THE ACADEMY OF MEDICINE OF CLEVELAND & NORTHERN OHIO
formerly known as AMC/NOMA

NORTHERN OHIO
PHYSICIAN
FORMERLY KNOWN AS THE CLEVELAND PHYSICIAN
July/August 2008 | Volume 93 | No. 4

THE VOICE OF PHYSICIANS IN NORTHERN OHIO

www.amcnoma.org

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Sponsors Two Sessions Examining Health Care Coverage Needs

AMCNO physician leadership spend an evening working on the CHAT program.

As part of the 2008 Cover the Uninsured Week initiative, The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) sponsored two Ohio CHATs about Healthcare sessions in May 2008.

The purpose of the CHAT – "Choosing Healthplans All Together" is to query the community, healthcare and policy leaders who are: considering coverage expansion proposals, assessing healthcare priorities and trade-offs and fostering team building and collaboration on the topic of health care for the uninsured.

On May 1st The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) and St. Vincent Charity Hospital co-sponsored a CHAT session at St. Vincent Charity Hospital. Presented by the Ohio Department of Insurance, this session included uninsured participants who were asked to examine a variety of healthcare coverage needs and set priorities on the relative importance of those needs. A second CHAT session, also presented by the Ohio Department of Insurance (ODI), and also sponsored by the AMCNO included physician leaders participating in the CHAT process.

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AMCNO President Addresses 2008 Medical School Graduates

Dr. Raymond Scheetz, Jr., president of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO), spoke at this year's Case Western Reserve University's School of Medicine commencement on behalf of the Academy of Medicine of Cleveland & Northern Ohio. The ceremony was held at Severance Hall on Sunday, May 18. The AMCNO is pleased to be a participant in the Case commencement ceremony, a tradition the AMCNO has been part of for many years. The AMCNO represents the physicians in the region and we are proud to be a part of this legacy in the community. It is a privilege to present to the graduating class at Case and we hope to continue the tradition far into the future.

Dr. Scheetz addressed the medical school graduates with the following remarks:
Graduates – I welcome you into the medical profession. Up until now, you have been students – studying topics preparing you to graduate from medical school. The word student comes from the Latin *studere*, meaning to direct one's zeal or enthusiasm at a particular subject. You have dedicated your zeal and enthusiasm at studying medicine. But, your role as a student does

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***Dr. Scheetz** delivers his remarks at the commencement ceremony.*

Photo courtesy of Chappell Graduation Images

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AMCNO COMMUNITY ACTIVITIES

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) Sponsors Two Sessions Examining Health Care Coverage Needs

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A key component of the CHAT is for the participants to design a basic benefits package using a computer-based game program called CHAT. CHAT is a computer based educational game and research tool designed to elicit opinions of all Ohioans. Built into CHAT's design is the need to make trade-offs, reflecting the realities of today's environment. Participants have to weigh various limitations – increased cost-sharing, restricted choice, less convenience and reduced services – as they consider a range of options. The data collected will be forwarded to Governor Strickland's Healthcare Coverage Reform Initiative and healthcare policy makers.

The uninsured indicated a strong interest in a benefits package with a choice of providers, with affordable premiums and co-payments. They also stressed the importance of coverage for mental and behavioral conditions requesting the highest coverage available in this category (to include counseling and medicine for smoking, alcohol and drug addiction problems). They also agreed that their basic benefit plan should include coverage for both dental and vision care.

Physicians participating in the CHAT agreed for the most part on the need for choice of providers and the need for affordable premiums, however, they placed more emphasis on the importance of coverage for the treatment of chronic care (i.e., treating chronic illness like diabetes, heart conditions, etc.) as well as stressing the importance of adequate coverage for maternity care.

The AMCNO was pleased to participate in the CHAT project, and our name was disseminated statewide by ODI in a news release regarding the project and the partners involved in the event. The ODI has expressed appreciation to the AMCNO for our involvement in the project. The AMCNO will continue to work with ODI on the issue of healthcare coverage reform in the state of Ohio.

Cover the Uninsured, a project of the Robert Wood Johnson Foundation, is a national effort to highlight the fact that too many Americans are living without health insurance and to request solutions from our nation's leaders. This includes raising awareness and building support among policymakers, health care professionals, grassroots advocates, faith leaders, the business community and active citizens through Cover the Uninsured Week. Cover the Uninsured Week ran from April 27 through May 3, 2008.

The Academy of Medicine of Cleveland & Northern Ohio supports physicians in being strong advocates for all patients as well as promoting the practice of the highest quality of medicine. AMCNO advocates on behalf of its more than 5,000 members as the region's premier professional medical society since its founding in 1824.

A group of uninsured individuals participate in the CHAT process at Saint Vincent Charity Hospital – an event co-sponsored by the AMCNO.

The ODI is assisting the State Coverage Initiative team, led by Governor Strickland, in developing mechanisms to provide adequate and affordable health insurance options for the state's uninsured. The goal is to reduce the state's uninsured population by 500,000 by 2011. Various activities are underway to gather information and engage stakeholders and the public in a discussion about developing comprehensive, effective reforms. ■

AMCNO President Addresses 2008 Medical School Graduates

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not end today. This role will continue your entire professional life. Every day in medicine, research leads to discoveries that change our understanding of illnesses and provide us with new and better therapies for our patients or new applications of older therapies. New technologies are being developed at a rapid pace requiring you to keep up-to-date to practice effective, efficient and safe medicine. In addition to continuing mandatory learning as a student in your medical future, I urge you to continue to be enthusiastic about medicine and to maintain a zealous attitude toward all of your medical endeavors. This will allow you to ignore the occasional annoyances of practice and to devote all of your energy to treating your patients.

Today, you take a new role as you are bestowed the well-deserved honorific of doctor, deriving from the Latin *docere* meaning to teach. So, you are now assuming a new role as teacher. You will have an obligation to teach other physicians following in your footsteps, as well as medical students, ancillary medical personnel, and above all, your patients. As you mature in your medical progression through residency you will function as role models for junior house staff, lending assistance in any way you can to further their medical education. You will teach your patients all they need to know about their maladies and give them sufficient information to allow them to successfully participate in the management of their own illnesses.

As you now continue in your role of student, and advance to your role of doctor or teacher, you are to be congratulated for fulfilling a most arduous curriculum and achieving the status of Medical Doctor on this most auspicious occasion in your lives.

Congratulations to all of you. Your efforts are duly recognized and appreciated. ■

AMCNO Joins the Partnership to Fight Chronic Disease

The AMCNO board of directors has agreed that the organization should become a partner in the Ohio coalition of the Partnership to Fight Chronic Disease (PFCD).

PFCD is a national effort committed to improving health care policies through more effective prevention and management of chronic disease, which PFCD defines as ongoing conditions that are generally incurable (i.e., cancer, heart disease, diabetes and others). Chronic diseases account for more than 75 cents of every dollar spent on health care in this country. PFCD is urging presidential candidates and other key policymakers to address chronic diseases when creating their health care platforms.

PFCD is national in scope and was officially launched in Ohio in November 2007 and since then they have been approaching health care, business, and labor groups about joining the local initiative. For more information go to www.fightchronicdisease.org. ■

AMCNO Meets With Ohio Department of Insurance Regarding Prompt Pay and External Review Issues

The Ohio Department of Insurance (ODI) convened a meeting of physician/provider groups to discuss how ODI handles prompt pay and external review issues. In brief, the ODI staff noted that they receive about 2,000 complaints a year from providers, however, over one-half of the complaints involve ERISA plans, Medicaid/Medicare or Federal Employee Benefit Plans and under the law these are all outside the jurisdiction of ODI, so only about 1,000 prompt pay complaints are evaluated by ODI each year.

