

Ohio Supreme Court to Again Consider the Issue of Providing Information to Juries on Medical Bill Reductions

AMCNO Files An Amicus Brief in *Jaques v. Manton*

By Martin Galvin, Attorney with Reminger Co., L.P.A.

The AMCNO Medical Legal Liaison Committee tracks cases for the AMCNO Board of Directors that come before the Ohio Supreme Court (OSC) that could impact or change the current tort reform law in Ohio. As a result, the AMCNO has become aware of such a case and we have filed a friend of the court brief on behalf of our members in the case described below.

In 2006, the Ohio Supreme Court released a nearly unanimous decision in *Robinson v. Bates*, 2006-Ohio-6362, holding that under what is known as the "collateral source

rule," juries should be entitled to hear evidence that medical bills introduced at trial were ultimately compromised for a reduced amount. Specifically, in *Robinson*, Plaintiff's

total medical bills were \$1,919.00, but her medical providers ultimately accepted payment of \$1,350.43, a difference of less than \$600.00. The *Robinson* Court concluded that both figures were relevant to the issue of damages and that the jury should be entitled to hear evidence of both figures.

After the *Robinson* decision was released,
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AMCNO Provides Video Testimonial for the Partnership to Fight Chronic Disease (PFCD) Health Reform Web Site

The Partnership to Fight Chronic Disease (PFCD) has launched the "Say 'Yes' to Health Reform" (www.sayyestohealthreform.com) campaign — an online video campaign directed at Congressional leaders in Washington. The campaign showcases patients, health providers, advocates and others voicing their support for health reform that prioritizes prevention and wellness. Several of these testimonials came from Ohio, including **Dr. Laura David, the president-elect of the Academy of Medicine of Cleveland & Northern Ohio (AMCNO)**; the Columbus Public Health Commissioner Dr. Teresa Long; Dr. Sarah Sams, president-elect of the Ohio Academy of Family Physicians, and many others. In addition, over the past few months the AMCNO has signed onto several letters sent to Congress from PFCD.

The PFCD campaign Web site features video testimonials of Americans from communities across the country talking about why they "say 'yes'" to comprehensive health reform that tackles issues of affordability, access and quality brought on by our nation's high rates of poorly prevented and mismanaged chronic

disease — and why they "say 'no'" to the status quo. The videos represent a diverse mix of concerned individuals — from patients and caregivers, to physicians, nurses and other clinicians, to business owners and local leaders. Many live with a chronic illness or care
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Dr. Laura David, AMCNO President-elect, provides her comments for the PFCD web site testimonial

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Ohio Supreme Court to Again Consider the Issue of Providing Information to Juries on Medical Bill Reductions (Continued from page 1)

most observers considered this issue settled. Nevertheless, plaintiff lawyers soon began advancing an argument that the *Robinson* decision was flawed, and that it contained a fatal loophole which prevented it from being applied to all but a small number of cases. This argument suggested that because the statute governing the collateral source rule, R.C. 2315.20, was amended after the *Robinson* decision was released, the decision would have no forward going effect. This argument, which is essentially a distortion of an innocuous footnote, has been consistently made, despite the fact that the statute had been amended in order to clarify the collateral source rule in almost precisely the same manner as *Robinson*.

The *Robinson* footnote at issue merely referenced revised R.C. 2315.20, stating "this new collateral benefits statute does not apply in this case, however, because it became effective after the cause of action accrued and after the complaint was filed." The point of this footnote was that the new statute was not passed in time to be applicable to the facts of *Robinson*. Yet, the footnote has been construed to invalidate *Robinson* for all claims arising after April 7, 2005, the effective date of the new statute.

Thus, although the Supreme Court decision in *Robinson*, as well as amended R.C. 2315.20, both sought to clarify that write downs of medical bills are a proper matter for jury consideration, numerous courts have reached the opposite conclusion, and are applying the collateral source rule as it existed in Ohio pre-2006. These courts are refusing to permit evidence that medical bills have been reduced to be submitted to juries. This trend among trial courts has been especially pronounced in Cuyahoga County.

Recently, with the assistance of the Reminger law firm, AMCNO filed an Amicus Brief, (literally "Friend of the Court") arguing that the *Robinson* decision, public policy concerns, and logic all compel the conclusion that *Robinson* remains in full force. This Amicus Brief was filed in the case of *Jaques v. Manton*, Ohio Supreme Court No. 2009-0820, and is accessible in PDF format from the Court's Web site. Amicus pleading generally allow individuals and entities who are not parties to a case, but who nevertheless have an interest in the outcome, an opportunity to be heard.

The *Jaques* lawsuit is on appeal from Lucas County and the Sixth District, both which agreed that juries are not entitled to be told that portions of medical bills have been written off. In *Jaques*, the total medical bills incurred by the plaintiff were \$21,874.80, yet her medical providers

accepted \$7,483.91 as full payment. This type of differential obviously impacts jury awards. If a jury only hears the higher hypothetical damage figure, the verdict ultimately reached will be much higher.

