concluded that "whether there is reasonable cause to suspect abuse or neglect does not require the use of medical judgment." Owens was joined by Judge William C. Whitbeck.

Too 'simplistic'

"[T]his is an overly simplistic reading of the statute," wrote O'Connell in his dissent.

He provided the example of a teacher observing a student "with strange discolorations on his arms and face." The teacher "might have reasonable cause to believe that the student had been abused" and would be obligated to make a report.

A doctor observing the same discolorations might conclude that these "were not bruises, but flare-ups of eczema.

"Although a layperson might think that these discolorations were signs of abuse, the doctor, *through the exercise of his medical judgment*, would not have reasonable cause to believe that this child had been abused," O'Connell wrote.

See "Negligence," page 14

Pending Legislation

Continued from 11

HB 4940 – HEALTH, Medical Equipment Reuse
Prohibit reuse of single-use medical equipment and supplies
Sponsored by Dian Slavens-D
Passed in House (108-0)
Status: Referred to Committee on Health Policy

SB 0151 – OCCUPATIONS, Physical Therapists
General amendments for individual licensing and regulation for physical therapists
Sponsored by Bruce Patterson-R
Passed in Senate (37-0)
Status: Referred to Committee on Health Policy

SB 0419 – HEALTH, Blood
Allowing blood donation at age 16 with parental consent
Sponsored by Wayne Kuipers-R
Passed in Senate (37-0)
Status: Referred to Committee on Health Policy

NPDB

Continued from page 8

According to the letter, "the aforementioned standard is [to] be applied broadly," emphasizing that actions "that have the potential to adversely affect patients" are reportable.

That being said, NPDB acknowledged that "[w]hether an action affects or could affect patient health or welfare is a factual determination in which the health care entity taking the action is in the best position to determine."

Thus, the NPDB provides the hospital with the sole discretion to determine whether a particular matter is reportable.

The letter then addressed a specific scenario wherein a physician is alleged to have been dilatory in his completion of medical records, stating that, in the NPDB's opinion, "a failure to complete medical records is related to a physician's professional competence or conduct and almost always has the potential to adversely affect a patient's health or welfare."

This broad construction of the duty to report is unnerving in light of the serious consequences a NPDB report may have on a physician's livelihood.

Increased effect

Furthermore, the effect of an NPDB report has increased with advancing technology.

When NPDB originally began collecting physician reports back in 1990, queries were paper-based and it often took a month or more for a hospital to receive a response.

This delay in time typically resulted in a delay in the domino effect that a NPDB report may have on a physician's career by allowing the physician and his or her legal counsel crucial time to handle the fallout caused by the report.

Now, with the advent of the Proactive Disclosure Service (PDS), hospitals can sign up for automatic e-mails to be sent to the hospital from the NPDB 24 hours a day, 365 days a year, for each physician the hospital registers with PDS for an immediate update on any reports to the NPDB on the subject physician.

With such increased speed, physicians will likely experience the negative effects of a NPDB report much sooner than in the past.

Physicians must be aware of the potential reportability of their actions by the hospital and take immediate proactive/prophylactic steps, with the assistance of experienced health law counsel, to ensure that spurious allegations do not become part of their permanent records. Absent such measures, physicians may find themselves angry/frustrated and possibly singing the following defeatist lyrics, also from "Kiss Off":

"You can all just kiss off into the air.
Behind my back I can see them stare.
They'll hurt me bad but I won't mind.
They'll hurt me bad, they do it all the time."

Negligence

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Expert testimony would be required to determine whether a doctor correctly chose to not file a report, O'Connell reasoned.

"Therefore, any potential error in judgment on the part of a doctor in such a scenario sounds not in ordinary negligence, but in medical malpractice," he wrote.

O'Connell wrote that the majority's decision will cause doctors to report any case involving a bump or bruise to the Department of Human Services.

Jefferson disagreed.

"The majority appropriately countered this argument by correctly pointing out that it's going to be clear in some cases when something is just an accidental bump or bruise," he said.

"In other cases, where there is a doubt, it's not up to the doctor to investigate, it's not up to the teacher to investigate or make an absolute decision. Judge O'Connell is suggesting that doctors have to exercise their medical judgment and come to a medical conclusion."

But Jefferson suggested that the statute requires less.

"If the story is not matching the injuries, whether you're a doctor or a teacher or a social worker, that's when there's reasonable suspicion," she said.