Fifty percent of those reviewed and submitted to ODI are not prompt pay issues and involve denials or other insurance issues and therefore, are not reviewed. Of the complaints that were valid and filed in 2007 – 27% of these were reversed or payments were made to the providers. ODI staff noted that it is important that physicians/providers understand that they have to go through the insurance company internal appeals process first before filing a complaint with ODI. Currently, no reports on prompt pay complaints are issued by ODI. AMCNO and other groups in attendance voiced concern that this information was not readily available and asked that ODI consider preparation of such reports for dissemination. It would be helpful to know what type of complaints are processed, how many involve hospitals, physicians or other provider types and what percentage are reversed each year. In addition, a breakdown by category of complaint and insurance company involved would be helpful. ODI plans to review this request and respond back to the AMCNO.

The next topic discussed was the Ohio Patient Protection Act. With regard to the external review process, ODI staff stated that an external review by an independent review organization (IRO) can only be done after the consumer has completed the health plan internal review process. After a consumer has been told that they have been denied by the insurance company there must be, by law, included on the explanation of benefits form or denial letter that is sent to the patient a notation from the insurance company stating that they are entitled to an external review process. This review could occur if it involves a medical necessity issue over $500.00 and if the member can show that the provider states that the service is needed; or it involves an experimental investigational therapy for a terminal illness with a probable cause of death within two years. The health insurance company would file the request for review and the IROs are randomly selected. When the IRO makes their decision the decision is binding on the health plan but not on the member – they can seek legal counsel.

The AMCNO raised the question regarding the issue of medical necessity and what was the definition of "medical necessity" utilized in the review process and did the IROs use a specific definition of medical necessity when making their decision. The ODI staff provided a brief overview of the Ohio statutes but then indicated that they need to research this further and respond back to both the AMCNO and the group on the medical necessity issue.

There was concern expressed by both the AMCNO and the group that the ODI appeal/external review process did not provide better consumer and physician/provider notice of the appeal process and outcome. At this time, the physician/provider is not made aware of the appeal and they do not receive information on the outcome. A discussion ensued of the value of a one-page document that outlined the rights and process for physicians and patients under this review process. ODI plans to prepare an explanatory document on the rights of consumers to an external review and provide this information to the AMCNO and the group for dissemination to association members.

Physician members and their staff are asked to provide the AMCNO with any experiences they may have had with the ODI with regard to prompt payment reviews or external reviews conducted on behalf of their patients. Please contact the AMCNO office at (216) 520-1000. ■

AMCNO ADVOCACY ACTIVITIES

AMCNO Physician Leadership Meets With Senator Voinovich

AMCNO physician leadership met with Senator Voinovich to discuss several health care related issues. The main topic of discussion was the issue of Medicare reimbursement. AMCNO stressed the point that if the government continues to ratchet back reimbursement levels for Medicare it will have an effect on both physicians and hospitals. There is also a very real concern that if something is not done with the Medicare reimbursement issue that there will be an impact on access, quality of care and health care costs.

Senator Voinovich is aware that physicians are very concerned about the Medicare reimbursement issue, and he has heard from physicians that they may not be able to continue to see Medicare patients if something is not done about the reimbursement levels.

AMCNO leadership noted that it is imperative to get the federal government to do something about the Medicare program. There is already data showing that Medicare will be bankrupt in less than twelve years and there needs to be a valid discussion on how the government plans to deal with that in the future. There is an aging population in the United States and as patients age utilization will continue to rise so there has to be a realistic discussion regarding Medicare.

Senator Voinovich stated that there are so many problems intertwined – and the health plans and concepts coming out of the presidential candidates will set the agenda dependent upon who is elected. He stated that these are key questions for the candidates – how do they plan to take care of the Medicare problem, the medical liability problem, the lack of physicians in primary care and are they at all concerned about the issue of losing certain specialists and the lack of physicians going into primary care.

With regard to the issue of health care coverage and access, the AMCNO leadership voiced concern that there continues to be a push toward a government-funded entity for all citizens. It is important to note that the biggest government-funded entity for health care – Medicare – is not doing well financially so it is hard to fathom how another such entity for all Americans would function in an adequate fashion.

AMCNO physician leadership pose with the Senator following their meeting to discuss legislative matters of importance to physicians. Left to right – ***Dr. Anthony Bacevice, Dr. George Kikano****, Senator Voinovich,* ***Dr. Laura David, Dr. George Topalsky, AMCNO President Dr. Raymond Scheetz, Jr.****, and* ***Dr. John Bastulli.***

Senator Voinovich noted that if there is to be change in health care it has to come from the health care industry and physicians are a big part of that equation. He asked that the AMCNO continue to dialogue on this issue and provide input to him and other Congressional representatives, and most importantly, to the presidential candidates during this election year. The Senator asked the AMCNO to consider supporting S1019, the Universal Health Care Choice and Access Act, a bill the Senator believes is a comprehensive attempt to reform our nation's health care system by increasing personal responsibility and preserving patient choice. The AMCNO executive committee has sent a letter of support for S1019. The AMCNO has also asked Senator Voinovich to support legislation to not only stop the impending Medicare physician payment cuts but to do something about the yearly problems with the payment issue. At press time, no legislation had passed to stop the July 1st payment cuts. ■

ATTENTION AMCNO MEMBERS

Election Update

Ohio voters will have a number of important decisions to make this year when they head to the polls, and arguably one of the most important decisions for physicians will be the selection of candidates for the Ohio Supreme Court. Once again we face the challenge to ensure that the justices on our Ohio Supreme Court interpret the law and do not legislate from the bench.

AMCNO members will find an insert in the magazine regarding this important issue.

Legislative Update

By: Michael Wise, J.D., AMCNO Lobbyist

Ohio Politics

We now have a presumptive Democrat nominee for President in Senator Obama. So it will be Senator Obama and the March 4, 2008 GOP winner, Senator John McCain, facing off in November. The other big race in November will be for control of the Ohio House. Currently, the Republicans hold a 53-46 majority. All 99 seats are up for election this fall.

ADR and Medical Malpractice Rates

We continue to track alternative dispute resolution ("ADR") activity around the U.S. AMCNO is a strong advocate of the use of ADR to more efficiently resolve professional liability cases and ultimately lower insurance premiums. *ADR World* notes that a study of the Department of Justice's (DOJ) use of alternative dispute resolution (ADR) processes with traditional litigation shows that 65% of the civil cases that were referred to ADR settled while only 29% of those that remained in litigation did so. In addition, it found that the earlier the referral to ADR, the quicker the parties reached a settlement. However, the study revealed that only a small number of cases were referred to ADR: 511 cases (3.3%) out of 15,288 cases on the litigation docket from 1995 to 1998.

The researchers also found a statistically significant difference in the percentage of cases that settled based on whether ADR was voluntary or mandatory: 71% of cases settled when ADR was voluntary, while only 50% settled when ADR was mandatory. The study revealed that there were significant savings in time when ADR was used. The researchers found that the timing of ADR had an impact on the percentage of settlements. When ADR was used within 90 days of filing the case, it only took 92 days to reach a settlement. When ADR was used between 91 and 180 days after filing, it took 190 days, on average, to reach a settlement. The study will be published early in 2009 in the *Ohio State Journal on Dispute Resolution*.

Tobacco Funding

As a follow-up to the issues with the Ohio Tobacco Prevention Foundation ("OTPF"), the General Assembly passed and the Governor signed legislation to abolish the Foundation. The legislation effectively eliminates funding tobacco prevention and cessation programs. It is estimated that without further funding the Ohio Department of Health will spend about $3 to $5 million per year on tobacco prevention and cessation in our state. Considering that the budget of the OTPF was around $46 million per year, it is obvious that the impact on the quality tobacco prevention and cessation programs around the state and the remarkable progress that has been made on lowering smoking rates in our state will be devastating. Current OTPF programs are funded through June 30, 2008. After that time, the ODH funding at the much lower amount will begin. It is unknown what, if any, programs of the OTPF will continue.