The issue of whether write downs of medical bills are admissible comes down to a dispute over the meaning of "reasonable value of medical care required to treat an injury." It is well-settled that in personal injury cases, an injured party is entitled to recover "necessary and reasonable expenses" arising from the injury. The question answered in *Robinson*, which is being revisited in *Jaques*, is how to determine the reasonable value of the medical care. The first option is to only admit evidence of the amount paid in settlement of the bills. The second option is to only admit evidence of the face value of the bills. The third option is to admit evidence of both the amount paid and the face value of medical bills, and then let juries sort it out.

Generally, under the collateral-source rule, a jury may not learn about a plaintiff's receipt of payment from a source other than the tortfeasor, so that a tortfeasor is not given an advantage from third party payments to the plaintiff. For example, if a person is injured in an accident and sustains \$1,000 in medical bills, which are covered by insurance, the collateral-source rule provides that the wrongdoer does not get the benefit of payment.

It is a universally accepted reality by plaintiff lawyers, defense lawyers, the courts, and others, that the amount of medical bills presented in a claim bears a direct correlation to jury verdicts, and also to settlements, arbitration decisions, and mediation outcomes. Thus, the amount paid out for virtually all claims will be affected by the Supreme Court's decision.

It is our hope that the Supreme Court will recognize that *Robinson* and R.C. 2315.20, as amended in 2005, are easily compatible, and will make it clear to courts across the state (yet again) that jurors are entitled to hear all evidence relevant to damages. ■

NORTHERN OHIO PHYSICIAN

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AMCNO Health Care Reform Survey Responses Sent to Congressional and State Leaders

The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) health care reform survey was conducted over a two-week period in September 2009. It should be noted that this survey did not contain a question regarding the issue of tort reform. This is due to the fact that the AMCNO did not believe that there was a need to address this question since we already have information from our membership in this regard. The AMCNO already has a strong stance on this issue and we believe there is a real need for additional tort reform proposals both at the state and federal levels. In addition, there is verifiable data that physicians in the Northern Ohio community are still experiencing high medical liability rates and excessive claim filings and this issue must be addressed in any health care reform legislation under review at this time.

This survey was conducted to obtain a snapshot of the opinions of practicing physicians in the Northern Ohio area with regard to health care reform. Questions revolved around the type of insurance options to consider, Medicare and Medicaid participation decisions, utilization issues and insurance costs. Results of the survey have been sent to Northern Ohio Congressional leaders, the Governor, the Ohio Department of Job and Family Services and to Ohio legislative leadership.

AMCNO Survey Response Overview

Respondents overwhelmingly opposed a government run single payer system; however, there appeared to be some support for a combination of a private health plan system with a government run (but not government subsidized) option. In addition, respondents overwhelmingly favored a mandate that everyone be required to purchase catastrophic insurance coverage.

Responses were mixed on supporting a mandate requiring employers with less than 10 employees to purchase health insurance for their employees; however, there was overwhelming support for the creation of a health insurance exchange to allow the uninsured or small business employees (less than 10 employees) to purchase health insurance. Responses were also mixed on the issue of how to pay for coverage for the under-insured and uninsured.

Respondents strongly favored reforms that would prohibit health insurance companies from cancelling or denying coverage due to health status or conditions as well as showing strong support for limiting health insurance company profits and overhead to 15%.

Over 85% of the respondents indicated that they participated in Medicare with over half of those respondents indicating that Medicare rates in their specialty were poor or unsustainable. In addition, over 40% of the respondents indicated that if Medicare payments are cut by 21% (as the existing formula calls for on January 1, 2010) they would either reduce their Medicare patient load or eliminate seeing Medicare patients altogether.

Close to 88% of the respondents are currently taking Medicaid patients and of

those over 70% noted that Medicaid rates in their specialty are poor or unsustainable. Over 35% of those respondents indicated that if Medicaid rates are cut even further they would either reduce or eliminate their Medicaid patient load.

Over 60% of the respondents agreed that physician driven over-utilization of services is part of the cost problem with over 87% of the respondents noting that patient driven demand is another part of the cost problem in American health care.

An overwhelming percentage of respondents believe that physicians practicing defensive medicine is a cost problem in American health care. This response, coupled with the need for medical liability data noted above illustrates a definitive need for the inclusion of tort reform as a part of the health care reform legislation.

In response to a final question, over 70% of the respondents believe that cost shifting (defined as charging insured or private pay patients more to compensate for uninsured or underinsured patients) is part of the cost problem in American health care. To view a complete copy of the survey go to the AMCNO Web site at www.amcnoma.org and go to the health care reform link. ■



Several physician members and members of the AMCNO board of directors met in September with Congressman Dennis Kucinich to discuss health care reform. The Congressman was provided with a copy of the AMCNO letter to Congress outlining our concerns with HR 3200. The Congressman indicated that he is considering regular conference calls with physicians to garner additional information as the debate on health care reform moves forward at the federal level.

AMCNO Hosts Legislative Lunch to Garner Feedback from Members on Legislative Issues and Health Care Reform

The AMCNO held a legislative luncheon in coordination with the Cleveland Clinic Beachwood Family Health & Surgery Center on Friday, October 2nd. The event was well attended by physicians as well as legislators from the Ohio Senate and House.