Engelhardt, on the other hand, said the rule of the case "is 'thou shalt report, no matter what."

She added, "I would be hard-pressed to think of an injury that couldn't be sustained as the result of abuse; any kind of broken bone, any kind of bruise, any bump on the head, any bump anywhere, any cut."

Under this decision, Engelhardt said, if there is any possibility that the injury could be the result of abuse, doctors run the risks of lawsuits if they don't make a report.

Vicarious liability

The majority further held that if the doctors violated their duty to report, the medical facilities where the child was examined may be vicariously liable.

The statute permits civil suits against a "person" who violates the act's reporting requirement. The institutional defendants argued that under the "plain language" of MCL 722.633(1), there is individual liability only.

"However," Owens wrote, "a well-settled common law principle, such as the doctrine of vicarious liability, cannot be abolished by implication.

"And there is no language in the statute that expressly abolishes the doctrine."

Owens pointed to a line of no-fault cases, each of which held that the no-fault act's enactment did not extinguish such common law doctrines as recoupment, mitigation and loss of consortium.

"[W]e have a line of Michigan cases that all conclude that the common law should not be abrogated by statute unless it clearly appears that was the legislative intent," he noted.

There is no indication in the Child Protection Act that the Legislature "intended to abrogate the common law doctrine of vicarious liability," Owens concluded.

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Parity

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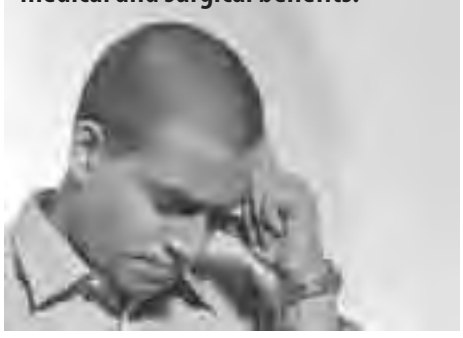
the important changes in the administration and availability of mental health benefits, as these changes promise to have a big impact on patient care.

Essentially, Wellstone-Domenici aims to increase access to mental health care and substance abuse treatment by imposing parity requirements with respect to health care plans' treatment limitations and financial requirements.

It also addresses plan transparency, the scope of coverage, plan costs, and the availability of out-of-network coverage, and was widely supported by a broad array of providers and advocacy groups.

While it does not mandate coverage of any particular diagnosis or treatment, the Wellstone Domenici Act does require that plans offering mental health and addiction benefits must do so on an even-footing with medical and surgical benefits.



Existing law

In 1996, Congress enacted the Mental Health Parity Act (MHPA), precluding carriers from imposing a lifetime benefit limit on mental health benefits if the carrier does not also include such a limit on "substantially all medical and surgical benefits."

Although Michigan does not have its own mental health parity law, there are 23 states that do. Therefore, practitioners, providers and plan administrators with operations outside of Michigan should consult with counsel in order to see whether a state law also is applicable.

Under the MHPA, if the patient's plan or coverage includes an aggregate lifetime limit on medical and surgical benefits, the plan must either (a) apply an equal limit to mental health benefits (while not applying these limits differently between the benefit classes) or (b) the limit on the aggregate lifetime mental health benefits must not be less than the corresponding limit on medical/surgical benefits.

This parity requirement has only two exemptions; one is for small businesses employing 50 people or less, and the second is an "Increased Cost Exemption," which applies when the application of the parity requirements result in a cost increase of 1 percent or more under the plan.

Wellstone-Domenici expands on the requirements imposed by the MHPA of 1996 by mandating that group health plans covering treatment for mental illness and substance use disorders provide that coverage on the same terms and conditions as medical and surgical treatment.

In order to achieve this goal, the 2008 Act requires that insurance plans provide parity with respect to two primary areas, treatment limitations and financial limitations.

Treatment limitations

As defined by the Act, the term "treatment limitations" includes "limits on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment."

The Act requires that group health plans ensure that "the treatment limitations applicable to … mental health or substance use disorder benefits are no more restrictive than the predominant treatment limitations applied to substantially all medical and surgical benefits."

The new law also requires that there are no separate treatment limitations that only apply to mental health or substance-abuse disorder benefits.

Financial limitations

The term "financial requirement[s]" is defined as including "deductibles, co-payments, coinsurance, and out-of-pocket expenses." However, it does not include the aggregate lifetime limit and annual limit subject set forth in the MPHA of 1996.