At the same time, legislation (HB 572) has been introduced in the House. The legislation corrects the imbalance between the "other tobacco products" (OTP) tax which includes all non-cigarette forms of tobacco and the cigarette tax, and dedicates the revenue generated—approximately $53 to $59 million a year—to tobacco prevention and cessation. The legislation would set up a special fund for the money and a special Center within the Ohio Department of Health requiring that the money be used for tobacco prevention and cessation. Both of these provisions would provide a layer of legislative protection to insure that the money is not used for other purposes. The AMCNO is a strong advocate for raising the tax on other tobacco products and we have become an active participant in the Investing in Tobacco-Free Youth Coalition campaign. The group is dedicated to reducing the problem of non-cigarette tobacco produced, or OTP. The AMCNO has sent strong letters of support to the sponsor of HB 572 as well as to all of the representatives on the committee reviewing the legislation.

Ohio State Board of Pharmacy Terminal Distributor Licensing

Physicians and other providers have expressed concern about the State of Ohio Pharmacy Board requirement that physicians who dispense medications, other than drug samples, obtain a terminal distributor license. The Pharmacy Board does have statutory authority to require physicians to obtain this license and the pharmacy board is enforcing the statute. The statute was changed in 1998, when the Ohio legislature changed section 4729.51 of the Ohio Revised Code. That section defines to whom a registered wholesale distributor of dangerous drugs may sell or distribute dangerous drugs. That list now includes terminal distributors of dangerous drugs, wholesale distributors of dangerous drugs, manufacturers, and licensed health professionals authorized to prescribe drugs (prescribers). A prescriber is defined as an individual who is authorized by law to prescribe drugs or dangerous drugs in the course of the individual's professional practice (4729.01(I) ORC).

Previously, this section used the term "practitioners" instead of prescribers and defined "practitioner" as a person or professional association or partnership of individuals authorized by law to write prescriptions for drugs or dangerous drugs. This information has been shared in the past with professional associations and wholesale distributors but has not been aggressively enforced by the Ohio State Board of Pharmacy. In the recent past there has been a national focus on the wholesale distribution of prescription drugs including "pedigree" legislation designed to track drugs from manufacturers to vendors to the patient. As the Board has been inspecting wholesale distributors and clinic facilities in Ohio, they have been asking how wholesale distributors are complying with Ohio law in the distribution of dangerous drugs. Physicians looking for more information on this requirement should go to the state pharmacy board Web sites at http://pharmacy.ohio.gov/WholesaleDistr-040901.htm and http://pharmacy.ohio.gov/NonResTD-040901.htm. The AMCNO would also like to know if our members have been experiencing problems with this law and whether or not it has impacted your practice. If you have concerns or comments about the law please contact the AMCNO legislative staff at (216) 520-1000, ext. 100.

Ohio Attorney General

On Wednesday May 14, 2008, Marc Dann resigned as Ohio Attorney General due to a probe that illustrated myriad problems within the attorney general's office. A temporary replacement was named by Governor Strickland. Nancy Rogers, the Dean of OSU's Law School was appointed at the end of May. She is a consensus solid pick to act as a caretaker until the end of the year when Ohio voters will pick a replacement. Both parties will name candidates for the post in the near future.

Despite the disappointing events in this office, AMCNO continues to work with the office and General Assembly on a number of issues:

1) The nonprofit status of hospitals – the Ohio AG and the Ohio General Assembly (through HB 456 – see below) are reviewing this matter and this issue will likely continue into next year.

2) Physician Ranking – we first reported on this issue because of activity out of the New York AG office. AMCNO then met with AG Dann on this issue. Colorado now has moved through legislation to regulate tiered networks. The state's bill follows national agreements by health insurers to make physician-rating systems more transparent and based less on costs. A bill on the desk of Colorado Gov. Bill Ritter Jr. would require plans to disclose data and methodology in reaching physician grades and tiering, a process by which insurers group physicians based on purported quality, then offer a discount to members who only see doctors in the highest-rated tier. The AMCNO is reviewing this legislation.

3) Medical Necessity – This issue was originally to be addressed in HB 125 that was recently signed by the governor. However, it was removed because of the strenuous objections of the insurance industry. The issue is still alive and AMCNO intends to review the activity around the country and provide an action recommendation to the AMCNO Board in the near future.

4) Out of network issues – A lawsuit filed in Connecticut against Ingenix pursues the claims of New York Attorney General Andrew Cuomo that the company is responsible for artificially low reimbursement rates insurers pay to out-of-network providers. The lawsuit, which seeks class-action status and was filed April 29 in U.S. District Court in Hartford, claims damages from an alleged conspiracy in which insurance companies calculate their usual, customary and reasonable rates from a flawed and manipulated Ingenix database. The low payments to providers, according to the lawsuit, left consumers with higher out-of-pocket costs. The AMCNO intends to review this matter further and provide an action recommendation to the AMCNO board.

Key Legislation

House Bill 456 – Ohio C.A.R.E.

This Bill introduced by Representative Jim Raussen would require the state to subsidize health insurance claims for people with chronic medical conditions and offer tax credits for poor adults that don't qualify for Medicaid. The AMCNO continues to closely follow this Bill with respect to the changes in contracting language between Medicaid Managed Care companies, the request that non-profit hospitals define charitable care/community benefits; the requirement of certain hospitals to post their tax liability as compared to their charitable care on their Web site; the requirement that ambulatory surgical facilities annually report certain data to the Director of Health; as well as a need to review how the discounts on premiums will be implemented for BWC employers who offer health and wellness programs. As the testimony on this legislation continues, the AMCNO will keep our members apprised of its' progress in the legislature.

House Bill 493 and Senate Bill 301

These Bills would allow pathologists to pursue direct billing of their services. The pathologists believe that direct billing for their services should be allowed and that markup charges are ethically wrong and financially exploitive. The markup practice may not be pervasive in the state, but testimony indicated that some clinicians are using markups to boost revenues. This practice ends in states that specifically forbid the practice. AMCNO member Dr. Jonathan Myles testified in support of the Bill. He said the bill could put an end to a practice that could "needlessly escalate" healthcare costs in Ohio. He said the bill does not involve any scope of practice issues and does not limit other medical specialists from performing anatomic pathology services. Dr. Myles added that several other states require direct billing, and noted that the practice is standard procedure for Medicare and the state's Medicaid program since 1984. There has been opposition voiced on the bills by specialty societies in the state and debate on this legislation is expected to continue into the year. The AMCNO is currently neutral on both bills.

We are now almost three quarters through this two-year legislative cycle. AMCNO has a comprehensive tracking system of all health care related legislation in the General Assembly. If you are interested in receiving a copy of this document, please contact Elayne Biddlestone at (216) 520-1000. ■

AMCNO 2008 Voter's Guide

The Academy of Medicine Cleveland & Northern Ohio Legislative Committee, in concert with our lobbyists and Medical Legal Liaison Committee, is currently updating a voting guide for the upcoming election on Tuesday, Nov. 4, 2008. As always, a summary of issues and candidates will be provided and will be made available exclusively to our physician membership.

The guide will contain:

- **District Information – District Number, Description, Map, and Partisan Index**
- **Background Information on the Democrat and Republican Candidates, including their education and previous elected experience.**
- **Information on Common Pleas, Appellate and Supreme Court judicial candidates.**
- **Candidate responses to questions from the AMCNO Legislative Committee on issues affecting the practice of medicine in Northern Ohio.**

Look for the AMCNO 2008 Voter's Guide in your mail soon!

For information on any legislative issues the AMCNO takes positions on, contact Elayne Biddlestone at (216) 520.1000.