Legislators participating in the event were Representatives Foley, Dolan, and Moran and Senators Cafaro and Patton. The AMCNO physician representatives provided the legislators with an overview of the AMCNO legislative initiatives in particular highlighting the work done by the AMCNO on the drafting of legislation that would address the physician ranking programs of health insurance companies. Attendees also learned that the AMCNO continues to look for alternatives to the current tort reform system and that the AMCNO Medical Legal Liaison Committee is looking at other alternatives such as special health courts or courts run by specially trained judges.

The legislators were provided with information and letters sent to Congress from the AMCNO regarding the health care reform debate occurring at the federal level. The AMCNO also provided attendees with information from the AMCNO health care reform survey noting that the results of that survey will be sent to the Northern Ohio Congressional leaders as well as to legislators and state officials (see related story on page 4).

The legislators in attendance provided their insight on the health care reform debate noting that there have to be some changes in how health insurance companies operate as well as a need to look at different types of health plans. Several legislators commented on the current



Legislators attending the AMCNO legislative lunch spend a moment with several physician attendees. Left to right – Michael Nemunaitis, M.D., Brooke Wolf, M.D., **Tom Abelson, M.D.**, Senator Capri Cafaro, Rep. Mike Foley, **Anthony Bacevice, Jr., M.D.**, Senator Tom Patton, **John Bastulli, M.D.**, Rep. Matt Dolan, Rep. Mike Moran and Ronald Krasny, M.D.

budget situation in Ohio and noted that there will be continued debate on how to offset budget shortfalls. At least one of the state legislators noted that they support a single payor plan. Others thanked the AMCNO for their strong representation at the Statehouse but stressed the need for physicians to engage in the debate as well and make a plan to come down to the Statehouse to discuss health care related issues with their legislators. ■

AMCNO Supports Multi-Payer Web Portal Initiative for Physician Claims

The Academy of Medicine of Cleveland and Northern Ohio (AMCNO) is pleased to announce our full support of the plan to launch a multi-payer portal project in Ohio. This landmark initiative will make delivering and getting health care easier for patients and their physicians by reducing the time, effort, and expense for the paperwork required for each office visit. America's Health Insurance Plan (AHIP) and Blue Cross Blue Shield Association (BCBSA) have brought their members' plans together in an effort that is designed to address the needs of Ohio physicians and patients to make health care office visit procedures simpler by streamlining and fully automating key office tasks.

Beginning in Ohio in early November 2009, health insurers will launch a multi-payer Web portal to assess how best to offer physicians access to multiple insurers through the same channel of information exchange (e.g., a web portal) for the purpose of conducting office tasks. The web portal will be provided free of charge to physician practices by the vendor Availity.

It offers opportunities to simplify the work associated with patient visits and achieve savings, streamlining the administrative process for physician practices by providing information in "real-time" that:

- Allows office staff to quickly determine key eligibility and benefit information (e.g., co-pays, co-insurance and deductibles, and differences in coverage for services provided in- versus out-of-network), minimizing the number of staff needed for such purposes;
- Gives physicians access to current and accurate information on the status of claims submitted by physician offices for payment by insurers. This will minimize the need for follow up steps by office staff or submission of duplicate claims that delay rather than expedite payment in most systems;

- Tests real-time referrals and timely pre-authorization of services; and
- Provides for the online submission of health care claims.

The portal will be implemented in a pilot phase beginning November 2009 and will continue for one year. The health plans participating in the initiative in Ohio are Aetna, CIGNA, Humana, UnitedHealthcare, Anthem Blue Cross and Blue Shield, WellCare Health Plans, Inc., and Medical Mutual of Ohio.

The initiative is a collaboration of the America's Health Insurance Plans (AHIP) and the Blue Cross Blue Shield Association (BCBSA). The effort will be conducted on a statewide basis because this allows for the participation of physicians and possibly government programs in given geographic areas and overlapping service areas for multiple insurers. Insurers are partnering with local physician organizations, like the AMCNO, throughout the year-long program to ensure the progress can be monitored and specific issues can be addressed directly. The AMCNO is one of the many physician organizations supporting the effort and we plan to work to encourage our

members to take part in the initiative. The AMCNO has been a strong proponent for reducing the administrative tasks that physician offices face when processing insurance claims and we have supported legislation meant to address this issue in Ohio. In addition, the AMCNO recently participated in statewide work groups advocating for this type of initiative on a statewide level. AMCNO will be providing additional information on this initiative to our members as it becomes available.

For more information on the multi-payer project vendor Availity, go to <http://www.availity.com/>. For a detailed backgrounder on this initiative go to <http://www.americanhealthsolution.org/assets/Uploads/Blog/Backgrounder-Ohio.pdf>. For additional information on the AMCNO support of this initiative contact Elayne R. Biddlestone at the AMCNO offices at ebiddlestone@amcnoma.org or (216) 520-1000 ■

AMCNO PCFD Testimonial

(Continued from page 1)

for a chronically ill family member. To date, the "Say 'Yes' to Health Reform" campaign features over 100 videos from the 17 states where the PCFD has chapters. We encourage you to visit and spread the word about this new site.