Therefore, when a group health plan provides both medical/surgical benefits as well as mental health or substance use disorder benefits, the plan (or coverage) must ensure that the financial requirements applicable to such mental health or substance use disorder benefits are no more restrictive than the financial requirements applied to substantially all medical and surgical benefits.

Similar to the treatment limitations, Wellstone-Domenici forbids any separate cost sharing requirements applicable only with respect to mental health or substance use disorder benefits.

Additional requirements & exemptions

Wellstone-Domenici maintains the small business exemption found in the MHPA of 1996, meaning that the parity requirements apply only to plans covering more than 50 employees.

It also is important to note that the Act does not require that plans guarantee access to particular treatments. Ultimately, the individual's scope of coverage is determined by the terms of the insurance plan, and relevant state and federal laws.

Furthermore, while the Act does not hamper the efforts of plan administrators to control costs by making their own determinations as to the medical necessity and the level of a particular treatment, it does seek to improve plan transparency by requiring that the criteria used in making such determinations, as well as the basis for any denial of reimbursement or payment for services, must be made available by the plan administrator upon request.

The new law also makes qualification under the cost exemption provisions more difficult.

Specifically, the Act allows for a plan's exemption from the parity requirement for one year only if the plan can document that compliance with the Act will have the effect of increasing costs by more than 2 percent initially (and 1 percent thereafter).

A plan may not apply for this exemption until six months after the plan has operated under the new parity requirements, and must produce an actuarial analysis demonstrating that the percentage increase results solely from these new parity requirements.

While it does not mandate coverage of any particular diagnosis or treatment, the Wellstone Domenici Act does require that plans offering mental health and addiction benefits must do so on an even-footing with medical and surgical benefits.

Here's hoping the Act will bring about a significant improvement in access to treatment for those patients and families who so desperately need it.

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HIPAA

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required under Michigan's Identity Theft Protection Act. The Michigan law creates and exception for entities that are subject to and comply with the HIPAA Privacy and Security Rules.

- **When to notify:** All notifications must be given without "unreasonable delay," but no later than 60 days after discovery.

Discovery is when the breach becomes known, or reasonably should have been known by exercising reasonable diligence; knowledge by workforce member/agent is imputed to the covered entity or business associate.

The notice must contain:

- Brief description of what happened, including date of breach and date of discovery
- Description of types of unsecured PHI involved (e.g., name, SSN, DOB, address, account number, diagnosis, disability code, etc.)
- Any steps individuals should take to protect themselves from potential harm
- Brief description of investigation, mitigation efforts and prevention of future breaches
- Contact procedures for additional information (e.g., toll-free number, Web site, etc.)

Individuals must be notified by first class mail (or e-mail if agreed to by individual). If there is insufficient or outdated contact information for less than 10 individuals, then substitute notice must be given via alternate written notice, telephone or other means.

If there is insufficient or outdated contact information for 10 or more individuals, substitute notice must be given via conspicuous posting on the covered entity's Web site for 90 days or conspicuous notice in "major print or broadcast media."

If more than 500 individuals are affected, notice must be given to "prominent media outlets" serving the state or jurisdiction.

If 500 or more individuals are affected, notice must be given to HHS at same time as notice is given to the individuals.

For all breaches affecting less than 500 individuals, the covered entity must submit a log of such breaches to HHS by March 1 for prior calendar year.

Veterans

Continued from page 6

have other negative effects when planning for long-term care. Many of these organizations will suggest and encourage gifting assets to the children. Once again this should only be done if there is a complete understanding of all the risks.

The Medicaid program has stricter rules and regulations regarding asset transfers than the Veterans AA Program. As such, it is very important that veterans and their families engage a veteran accredited and qualified elder law attorney when developing a long-term care plan. For instance, transferring assets to qualify for AA benefits could result in a five-year ineligibility for Medicaid benefits.

Attorney accreditation

The U.S. Department of Veterans now requires attorneys to be accredited in order to represent or advise a veteran on eligibility requirements relating to improved pension benefits.

While the planning process necessary to qualify a veteran or their spouse for Veterans Aid and Attendance/Improved Pension Benefit may seem simple, when you consider the potential consequences, such as capital gain taxes, income taxes, and potential ineligibility for Medicaid benefits the program becomes very complicated.