House Bill 125 – the Healthcare Simplification Act

Ohio recently enacted legislation that requires health plans to be much clearer and open about contract terms with physicians, including disclosing what insurers will pay for services and regulating the use of so-called silent preferred provider organizations (PPOs). The Healthcare Simplification Act, signed in late March by Ohio Gov. Ted Strickland, was the culmination of a legislative fight between physician organizations that demanded health plans to be more transparent about contract terms, and insurers and corporate interests who viewed the law as cumbersome and not cost-effective. The bill will become law on June 25, 2008.

The AMCNO supported HB 125 and the AMCNO lobbyists attended the interested party hearings on this legislation. House Bill 125, sponsored by Representative Matt Huffman does the following:

- establishes uniform contract provisions between health care providers and contracting entities;
- establishes rules for standardized credentialing, requiring insurers to credential physicians within 90 days, and establishes a $500 per day penalty or requires retroactive reimbursement if an insurer does not meet the deadline;
- ensures that physicians get a copy of their full fee schedule from HMOs, third party administrators and other insurers;
- requires insurers to provide physicians with a summary disclosure form of the contract that outlines contract terms such as compensation, coverage categories, contract duration, the entity responsible for processing claims, and also a dispute resolution process. The bill also requires that physicians receive notice of any addenda to the contract;
- modifies the fees that may be charged for electronic copies of certain medical records (i.e., BWC, ODJFS, and others) and allow an authorized person to obtain one copy of a person's medical record without charge (this does not alter the current law for other physician record fees);
- restricts the selling or renting of a physician's contract to another company under certain conditions;
- requires insurers to notify physicians 90 days in advance of changes to the contract that would decrease payment, increase expenses or add a new product;
- restricts the usage of "all products" clauses but only under certain conditions;
- requires the Ohio Department of Job and Family Services to allow managed care plans to use providers to render care;
- creates an Advisory Committee on Eligibility and Real Time Claim Adjudication; and
- provides for a moratorium on the usage of most favored nation clauses (MFNs).

The MFN issue elicited a lot of debate during discussion of the legislation and became a key issue. During the moratorium on the usage of MFNs, the Bill forms a joint legislative committee to review this topic. The 15-member Joint Legislative Study Commission on Most Favored Nation (MFN) clauses in health care contracts is to be chaired by the Superintendent of Insurance and is charged with studying specified areas pertaining to most favored nation clauses in health care contracts, and requires the Commission to submit a final report of its findings and recommendations to the General Assembly. There is also a Moratorium on MFN clauses of two years during the deliberations of the Committee. There is also an outright ban on the MFN clauses that begins in three years. The MFN ban and moratorium does not apply to hospitals. The AMCNO has prepared a detailed synopsis of HB 125 – for a copy of the AMCNO synopsis, please contact our offices at (216) 520-1000. ■

Impact of "Never Events" on Medical Claims

By R. Mark Jones and Tammi Lees, Roetzel & Andress, LPA, Cleveland

The Department of Health & Human Services (HHS) created the Centers for Medicare & Medicaid Services (CMS) to administer the Medicare and Medicaid programs. The CMS Mission Statement is "to ensure effective, up-to-date health care coverage and to promote quality care for beneficiaries." Conspicuously absent from this Mission Statement is any reference to containing costs to these programs. However, the Deficit Reduction Act of 2005 directed the HHS Secretary to designate "at least two conditions" that result in a heavy financial cost to these programs that evidenced-based guidelines could reasonably prevent. The Act directs that Medicare and Medicaid will not reimburse hospitals for costs incurred to treat these conditions after October 2008 if the conditions were not present at the time of admission.

Directed to designate at least two such conditions, the CMS in its zeal designated eight conditions, often referred to as "never events," that it determined met these prerequisites: (1) retained surgical objects, (2) air embolism, (3) blood incompatibility transfusion, (4) catheter-associated UTI, (5) vascular catheter-associated infections, (6) pressure ulcers, (7) post-CABG mediastinal wound infections, and (8) hospital-acquired injury (injury from falls, burns, etc.). The CMS is empowered to add to this list each year and is expected to do so aggressively.

Regulations designating these "never events" pose two distinct potential problems to the defense of medical claims: (1) they are a new evidentiary weapon to support allegations of negligence; and more ominously, (2) they might be used to create a new theory of liability that does not require proof of negligence.

Evidentiary Support for Negligence Claims

"Never events" will have substantial evidentiary weight at trial. Under Ohio law it is generally accepted that a violation of an administrative regulation is admissible as evidence of negligence. Defense attorneys can now expect that opposing counsel and their experts will refer to the CMS "never events" as support for their position that the occurrence of one of these problems was the result of hospital negligence.

Unlike the use of medical literature at trial, the use of these "never events" regulatory determinations will be a one-way street at trial – plaintiff's attorneys will use them to support negligence claims, but defense attorneys cannot use them, or find contrary regulations, to defend against such claims. Defense counsel will be limited to attacking the basis for the regulations by pointing out, for instance, that the regulations were not "peer reviewed," that the methodology of the regulatory process is flawed compared to the rigorous methodology used in a well-designed medical study, or that the impetus for the "never events" was cost-saving, not patient care.

Attorneys representing patients and patient families often use the 1999 Institute of Medicine report, *To Err Is Human*, at trial during jury selection, expert witness testimony, and arguments. This is the report estimating that 98,000 hospital patients die every year as a result of medical errors. Putting aside for the purposes of this article the legal arguments as to whether the conclusions from this study are competent, relevant and material evidence at trial, the reality is that trial court judges often allow attorneys for injured patients and their experts to refer to this article. The evidentiary weight of this report, like the use of all medical literature in trial, is limited. However, imagine trial counsel arguing that (1) the 98,000 patients who die each year as the result of medical errors prompted the CMS to empanel a committee of "experts" to determine if certain problems are avoidable with proper hospital policies and procedures, hold public hearings on the problems, and invite comment on "evidence based guidelines" to avoid the problems, and (2) that the "never events" are the culmination of that committee's work. One can see how these "never events" can be used by plaintiff's experts and in counsel's argument to the jury to support a finding of hospital negligence.

For physicians involved in treating hospitalized patients who develop problems defined as "never events," there is likely to be a "guilt by association" problem in defending a claim brought for injuries resulting from such events.

Support for New Theory of Liability

Although there is nothing in the CMS regulations on hospital reimbursement restrictions that imposes any civil liability on hospitals if a "never event" occurs, a concern is that this might be the springboard for claims of negligence *per se*. Negligence per se is a legal principle that holds that the violation of a law is proof of negligence without the need for other evidence. The issue is whether the violation of a regulation promulgated pursuant to a law has the same effect as a violation of the law itself.

A divided Ohio Supreme Court in the 1998 case *Chambers vs. St. Mary's School*, held that if the Court allowed a violation of an administrative rule, as opposed to a statute, to constitute negligence *per se*, "we would in effect bestow upon administrative agencies the ability to propose and adopt rules which alter the proof requirements between litigants. … Giving administrative agencies the ability to adopt such rules would be tantamount to an unconstitutional delegation of legislative authority." Although this is currently the law, it must be emphasized that this was a "divided" Court, and that changes in the membership of the Court can change the outcome of such cases. The dissenting opinion, supported by three of the seven justices, pointed out that there are substantial prior cases and arguments that could lead to a different conclusion. Therefore, currently the law in Ohio is that if the statute states that a violation of some provision of the statute imposes civil liability, then a violation is negligence *per se*. If the statute is silent on this point, the violation of a regulation promulgated pursuant to that statute will not be negligence *per se*.

Some concern is raised in the defense bar that the CMS "never events" might be used in the future to create "strict liability" for hospitals. The concern does not include physicians because the

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Impact of "Never Events" on Medical Claims

(Continued from page 9)

regulations refer only to hospitals and their policies and procedures. Strict liability is a legal principle usually applied in product liability cases that holds that the manufacturer of inherently dangerous products can be held liable for injury in the use of the product as intended if there is a flaw in the design of the product, even if the design was not negligent. Strict liability avoids the plaintiff's burden of proof on negligence and proximate cause.