The AMCNO is an active partner in the PCFD. To view the statement on the PCFD Web site provided by Dr. Laura David sent on behalf of the AMCNO go to: <http://www.sayyestohealthreform.com/2009/09/24/dr-laura-david-of-cleveland-ohio/> ■

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AMCNO Sponsored Seminar on Recovery Audit Contractors – What You Need to Know Now

On September 9th, Dr. Laura David, AMCNO president-elect, welcomed a capacity audience of physicians and office managers to the AMCNO Recovery Audit Contractors (RAC) seminar. Dr. David spoke briefly, yet pointedly, about membership in the AMCNO and how it helps care for the unique interests of physicians in Northeast Ohio. She then introduced the evening's speakers Dave Valent, Esq. and Jim Peters, Esq. of Reminger Co L.P.A.

Are you RAC ready? The evening began by Mr. Valent providing the background and history of Medicare reimbursements and the current process the Centers for Medicare and Medicaid Services (CMS) uses with its program safeguard contractors (Advance Med) to audit healthcare providers. He went on to explain the future changes coming with the RAC program and highlighted some differences between the current program and the RAC program with one major difference being that RACs are paid a contingency fee for every dollar collected, i.e. a recovery of \$1 million gives the RAC 12.5% return or \$125,000. This provides a huge incentive for RACs to identify overpayments to providers and noted inpatient hospitals are an easy target with their computer records and such a high dollar potential.

Another difference is the recovery process between the current and RAC programs. An advantage under the new program is that providers will enter into a 30-day discussion period to contact CGI, the Ohio RAC, during which they can submit evidence about their billing practices. The appeal process also was explained should a provider disagree with the RAC's determination. Overall the provider's burden is minimized under the new program with a limit on the "look back period" of three years.

The RAC Web site is supposed to post information obtained from audits in an effort to warn and educate providers about mistakes. As of this time, the Ohio RAC Web site is not up and running.

The last part of the presentation informed providers about what they can do to get ready:

- Know where previous improper payments have been found.
- Know if you are submitting claims with improper payments by conducting an internal assessment to identify if you are in compliance with Medicare rules. Then



The AMCNO sponsored recovery audit seminar was filled to capacity by physicians and staff interested in learning more about the upcoming audits.

identify corrective actions to implement for compliance. Make sure to not only focus on coding, but also on documentation so you can substantiate what you did. Consider having periodic compliance audits to proactively identify any problems.

- Prepare to respond to a RAC medical record request by putting an action plan in place identifying specific steps to take when you receive a request, including designating a single contact person to speak with CGI.
- Appeal when necessary; only 14-16% of cases are appealed.
- Learn about the factors that trigger audits and safeguard against them, i.e. submitting codes outside of a specialty, submitting an increased number of claims, submitting claims beyond the national average for certain specialty areas.

Both Mr. Valent and Mr. Peters discussed the particulars of a hypothetical case example to provide insight into the provider's handling and suggested ways to improve the process.

At the earliest, RACs are coming to Ohio as soon as October 2009 after completion of an educational program and will rollout with random automated reviews first, then complex reviews; however, the thought was that it could take until January 2010 to see any activity by the RACs.

On the Internet: <http://racb.cgi.com> or <http://www.cms.hhs.gov/RAC/> ■

AMCNO Practice Tip:

With the Medicare Recovery Audit Contractor program starting soon, it is especially important to be thorough and accurate in your documentation. The following is a list of principles to guide you in documenting E&M services:

- Current procedural terminology and ICD-9 codes reported on the Medicare, Medicaid or insurance claim or billing statement must correspond with the documentation in the medical record.
- For each visit, the physician must document the chief complaint or reason for the visit, relevant history, physical examination findings, prior diagnostic test results, assessment, clinical impression or diagnosis, plan for care, date of visit, and the name of the health care professional who provided the service.
- The physician must document the rationale for ordering diagnostic or other ancillary services; if not, the rationale should be easily inferred.
- The medical record should be complete and legible.
- An addendum to the medical record should be dated the day the information is added to the medical record, not the date the service was provided.
- Physicians should document the visit as it is happening, or shortly thereafter. Delayed entries within a reasonable time frame — 24 to 48 hours — are acceptable when you are clarifying information, correcting an error, adding new information not initially available, or if unusual circumstances prevented you from including the note at the time of service.

With proper documentation you can avoid these common errors:

- Incomplete or insufficient documentation:
 - it does not support the level of service billed (i.e., upcoding or downcoding of services);
 - the required components (as required by the CPT book) are not documented in the medical record;
 - the history component is incomplete or absent; or
 - the medical decision-making documented is inappropriate or incomplete, or the services were rendered by one physician or billed by another.
- Documentation that does not support a face-to-face encounter between physician and patient.
- The medical record contains conflicting information (e.g., the diagnosis on the claim is inconsistent with the diagnosis in the medical record; the documentation in the patient's history conflicts with the examination; the date of service in the documentation is different from the date of service billed).
- The service is not performed on the date of service billed, not dictated on the date of assessment, or not documented on the date of the visit.
- The medical documentation does not support medical necessity for the frequency of the visit.