Accordingly, it is wise for the professional to have the proper expertise or seek the appropriate counsel before assisting a veteran or his or her spouse in qualifying for this benefit.

Don L. Rosenberg is an elder law attorney with Troy-based Barron, Rosenberg, Mayoras & Mayoras, P.C., also known as The Center for Elder Law. He is chairman of the board of directors for the Greater Michigan chapter of the Alzheimer's Association, and is incoming chair of the Elder Law and Disability Rights Section of the State Bar of Michigan. Contact him at (248) 641-7070 or rosedr@brmmlaw.com.

Family

Continued from page 1

propriate. Pursuant to the American Medical Association's (AMA) Council on Ethical and Judicial Affairs Opinion 8.19, routine medical care given to a family member for short-term, minor problems is ethically appropriate.

The AMA does, however, caution physicians that they should avoid treating family members and should not act as the primary physician for a family member, since the physician's objectivity and judgment may be compromised when treating a loved one.

Prescribing controlled substances for an immediate family member is not appropriate under the AMA's ethical guidelines, federal law, and the law of most states.

Beyond this, there are few standards that apply to treating family members. However, there are numerous statutory requirements that apply to the creation of, maintenance of and access to medical records.

While it is easy for a physician who cares for a family member at the office to keep written medical records, care for immediate family members is often rendered informally at home and thus physicians do not tend to keep such records.

This creates a significant probability that there will be no record of the patient's treatment, or even if notes or another informal record is kept, it will not be made accessible to other treating physicians.

Failure to keep such written medical records or make them available to treating physicians is considered a negligent practice that can result in sanctions against a physician's license to practice medicine.

Michigan law defines medical records as meaning "information, oral or recorded in any form or medium that pertains to a patient's health care, medical history, diagnosis, or medical condition and that is maintained by a licensee in the process of providing medical services."

The relevant statutes do not provide any detailed requirements for the content of medical records kept in physician's office, but merely state that such records should include a full and complete record of tests, examinations performed, observations made, and treatments provided. Therefore, it is part of the standard of care to keep such records.

Importantly, there are no exceptions under existing state statutes that relieve a physician of the requirement to keep medical records for any patient to whom the physician has provided medical care or written a prescription.

Thus, all family members to whom a physician provides care are "patients" with-

[S]tate medical licensing boards are likely to view the failure to keep a written medical record as a negligent practice.

in the meaning of these statutes.

While physicians treating close family members may have a tendency to rely on their memory, if there is no written record of the treatment provided it is quite likely that only the physician and the family member he or she treated will know about the care given.

Patients, especially minors, cannot be expected to fully remember what care they received. If the physician dies, becomes mentally incapacitated, or cannot be reached and no written record exists, the care of the patient may be compromised by the lack of a written record to forward to another treating physician.

For these reasons, state medical licensing boards are likely to view the failure to keep a written medical record as a negligent practice.

They also are apt to view the failure to reduce any oral record to a written record within a reasonable amount of time after care has been given to be a negligent practice. Accordingly, physicians who provide medical care to immediate family members run the risk of a licensing violation if they fail to keep appropriate written medical records.

Physicians should not be misled by the idea that there is safety in treating family members, as there is always a risk that a family member or another treating physician would complain to a state licensing board about the lack of a formal medical record.

Such complaints are most likely to occur in situations:

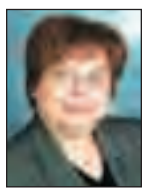
- Where the relationship between the physician and immediate family member (or the parent of that family member) has disintegrated and there is dissatisfaction with the care rendered by the treating physician;
- Where divorced parents of minor children disagree about whether a physician family member should be treating the child and try to prevent the family member from treating the child;
- Where a subsequent treating physician believes his or her delivery of care has been compromised due to the lack of a formal written record.

With the current focus on electronic medical records and the integration of patient information, issues involving the importance of keeping of medical records are becoming more prominent and medical records are subject to greater scrutiny. Consequently, the lack of a medical record may be more easily detected than in the past.

Physicians can take two simple steps to protect themselves. First, if a physician provides medical care to a family member, a formal written medical record of that care must be created contemporaneously and kept by the physician even if the record is only handwritten.

Second, a copy of that formal written record should also be forwarded to the family member's regular treating physician and made a part of the regular physician's records.

Doing so will protect physicians from charges that they failed to keep such records.



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