The transfer of the legal reasoning from manufactured products to medical care is not as far a stretch as one might think. In the rulings of an activist trial judge, supported by an activist appellate court, new theories of liability have evolved. There is no need to have the legislature pass a law creating the new basis for liability since new theories of liability continue to develop from arguments for extending liability in court cases – the so-called "common law."

Each element of strict liability in the product design context (following in italics) has a potential parallel in the medical negligence context (following in brackets): (1) the defendant supplied *an inherently dangerous product* [medical service]; (2) the *product* [medical service] had a defect in its *design* [hospital policies and procedures]; (3) the defect in design [hospital policies and procedures] caused an injury to the plaintiff; and (4) plaintiff's injury resulted from *a use of the product as intended* [receipt of medical care in conformance with policies and procedures] that was reasonably foreseeable by the defendant.

Take as an example a pressure ulcer that developed during a long hospitalization of a malnourished, severely debilitated, and incontinent patient. Such cases are often successfully defended in Ohio courtrooms on standard of care and proximate causation grounds through the presentation of nurses' and doctors' testimony regarding the practical difficulties in managing these patients, with the support of expert witness testimony. Using the "never event" determination from the CMS, an enterprising attorney may convince a receptive trial judge to grant a motion for summary judgment on strict liability against a hospital under these circumstances by proving that the defendant hospital controlled the provision of medical services by requiring all medical and ancillary staff practicing in the hospital to follow the policies and procedures promulgated to prevent pressure ulcers (turning schedules, nutrition consultations and interventions, bathing schedules, etc.), and then arguing that (1) the CMS finding that evidence-based guidelines should reasonably have prevented a pressure ulcer establish that the hospital's policies and procedures were inadequate as a matter of law; and (2) the pressure ulcer resulted despite the medical care providers following the policies and procedures as the hospital intended or resulted from the hospital not ensuring that those policies and procedures were followed.

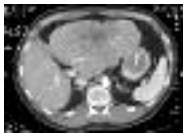
Although the CMS "never events" are targeted at hospitals for fiscal control purposes, they will necessarily impact the trial of medical negligence cases against both hospitals and physicians, and raise the possibility that changes in the receptiveness of the trial and appellate courts in Ohio might change the theories of liability for hospitals, and such new theories of liability will likely have unintended, but significant, consequences for physicians. ■

Liver Malignancies

By Juan Sanabria MD MSc FRCSC FACS
Assistant Professor of Surgery & Nutrition, Case Western Reserve University
Director Pancreas Transplant Program, University Hospitals – Case Medical Center

Liver malignancies are very common among patients with cancer. They can be originated within the liver, primary tumors, or they can be originated in another part of the body and spread to the liver. Primary malignancies of the liver among others include hepatocellular carcinoma (HCC), the most frequent tumor in the world and cholangiocarcinoma. In the Western World the most frequent malignancy of the liver is metastatic disease. Tumors originated in the abdomen spread very frequently to the liver. Colon, pancreas, small bowel and stomach cancers are the most common. Rare tumors that spread to the liver include ovarian cancer, Gastrointestinal Stroma tumors (GIST), carcinoid and neuroendocrine tumors. In addition, any neoplasm that originate in any other part of the body can also spread to the liver, i.e., lung, breast, melanoma. In the following paragraphs we will describe the main characteristics of liver tumors, the risk factors associated with them and their main treatment modalities.

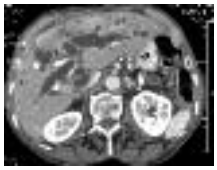
Hepatocellular Carcinoma (HCC)



Although HCC has been a relatively uncommon malignancy in the United States, HCC remains the most common tumor in the world and one of the most frequent causes of cancer death. There are approximately 12,000 new cases of HCC in the United States each year, with more than 300,000 new cases worldwide. In addition recent data suggest the incidence of newly diagnosed cases is increasing especially among younger patients and minority groups. Risk factors for HCC include viral hepatitis (hepatitis B and C), genetic factors (alpha-1-antitripsine deficiency, Wilson's disease, hemochromatosis), environmental exposure (aflatoxin B, vinyl-chloride) and alcohol induced cirrhosis. In the United States, the most common causes are alcohol induced cirrhosis and hepatitis C infection and hepatitis B remains the next most common associated risk factor world wide. In Ohio, the incidence of liver disease is increasing as a result of the prevalence of HCV infection, obesity and diabetes. Overweight patients are at risk of developing insulin-resistant diabetes (type 2), high blood pressure and high levels of lipids in blood (metabolic syndrome). Individuals with the metabolic syndrome are at risk of developing fatty livers and NASH (Non-Alcoholic Steato Hepatitis), the new most common cause of cryptogenic cirrhosis. A patient with established cirrhosis has a risk 13 times higher of developing HCC than a person without cirrhosis.

Surgical resection or liver transplantation have been the preferred treatment modalities for HCC. They confer the best chance for patient survival. Unfortunately, only about 10% to 20% of all patients with HCC are suitable candidates for standard resection or transplantation. At the time of diagnosis, tumors are very large to remove or they have spread beyond the liver, or patients have other medical conditions that prohibit surgery. In addition, the majority of patients with cirrhosis can't have a major resection since they do not have enough liver reserve to survive. Multiple alternative therapies have been developed, including liver-directed therapies such as arterial chemoembolization and percutaneous ethanol injection and, local tumor ablation (radio-frequency ablation [RFA] and cryosurgical ablation). The hepatic artery can be reached through standard techniques and chemotherapy can be administered directly to the tumor with decreased systemic side effects. Ethanol can be injected directly into the tumor through a needle placed percutaneously under ultrasound guidance. The preferred treatment nowadays is destruction of the tumor without removing additional liver tissue by means of microwave heat (RFA) or freezing temperatures (cryoablation). However, RFA is not very effective for tumors larger than 4cms. A new form of gamma-radiation therapy, Cyberknife, targets large liver lesions with a precision of 1mm respecting normal liver. Preliminary results are encouraging. The proper diagnosis and staging of a patient with HCC requires a highly specialized team of doctors (hepatologist, radiologist, oncologist, radiation oncologist and HPB/Transplant surgeons). They will study an individual case and recommend the best treatment modality available for the specific needs of the patient.

Cholangiocarcinoma



Cholangiocarcinomas are a group of tumors that originate in the lining cells of the bile ducts. They can be intrahepatic or extrahepatic. When they are extrahepatic they can be localized very close to the liver (at the bifurcation of the bile ducts, called Klatskin's tumor), within the gallbladder or distal to the liver with or without an association to the pancreas. The total incidence is estimated at 1 case per 100,000 people in United States. Multiple risk factors have been described. They include congenital cysts, Primary Sclerosing Cholangitis (PSC), Recurrent Piogenic Cholangitis (RPC), exposure to thorium dioxide (Thorotrast), exposure to

(Continued on page 12)

Figure 1. *The Management of Liver Cancer requires a Multidisciplinary approach. Surgeons, oncologist, radiation oncologist, radiologist, pathologist, nurses, physiotherapist and social workers are part of a team that focuses on diseases of the liver. They work together to find the best treatment approach for the individual patient according to his overall medical condition and the stage of his neoplastic disease.*

Liver Malignancies

(Continued from page 11)

Vynil Chloride (PVC) and through Middle East and Asia, parasitic infestations. After the appropriate work-up and evaluation, less than one-third of the patients are eligible for the only treatment that has shown to improve survival, complete surgical resection. Treatment options such as transplantation, chemotherapy, radiotherapy and ablation therapies have also been evaluated. However, the results of these alternative therapies have not changed the dismal prognosis of this cancer. Newer protocols involving the use of Neo-adjuvant therapy with Cyberknife and Gencitabine in combination with liver transplantation have achieved the best survival results in selected patients.