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The Physician Witness: Issues and Ethical Considerations

By Victoria Vance, Esq. and Jane F. Warner, Esq., Tucker Ellis & West LLP

Physicians are frequent participants in civil litigation. They may be a party or a party's treating physician; or, they may be acting as the medical expert whose purpose is to define the standard of care, opine as to whether the care at issue met the standard and testify about the cause of an injury. Regardless of the role, physician witnesses face distinctive challenges that lay litigants and witnesses do not. The purpose of this article is to alert physicians to these challenges and offer recommendations as to how to avoid legal pitfalls.

Physicians' Ethical Obligations to Participate in the Medico-Legal System

Physicians do not have a legal obligation to testify as an expert or treating physician; they do however, have an ethical obligation "to assist in the administration of justice." AMA Policy E-9.07. This policy recognizes that physicians, through their participation in litigation, contribute to the improvement of public health. It also recognizes that physicians, by virtue of their education, training and experience, are in a unique position to aid juries in medically-complex litigation and prevent the legal system from becoming "arbitrary and unfair." CEJA Report 12-04. Thus, the AMA and other professional medical societies encourage their members to be active participants in the legal process.

The physicians' primary obligation as a witness is to provide testimony that is "honest and independent." *Id.* Honest testimony is based upon experience, published research, consensus statements or evidence-based medicine. *Id.* Honest testimony also incorporates standards of care that prevailed at the time the event under review occurred. *Id.* If physicians offer testimony based upon standards that are or were not widely accepted, honest physicians are obligated to make that known. *Id.*

In Ohio, physicians are held to the ethical standards set forth in AMA policies and policies promulgated by national professional organizations. R.C. 4731.22(B)(18) authorizes the State Medical Board of Ohio to discipline any physician who violates the codes of ethics promulgated by the AMA or national professional organizations. Thus, a physician who undertakes to assist the administration of justice by offering testimony should not do so lightly.

Practical Considerations

1. Setting Fees

Independent medical testimony is that

which is free from external influence. To assure independence, physicians should identify potential conflicts of interest before accepting a role in litigation. Financial interests present the most obvious conflicts. For example, in a medical malpractice action, if the physician-witness and the physician-defendant share the same insurance coverage, and an adverse judgment against the defendant affects the financial interest of the witness, the witness may feel pressured to offer testimony that is favorable to the defendant. Similarly, the physician-witness may feel compelled to offer favorable testimony in a medical device or pharmaceutical case if he has a financial relationship with the manufacturer. If financial interests are at stake, physicians should strongly consider declining involvement in litigation.

Professional fees are another matter. Physicians routinely are compensated for the professional time they devote to civil litigation. These fees, however, must be reasonable; otherwise it appears as if physicians are being paid for their testimony and not their time. Testimony that appears "bought and paid" is not likely to be perceived as honest or independent. Thus, reasonable fees are paramount. Physicians may seek advice from colleagues or the attorneys who request their services to determine whether their fees are reasonable.

2. Clarify the Scope of Testimony

Physician witnesses can enhance their ability to provide honest and independent testimony by defining the scope of involvement at the time they are retained. In other words, the physician should ascertain what he is being asked to do. For experts, this means identifying the standard of care and proximate cause issues they are expected to address so that they can determine whether their training and experience allows them to offer the required opinions.

Defining the scope of involvement is especially important for treating physicians, and this presents two separate issues. First, treating physicians must consider the duty of confidentiality that is owed to their patients. In Ohio, a patient who files a lawsuit generally waives the physician patient privilege, but the waiver is limited and treating physicians may discuss only those aspects of care that are relevant to the lawsuit. If treating physicians provide information that exceeds the scope of waiver, they may unwittingly find themselves at the wrong end of a lawsuit for invasion of privacy.

3. Clarify Expectations

Treating physicians also need to clarify patient expectations. Does the patient need a written report, or will the patient ask his physician to testify at trial? Does the patient expect the physician only to discuss the diseases or conditions diagnosed and the treatment rendered, or does the patient expect the treating physician to double as a medical expert and offer opinions on the standard of care and the cause of injury? Such issues must be outlined prior to becoming involved in litigation; otherwise, treating physicians may inadvertently implicate themselves or colleagues in the litigation.

4. Consult with Counsel Early in the Process

Physicians can avoid the pitfalls associated with medical testimony by obtaining as much information as possible. Potential experts should have a full discussion with the retaining attorney before agreeing to review records. Treating physicians should consult with their patients, their patients' attorneys, and they also should consult with their own attorney. Attorneys will explain the litigation process in detail and help the treating physicians identify issues that may surface during deposition. Attorneys also will act as liaisons with attorneys for the parties, and in so doing, attorneys can solicit agreements from the other attorneys as to the timeframe, logistics and scope of the treating physicians' anticipated testimony. At depositions, attorneys can protect the treating physicians' legal rights, something the attorneys for the parties have no obligation to do.

Engaging in the medico-legal process can be rewarding, intellectually stimulating, and a public service. But, the physician should do so with an awareness of the expectations of the court, counsel, and the patient. ■

Legislative Report

By Connor Patton, AMCNO lobbyist

AMCNO Scores a Victory with the Passage of HB 122 in the Ohio House Health Committee

On Wednesday October 14th, HB 122 passed out of the Health Committee in the Ohio House of Representatives with a unanimous vote. The bill was introduced to the Ohio House of Representatives by AMCNO on April 2nd under the sponsorship of State Representative Barbara Boyd from Cleveland Heights who also serves as chairwoman of the committee. HB 122 was introduced to establish standards for physician designations by health care insurers. With the help of Rep. Boyd, the bill was able to navigate through the rigorous committee process and after four hearings it cleared the committee. Rep. Boyd believes the bill is much needed and the legislation protects consumers, promotes fairness, and ensures due process.

A clerical amendment was added to the bill before the bill was brought up for a vote and Rep. Boyd asked the committee to favorably report the legislation. The amendment made changes to the bill that gave the Ohio Department of Insurance rulemaking authority and the authority to establish a process to approve the appointment of independent ratings examiners, expanded the scope of the bill to third party administrators, and lengthened the process for timelines and appeals.

On behalf of AMCNO, **Dr. John Bastulli** appeared before the Health Committee to urge its passage and no parties appeared before the committee in opposition to the bill. AMCNO met with many groups during this process including: Attorney General Richard Cordray, the Ohio State Medical Board, the Ohio Department of Insurance, the Speaker of the Ohio House of Representatives Armond Budish, and numerous members of the Ohio General Assembly. Interested parties in the legislation were the Ohio Association of Health Plans (OAHP) and the Ohio Department of Insurance.

The next step in the process will be for the bill to be brought to the floor of the Ohio House of Representatives for a vote by the entire chamber and then reported to the Ohio Senate where it will be referred to a committee and go through the same

process as in the House. After a bill goes through both chambers of the Ohio General Assembly it is then sent to the Governor's desk where he can do one of three things: sign the bill and make it into law, not sign the bill and after a period of ten days it becomes law, or veto the bill. With the sponsorship of Rep. Boyd the bill is certain to pass the Ohio House. Members of the Health Committee from Northern Ohio that voted in favor of the bill were Rep. Kenny Yuko of Richmond Heights, Rep. Robert Hagan of Youngstown, Rep. Tom Letson of Warren, Rep. Steve Slesnick of Canton, and Rep. Scott Oelslager of Canton.

Budget Woes

On the state budget side Gov. Strickland has proposed to postpone or "freeze" a 4.2 percent income tax cut that is the last phase of a 21 percent income tax reform that began in 2005. This is Gov. Strickland's proposal to make up for the \$851 million that was dedicated to education in the state operating budget (HB 1) which was to be funded with revenue from the installation of VLT's at the state's 7 horseracing tracks. The Supreme Court of Ohio has ruled that the VLT portion of HB 1 is subject to referendum and as a result the funds are not able to be dedicated. So, in anticipation of the need for the revenue, legislation needs to be introduced to correct or change the language in HB 1. Expectations are that the proposed changes will be introduced in the Ohio House of Representatives. If revenue is not found to make up for the hole in the budget this could have major negative implications on many programs such as Medicaid and agencies like the Ohio Department of Jobs and Family Services (ODJFS). These two areas have some of the largest budgets in state government and are always looked at first to make cuts.

Other Statewide Activity

On September 24th and 25th meetings were held in Columbus for the Ohio Healthcare Coverage and Quality Council (OHCQC) and a public forum for the Ohio Health Information Partnership (OHIP) which was created to oversee and coordinate the electronic medical records (EMR) initiative and create a health information exchange (HIE) in Ohio. At the OHCQC meeting an update was given on the State of Ohio's federal application for State Health Access

Program which was denied. It was denied because Ohio did not have the infrastructure or programs in place to meet the qualifications for the program.

Other reports were given from the Payment Reform Task Force noting that this group has been meeting with providers and payers and they are addressing the following general issues: what is the current system, what are the alternatives as well as a need to look at vision, mental health, oral health, and lifestyle. Representatives from the Ohio Department of Insurance (ODI) provided an overview of coverage items that will go into effect such as open enrollment and it was noted that the State of Ohio will expand coverage to 52,000 more Ohioans in January 2010 and how changes in HB 1 will produce 50%-70% savings. Among other items discussed were the expansion of insurance coverage to unmarried dependents up to the age of 28, section 125 (cafeteria) health plans, mini-COBRA expansion from 6-12 months, state income tax benefits empowering employers to be notified of savings for employer-sponsored coverage, tax deductions for employer-sponsored coverage, medical loss ratio reporting, rate filing requirements and that group rates are being filed with ODI. The next meeting of the OHCQC will be in Columbus on December 3rd.