Metastatic Disease of the Liver

Metastatic disease is the most common malignancy to the liver. By far the most frequent tumor to spread to the liver is originated in the colon and rectum. More than 120,000 new cases of colon cancer are diagnosed in the United States every year and it has been estimated at least 20 to 30% of those cases have some hepatic involvement. Unfortunately, only 15 to 25% of the patients with liver metastases are eligible for the treatment of choice, surgical resection. As in other tumors, at the time patients are diagnosed, the tumor has spread to other organs or their medical condition prohibits surgical resection. Due to the biological behavior of an already spread malignant disease, transplantation is not an option, i.e. the drugs given to avoid rejection of the transplanted graft will enhance tumor recurrence and growth. Significant progress has been done in alternative modalities for the treatment of these tumors. Although destruction of the tumor(s) may not achieve cure of patients non-eligible for resection; RFA or cryoablation in combination with chemotherapy can increase patient survival. Other forms of therapy include trans-arterial embolization of the tumor with chemotherapy (TACE) or with Ytrium 90 microspheres.

In summary, primary and metastatic tumors of the liver are frequent and their incidence is rising in Northem Ohio. A multidisciplinary approach composed of GI doctors, radiologist, oncologist, and surgeons is necessary for the optimal treatment approach to this complex disease. Each case must be individualized to formulate the best treatment approach for the specific circumstances of the patient disease and medical condition.

Editor's note: *The AMCNO welcomes article submissions from our members.* The Northern Ohio Physician *does not obtain medical reviews on articles submitted for publication.*

AMCNO members interested in submitting an article for publication in the magazine may contact Ms. Debbie Blonski at the AMCNO offices at (216) 520-1000, ext. 102. ■

ANNUAL MEETING 2008

The Academy of Medicine Cleveland & Northern Ohio (AMCNO) held its Annual Meeting Dinner and Awards Presentation on Friday, April 25. One of the meeting highlights was the awarding of eight medical student scholarships by the Academy of Medicine Education Foundation to local medical students.

The 2008 list of honorees was led by **John A. Bergfeld, MD**, receiving the John H. Budd MD Distinguished Membership Award for his exemplary accomplishments in the local healthcare community over the course of his career. **George E. Kikano, MD**, was honored with the Charles L. Hudson Distinguished Service Award in recognition of his longstanding allegiance and years of service to organized medicine. The 2007 Clinician of the Year designation went to **Victor M. Bello, MD**, for his devotion and service to his patients and his longstanding commitment to the Northern Ohio community.

Dale H. Cowan, MD, JD, received the Special Honors Award and **John D. Clough, MD**, received the Outstanding Service Award to acknowledge their significant contributions to the AMCNO.

A Special Recognition award was given out to James M. Mehrling, WCLV Production Manager, for his longstanding work on the AMCNO *Healthlines* radio program. Each award recipient was afforded an opportunity to thank the AMCNO for the award.

The Academy of Medicine Education Foundation (AMEF) presented eight local medical students with scholarships worth $5,000 each at this year's AMCNO Annual Meeting. The scholarships were awarded to **Shelley Chang**, Case Western Reserve University, **Amir K. Durrani**, Cleveland Clinic Lerner College of Medicine, **Craig Jarrett**, Cleveland Clinic Lerner College of Medicine, **Jovana Martin**, Case Western Reserve University, **Jason O. Robertson**, Cleveland Clinic Lerner College of Medicine, **Rachel M. Roth**, Cleveland Clinic Lerner College of Medicine, **Elim Shih**, Northeastern Ohio Universities College of Medicine, and **Aaron D. Viny**, Cleveland Clinic Lerner College of Medicine.

Dr. James Taylor *delivers his outgoing address to the annual meeting audience.*

The 2008 annual meeting honorees pose for a picture prior to the meeting – left to right – ***Dr. Victor Bello, Dr. George Kikano,*** *James Mehrling,* ***Dr. Dale Cowan*** *and* ***Dr. John Bergfeld.***

The 2008 50 year awardees gather for a group photo – left to right – ***Dr. Richard Hutchinson, Dr. Aboutaleb Rastgoufard, Dr. Daniel Weidenthal, Dr. Doris Schulz, Dr. Marinos Hionis****, Mrs. Richard Fratianne (receiving the award on his behalf) and* ***Dr. Yousef Demian.***

The AMEF scholarship recipients gather at the podium after receiving their $5,000.00 scholarship award. Left to right – Shelley Chang, Amir Durrani, Craig Jarrett, Jovana Martin, Jason Robertson, Elim Shih and Aaron Viny.

The AMCNO past presidents in attendance for the evening shared a moment together prior to the start of the festivities. Left to right – ***Dr. Kevin Geraci, Dr. George Leicht, Dr. Paul Janicki, Dr. George Kikano, Dr. Victor Bello, Dr. William Seitz, Dr. John Bastulli, Dr. Wilma Bergfeld, Dr. Beno Michel, Dr. Ronald Savrin*** *and* ***Dr. Dale Cowan.***

This was the third year scholarship monies were presented to recipients as part of the program of the AMCNO's Annual Meeting and Awards dinner, with students and their respective families in attendance.

Drs. George P. Leicht and **Richard B. Fratianne** both received recognition awards for their years of service to the Academy of Medicine Education Foundation.

And as always, physician members celebrating the fiftieth anniversary of their medical school graduation were honored during the program as well.

Following the awards ceremonies, outgoing president **James S. Taylor, MD,** passed the AMCNO gavel for the 2008-2009 year to **Raymond J. Scheetz, Jr., MD**

ANNUAL MEETING 2008



















Constitution and Bylaw Amendments

In accordance with The Academy of Medicine of Cleveland & Northern Ohio's bylaws, the following changes to the Constitution and Bylaws of the organization are published to the membership. Comments on these changes (if any) should be sent to ebiddlestone@amcnoma.org.

Article III (Constitution)
Membership

Section 1. Eligibility. Any legally qualified and reputable Doctor of Medicine or Doctor of Osteopathy licensed to practice medicine in the State of Ohio, hereinafter referred to as a "Physician," or an individual who has given notable service to medicine or who has been long active in the interests of the AMCNO, or a healthcare provider that becomes a corporate/group member of the AMCNO through a hospital medical staff group membership, shall be eligible for membership in the AMCNO subject to any further provisions by this Constitution and Bylaws and to such rules and regulations as may be adopted by the Board of Directors. ~~As a condition of membership in the AMCNO, a Physician agrees to~~ MEMBERS OF THE AMCNO SHALL abide by the principles of Medical Ethics of the American Medical Association and the Constitution and Bylaws of the AMCNO.

Article I (Bylaws)

Section B2 and B7

(2) Non-Resident Membership: Any physician who has the major portion of his/her practice in AN AREA OF THE STATE OF OHIO OUTSIDE OF ~~county other than~~ NORTHERN OHIO ~~Cuyahoga County~~ and who is of good professional standing and meets the criteria as outlined in Article I, Section 1, of these Bylaws may qualify as a non-resident member. Non-resident members may serve on committees as determined by the President and approved by the Board of Directors.
~~(7) Medical Society/Association Advocacy Group Membership: Medical Societies and Associations are eligible for Advocacy Group Membership in the AMCNO. Such advocacy group membership shall be at the discretion of the Board of Directors of the AMCNO. Medical Society/Association group members may serve on committees and the AMCNO Board of Directors as determined by the President and approved by the Board of Directors.~~
Section 3. Manner of Application and Election of Members.