On September 25th, the Ohio Health Information Partnership (OHIP) held its very first public forum that was well attended by various interested parties that included groups of doctors, IT companies, hospital representatives, and the medical insurance industry. OHIP is a nonprofit started in recent months as a subsidiary of BioOhio, which acts as the statewide association for bioscience firms. An overview of Ohio's health information technology (HIT) Roadmap was presented to the group noting that the goals of the partnership are to bring together government and private sector interests to build a statewide health information exchange, and to encourage providers to adopt new technology that will connect to the exchange. There are plans for OHIP to eventually become an independent entity, but it was begun as a BioOhio offshoot so that it could immediately inherit the perks of nonprofit status, such as the tax exemption.

It was also noted that the State of Ohio is coming up on two notable opportunities for federal stimulus money. First, an application

AMCNO LEGISLATIVE UPDATE

is due in mid-October in the drive to form a statewide health information exchange and a letter of intent has already been sent to the federal government. Second, the state expects to hear back soon on its preliminary application for the state to form a "statewide extension center" — an outfit equipped to provide technical assistance to health care providers who are looking to incorporate technology into their practices and also help physicians seek funding if necessary.

Many believe that there is an obstacle to achieving meaningful use because about half of all health care in Ohio is provided by small, independent operations in rural areas — operations that would have the hardest time getting the technical and financial means to install more technology and use it. Therefore, employing OHIP or other entities to establish group purchasing or other collaborative arrangements will be important to overcoming these obstacles. More workforce development will need to be done, both to ensure an adequate supply of people who can install and service the new technology, and to provide training for its use by doctors. OHIP will also be setting standards so that providers will know what to look for in new technology systems, and to ensure that issues like security and privacy are addressed. (see related story on page 13).

Other Legislative Activity

In addition to HB 122 noted above, the AMCNO is also tracking all of the healthcare related bills under review in the Ohio legislature. For detailed information on the AMCNO position on other healthcare related bills currently being debated in the Ohio House or Senate please contact the AMCNO offices at (216) 520-1000, ext. 100. ■

It's Time For Your Portfolio Check-Up

In light of the recent market volatility, it may be a good time to let a professional review your current portfolio(s) and offer a second opinion. A professional opinion will offer you ideas on how to reallocate some of your portfolio and allow you to consider the addition of alternative investments to help remove some of the portfolio volatility. Second opinions are always helpful.

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Top 10 Computer Security List

By Gary R. Pritts, MBA, Healthcare Consultant, Eagle Consulting Partners

Physician practices have become more reliant on computer technology, the internet has connected most computers, and small mobile devices are everywhere. The net result is that practices are more exposed to computer security problems than ever before. Consider the following:

- Security breaches are in the news routinely, such as the Veterans Affairs (VA) computer system breach exposing the records of over 20 million veterans. Closer to home we have had large breaches at Cleveland State, Ohio University and the State of Ohio,
- Practices, especially smaller ones, fail to back up their computer data and suffer huge losses when these systems fail,
- The federal incentives for electronic records, which total up to \$44,000 for most physicians, will likely require HIPAA security compliance as part of the “meaningful use” mandate.

In early 2002, physician practices made changes to comply with the HIPAA Privacy regulations. The next year they invested in computer software upgrades for the HIPAA Electronic Transaction changes. After this, many developed “HIPAA fatigue” — and simply ignored the 3rd HIPAA wave — the HIPAA Security regulations.

HIPAA Security regulations are based on widely accepted standards for computer security. They include 42 standards — 20 that are required, and another 22 that apply based on the size and complexity of the practice. Some of these requirements are more important than others. Here is Eagle Consulting’s Top 10:

- 1) **Offsite Backup.** If you do nothing else, invest in a review of your backup procedures. Think through the systems you use — billing, electronic records, correspondence, financial records, email, spreadsheets. Make sure that everything that is important is backed up, and use the encryption feature that most backup software offers. Keep a recent backup copy off the premises. Have a staff person verify that the backup runs on a daily basis. On a quarterly basis, check that you can restore files from your backup.
- 2) **Physical Security.** If your office layout allows, store your computer server and/or your paper records in a locked room. There is a saying, if you can touch

it, you can own it. Limit physical access to your server and records. Consider an alarm system for fire and intrusion detection.

- 3) **Wireless Security.** Don’t broadcast all of your patient data throughout the neighborhood. If you employ a wireless network, configure it for security. Get technical help if necessary to enable these security features on your wireless router or access point:
 - Disable Beacon
 - Change SSID
 - Enable WEP
 - Use MAC filtering
- 4) **Computer Inventory.** The largest single cause of data breaches last year was the loss or theft of a laptop computer. Keep track of your computer equipment, especially the portable ones. Maintain an inventory, including description and location for
 - Servers
 - Desktop computers
 - Laptops, smartphones (Blackberries, iPhones, etc) and other portable computers
 - External Disk Drives and flash drives
- 5) **Media Disposal.** Don’t give away old computers or throw away media without taking precautions:
 - For hard disks or floppy disks, reformat
 - For CDs, DVDs and Tapes, use a service for certified destruction
- 6) **Use Software Audit Control features.** Any medical software built for compliance with HIPAA security standards includes audit control capabilities. Windows and other operating systems also includes this capability. Enable these features which will keep a record of who does what when. Review the audit logs that are created and take action when unauthorized or inappropriate access is made to patient data. Make sure staff knows that you are watching who accesses what information.