(A) Application for Membership:

(1) Application Form PROCESS – an individual seeking Active membership in this society shall BE ASKED TO complete an application form which ~~shall~~ MAY include, but not be limited to, (a) INFORMATION NECESSARY TO PROVE EMPLOYMENT STATUS, PHYSICIAN GROUP AFFILIATION, professional training and experience, current licensure, and hospitals at which the applicant is a current member of the medical staff. ~~(b) completed or pending professional disciplinary action or licensure limitations; (c) voluntary or involuntary termination of medical staff membership or voluntary or involuntary limitation, reduction or loss of clinical privileges.~~ IF THE APPLICANT IS PART OF A GROUP APPLICATION OR DOES NOT COMPLETE THE INDIVIDUAL APPLICATION FORM AS REQUESTED, THE AMCNO MAY, AT ITS DISCRETION, OBTAIN THE INFORMATION NECESSARY TO COMPILE THE KEY ELEMENTS OF AN AMCNO APPLICATION FORM FROM THE GROUP OR OTHER SOURCE.

~~(2) Effect of Application – by signing the application form for membership in this society, the applicant: (a) authorizes consultation with others who have been associated with him or her, and authorizes such individuals to candidly provide all information regarding the applicant's competence and qualifications; (b) consents to inspection of records and documents that may be material to an evaluation of his or her qualifications, and authorizes all individuals and organizations in custody of such records and documents to permit such inspection and copying. This authorization includes access to county, state or federal data collection agencies regarding professional qualifications and competency; (c) consents to disclosure to hospitals, medical associations, licensing boards and other similar organizations any information regarding his or her professional standing or competence; and (d) acknowledges responsibility for timely payment of dues.~~

(B) Verification of Information:

(1) ONCE AN INDIVIDUAL APPLICATION OR GROUP APPLICATION IS COMPILED ~~The applicant shall deliver a completed application to the society. The~~ the Board of Directors, the Membership Committee or an appointed employee of the society, at the Board's direction shall seek to collect and verify ~~references~~, licensure status, medical staff status, and other INFORMATION ~~evidence~~ NECESSARY TO COMPLETE THE ~~submitted in support of the~~ application. IF AN APPLICANT OR GROUP APPLICANT IS A MEMBER IN GOOD STANDING OF THE MEDICAL STAFF OF A HOSPITAL WITHIN THIS COUNTY OR ANOTHER COUNTY, AND/OR HAS A VALID OHIO MEDICAL LICENSE WITH NO DISCIPLINARY ACTIONS PENDING AND/OR TAKEN BY THE OHIO STATE MEDICAL BOARD, THE BOARD OF DIRECTORS OR THE MEMBERSHIP COMMITTEE MAY TERMINATE THE INVESTIGATION AND VERIFICATION OF THE APPLICANT'S CREDENTIALS AND QUALIFICATIONS AND APPROVE THE APPLICATION FOR MEMBERSHIP.

The applicant shall be notified of any problems in obtaining the information required, and it shall be the applicant's obligation to obtain the required information if necessary.

~~(2) If the applicant is a member in good standing of the medical staff of a hospital within this county or another county, and such information is verified, the Board of Directors or the Membership Committee may terminate the investigation and verification of the applicant's credentials and qualifications and approve the application for membership.~~

(C) Action on Application and Election of Member:

(1) When collection and verification of all necessary information is accomplished, the information shall be submitted to the Membership Committee. The committee shall review the information and refer the applicant/GROUP APPLICANTS to the Board of Directors with a recommendation. At its next regular meeting after receipt of the information, or as soon thereafter as is practicable, the Board of Directors shall consider the information, and (a) approve the application/GROUP APPLICANTS for membership; (b) deny the application/GROUP APPLICATION for membership; or (c) return the application/GROUP APPLICATION for further investigation.

(2) If the application/GROUP APPLICATION is denied, the member shall have the right to notice and hearing as set forth in this Article I, Section 5, of these Bylaws. Whenever an applicant has been denied membership, no further application from the applicant may be considered for a year from the date of denial.

(3) If the application/GROUP APPLICATION is approved, the Board shall direct the Secretary to send notice of the approval to the applicant/GROUP APPLICANTS and enter the applicant's name on the membership roll. A majority vote of the Directors present shall prevail in all actions pertaining to membership, except as provided in Article 1, Section 5, of these Bylaws.

Article IV
Directors

Section 1. The Board.

(C) Voting Districts. Each Voting Member except members of the physician-in-training section shall belong to that district in which the hospital or group/corporation which the member has previously designated as that member's primary hospital or group/corporation is located. Active members with no primary hospital OR GROUP/CORPORATION affiliation OR A MEMBER THAT IS PART OF A PRIMARY HOSPITAL OR GROUP/CORPORATION WITH LESS THAN FIVE AMCNO MEMBERS will be assigned to the district nearest to that physician's primary office address. A non-active voting member will vote in the district in which the hospital or group/corporation the physician last designated as the primary affiliation is located. At each election any voting member shall be entitled to vote for one (1) candidate from that member's district and as many candidates-at-large as there are at-large positions to be elected. District boundaries shall be determined periodically when appropriate by the Board. In the event that a new hospital is established, the Board shall determine the district in which a voting member who has designated the new hospital as the member's primary hospital shall vote.

Article VI
Dues

Section 3. A.M.A. Dues. In addition to the foregoing annual local dues payable to this AMCNO, the members of this AMCNO ~~shall~~ MAY pay to the Secretary-Treasurer of this AMCNO, and if applicable, any dues payable to the American Medical Association, and the AMCNO shall forward promptly to the AMA dues so collected. All payments received shall be deemed to be in payment of local dues until the local dues are paid in full.

Section 5. Reinstatement. A member dropped for nonpayment of dues may be reinstated in good standing by the Board of Directors, but only when he/she has paid the dues in arrears at the date when he/she was dropped plus the current dues, and provided that the time which has elapsed between the date when he/she reapplies shall not have exceeded six (6) months. Such reinstatement shall not require ~~endorsement by AMCNO members or publication of the applicant's name.~~ REVIEW BY THE AMCNO MEMBERSHIP COMMITTEE OR BOARD OF DIRECTORS.

Welcome to the 2008-2009 AMCNO Officers and Board of Directors

2008-2009 Officers and Board of Directors

Raymond J. Sheetz, Jr., MD
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Anthony E. Bacevice, MD
President Elect

John A. Bastulli, MD
Vice President of Legislative Affairs

Laura J. David, MD
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District V
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Lawrence T. Kent, MD

District VI
Jonathan L. Myles, MD
Francis A. Papay, MD

At Large
Anthony E. Bacevice, MD
John A. Bastulli, MD
Nathan A. Berger, MD
John D. Clough, MD
Debra A. DeJoseph, MD
George E. Kikano, MD

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PHYSICIAN

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THE NORTHERN OHIO PHYSICIAN (ISSN# 1935-6293) is published bi-monthly by the Academy of Medicine Cleveland & Northern Ohio (AMCNO), 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131. Periodicals postage paid at Cleveland, Ohio. POSTMASTER: Send address changes to NORTHERN OHIO PHYSICIAN, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131. Editorial Offices: AMCNO, 6100 Oak Tree Blvd., Suite 440, Cleveland, Ohio 44131, phone (216) 520-1000. $36 per year. Circulation: 2200.

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

ADVERTISING: George H. Allen, Jr., Commemorative Publishing Company
P.O. Box 450807, Westlake, Ohio 44145
P: (440) 808-0240 • F: (440) 808-0494

The Academy of Medicine Cleveland & Northern Ohio

The VOICE of NE Ohio Physicians for more than 180 Years

Highlights of 2006-07 AMCNO Working on Behalf of Our Members and their Patients

LEGISLATIVE ACTIVITIES

- Continued our work on legislation that would create a mandatory arbitration pilot program to resolve medical liability cases in NE Ohio counties prior to going to court.
- Advocated for and provided input on HB 125 – the Healthcare Simplification Act, legislation that requires health plans to be much clearer and open about contract terms with physicians, including disclosing what insurers will pay for services.
- Facilitated meetings with legislators, judges and state leaders to continue strong working relationships for the AMCNO.
- Joined in an amicus brief filed with the Ohio Supreme Court in support of the constitutionality of non-economic damage caps, resulting in the Court supporting the constitutionality of the caps in certain types of cases.
- Actively participated in the Investing in Tobacco Free Youth Coalition campaign inclusive of AMCNO members lobbying the legislature to consider introducing legislation to increase the other tobacco products tax and utilize the tax income exclusively for tobacco cessation programs.
- Joined in an amicus brief filed with the Ohio Supreme Court (OSC) and scored a victory when the OSC invalidated a regulation which prohibited anesthesiologist assistants (AAs) – a decision which maintained the practice of AAs in Ohio.
- Supported and helped achieve a reversal of the 2007 Medicare payment cuts – while continuing to advocate for a change to the Sustainable Growth Rate (SGR) formula used to calculate physician fees.
- Reviewed and took positions on over 100 healthcare related bills under review at the State legislature making our position known to bill sponsors and committee chairman – inclusive of written testimony – enhancing the AMCNO presence at the Statehouse.
- Presented testimony before the House Health Care Access and Affordability Committee keying in on specific points related to care of the uninsured and preventative care.
- Continued our legislative breakfast concept – changing the concept to a luncheon format, an opportunity for physicians at area hospitals to meet and greet legislators from their district.

PRACTICE MANAGEMENT

- Met with representatives of the Medicare Payment Advisory Commission to discuss private payer plans usage of episode grouper (pay-for-performance) software and provide input into a study coordinated by Mathematica Policy Research.
- Participated in a forum hosted by the Centers for Medicare and Medicaid Services (CMS) to garner information on CMS' electronic health record project.
- Met with and provided detailed comments to the Director of the Ohio Department of Job and Family Services (ODJFS) regarding the rollout of the Medicaid Managed Care plans in Northern Ohio.
- Provided timely information to our members on managed care issues and the yearly update on the fees to be charged for transfer of medical records.
- Requested and obtained specifics from the Ohio Department of Job and Family Services (ODJFS) on how physicians could expect to alleviate concerns with continuity of care issues when Anthem exited the Covered Families and Children (CFC) managed care program in Northeastern Ohio.
- Became an active participant and provided comments to the UnitedHealth Care Physician Advisory Board.
- Disseminated timely and topical news to practice managers through our publication Practice Management Matters.
- Provided our members with services designed to resolve insurance company disputes with third party payers in Northern Ohio.
- Co-sponsored a well-attended Webinar on the Physician Quality Reporting Initiative (PQRI.)
- Provided a third party payor seminar for practice managers and physicians – an event created by the AMCNO now entering its twenty-sixth year.

COMMUNITY EFFORTS

- Conducted our eighth annual successful Vote and Vaccinate event on Election Day offering flu and pneumonia vaccines through our community partnerships in underserved areas.
- Hosted the 23rd annual Mini-internship program that allows community members to shadow AMCNO physicians in their practice setting.
- Provided funding through The Academy of Medicine Education Foundation (AMEF) for the Vaccinate Before you Graduate program at an area high school.
- Became an active participant in the Steps to a Healthier Cleveland initiative.
- Garnered support from our members for their participation in the Ohio Medical Reserve Corps.

Benefits of Membership in the AMCNO

Renowned Physician Referral Service

Representation at the Statehouse through McDonald Hopkins, Co. LPA

Specialty Listing in *Member Directory & Community Resource Guide*

Practice Promotion via *Healthlines* radio program

Reimbursement Ombudsman

CME Seminars

Peer Review

Speaker's Bureau opportunities

Insurance/Financial Services

Weekly, quarterly and bimonthly publications offering healthcare news and practice guidance

Member Discounts including Worker's Comp, Practice Management Classes at Tri-C and so much more!

PUBLIC RELATIONS

- Participated as a keynote speaker at the City Club Forum on the topic of medical liability reform and alternative dispute resolution concepts.
- Conducted an exclusive interview on the Healthlines radio program with the Chairman of the House Health Care Access and Affordability Committee on the topic of health care reform in Ohio.
- Entered the 48th year of operation for the AMCNO Pollen Line.
- Added the capability to conduct our award-winning "Healthlines" radio program through "on the road" interviews – eliminating the need to travel to the studio and to assist with the myriad AMCNO member interviews conducted each year.

SCHOLARSHIPS

- The Academy of Medicine Education Foundation (AMEF) awarded eight $5,000 scholarships to local third and fourth year medical school students.

PHYSICIAN EDUCATION OPPORTUNITIES

- Hosted topical sessions addressing medical legal issues such as current trends in malpractice allegations and risk management, practice pitfalls – HIPAA compliance and informed consent issues, electronic health records/technology issues and patient communication and Stark III compliance issues.
- Provided a forum for resident members outlining how young physicians should prepare for the business aspects of practicing medicine.

BOARD INITIATIVES/ADVOCACY

- Provided ongoing input into the to the Ohio Department of Insurance (ODI) with regard to the various types of health care reforms under review in the State of Ohio to assist in the Governor's goal to provide access to affordable health insurance coverage for all uninsured Ohioans and to increase the number of small employers who are able to offer coverage to their workers.
- Garnered support from area physician groups to increase the AMCNO membership numbers to over 5,000 area physicians.
- Requested that the Ohio Attorney General investigate and review doctor-ranking programs and consider establishing consent agreements with health plans in Ohio, inclusive of plan oversight to assure compliance with outlined physician ranking protocol as established through agreements made with the New York Attorney General.
- Agreed to become an active participant in the Aligning Forces for Quality – The Northeast Ohio Collaborative, a multi-stakeholder alliance committed to improving the quality of care for people with common chronic conditions.
- Initiated a strong advocacy campaign in cooperation with other medical organizations to delay the mandated usage of tamper-proof prescription pads.
- Responded in opposition to federal legislation that would have changed the beneficiary review process for Medicare Quality Improvement Organizations (QIOs) which would have resulted in additional regulatory oversight of physicians.
- Joined national, state and local organizations in endorsing the Family Smoking Prevention and Tobacco Control Act , legislation that gave the U.S. Food and Drug Administration the authority to regulate tobacco products.
- Provided cogent arguments to the Centers for Medicare and Medicaid Services (CMS) stressing the need to change the state of Ohio calculations for the Geographic Practice Cost Indices (GPCIs) to provide for fairer reimbursement levels for Northern Ohio physicians.

Is YOUR Voice Being Heard?

Already an AMCNO member? Now is the time to renew your commitment to organized medicine that makes a real difference in your practice and our region. Look for a 2009 dues billing in your mail soon!

Not yet a Member? Now more than ever is the time to join the only regional medical association tirelessly working in the best interest of you—the NE Ohio physician. Call our membership department at (216) 520.1000 ext. 101 for details on all the benefits and services available exclusively to our members.

#1 Investment Strategies
#2 Appropriate Insurance Coverage
#3 Credit Management

YOU ENCOUNTER THE 13 WEALTH ISSUES EVERY DAY. NOW ADDRESS THEM WITH AN ADVISOR.

Every day you have to make decisions regarding your wealth. And with a Key Private Bank advisor you can make those decisions easier with our 13 Wealth Issues: a comprehensive way we look at your wealth and how to best manage it. Combined with our solid reputation, unbiased advice and personalized approach, this process makes sure we're not just taking care of your every day, but taking care of your tomorrows.

To learn more about the 13 Wealth Issues call 440-995-2112 or visit key.com/kpb.

Investment Management	Private Banking	Trust Services

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