- 7) **Access Control.** Control who can access what and keep track. Set up your software so that people have access to the data they need and not more. Maintain an inventory of users. Set each user up with their own User ID (don’t share a single user ID!). Each person should also have their own password. When a person leaves, disable their access.

- 8) **Encrypt.** Use encryption for data transmitted on networks and for data stored on mobile devices and backup tapes. Most practices do not encrypt email — which is OK as long as you don’t use it to transmit patient data. For your laptops and smartphones that store patient data, hire a vendor to select and implement an appropriate encryption solution.

- 9) **Keep Operating System, especially Windows, updated.** For any operating system software, but especially the security-flawed Microsoft Windows, make sure that it is updated on a regular basis. Unless your computer support organization recommends against it, use the Windows automatic update features.

- 10) **Use Firewall/anti-virus/anti-spyware software.** Use a reputable vendor of security software and enable firewall software and set this for automatic update.

These top recommendations will give you a good start on your computer security. For additional guidance on computer security, consult <http://www.hhs.gov/ocr/privacy/hipaa/administrative/securityrule/securityruleguidance.html> which includes introductory tutorials, complete details on the HIPAA Security regulations, advice for small practices, and other technical materials. All practices should review this site because the federal stimulus bill included over 20 pages of changes to the HIPAA regulations, some of which have already gone into effect! Because of the technical nature of this subject, many practices will benefit from expert advice and should consider a consultant or other technical advisor.

The benefits of an investment in computer security include the privacy of your patient data, the availability of information when you need it for patient care, and in some cases, the survival of the practice itself. ■

Impact of Funding for Regional Extension Centers

By Bob Elson, MD, MS

Healthcare Program Manager, Regional Stimulus Office, OneCommunity President, Clinical Systems Design, LLC

This presentation was provided to the AMCNO Board of Directors at their September 2009 meeting.

In February of this year, Congress passed and the President signed into law a large (\$787B) economic stimulus package (ARRA). An important portion of ARRA — known as HITECH — was targeted to healthcare information technology (HIT). Recent estimates by CMS put the total HITECH-related outlay at \$47B. The vast majority — \$45B — will be paid as Medicare or Medicaid bonuses to hospitals and physicians who achieve meaningful use of electronic health records (EHRs) between 2011 and 2015. Individual physicians can receive as much as \$44K per physician from Medicare or over \$60K from Medicaid. HITECH provided an additional \$2B to the Office of the National Coordinator for HIT (ONC) for discretionary programs, including healthcare information exchange (HIE), HIT “extension centers,” and HIT-related workforce development. This article is about the extension center program and its anticipated impact on Northeast Ohio.

The extension centers — actually, *regional* extension centers, or RECs — are being created to help physicians select and deploy EHR technology and use it meaningfully. Just as agricultural extension centers brought the latest in agricultural technology to small/independent farmers, these HIT extension centers will help physicians in small, independent practices get up to speed and achieve meaningful use with HIT. Specifically targeted for help by the RECs are primary care providers who practice in groups of 10 or fewer. Groups can be larger if they are a community clinic (e.g., a federally qualified health center) or otherwise service the underserved. ONC will use \$500M of the \$598M REC funds to pay the RECs to help 100,000 of these so-called “priority” providers achieve meaningful use within 2 years. This is an ambitious goal to be sure, but ONC will only pay the RECs for providers who actually achieve meaningful use. Of relevance to these priority providers is that the REC in their neighborhood will be able to bring \$5K per provider of federally subsidized services to bear in order to help them on their meaningful use quest. That said, each REC must become self-sustaining within 2 years, and they will likely need to ask providers to cover some part of their costs.

What “meaningful use” is, exactly, is still being worked out by ONC. While the final meaningful use definition may not be available until well into next year, an advanced draft is available now (see <http://image.exct.net/lib/ff051671746501/d/1/Meaningful%20Use%20Matrix%20from%20ONC%208-14-09.pdf>). Generally speaking, the meaningful use requirements fall into one of several broad categories: clinical decision support, quality reporting, and interoperability, along with a hefty dose of privacy and security management.

The requirements for 2011 will be challenging enough, and they will get progressively tougher in 2013 and 2015. Indeed, ONC was very smart to recognize that providers in small practices typically would not have the resources to achieve meaningful use on their own. The REC program — based on actual experience in small practices throughout New York City (see <http://www.nyc.gov/pcip>) — is a clever and (hopefully) cost-effective approach to helping small practices nationally get over the HIT hump.

Importantly, ONC has also had the wisdom to not over-specify what type of HIT should be used in order to achieve meaningful use. This means that a practice can use a full-featured electronic medical record (EMR) to reach meaningful use or, instead, can use a patchwork of niche or standalone products, such as ePrescribing, registry, document imaging, and some sort of a Web portal, perhaps provided by a local hospital or a regional health information exchange. While the latter “modular” approach to meaningful use allows for considerable flexibility, it does create integration and workflow issues that must be addressed. Whatever the approach chosen, HIT components used to achieve meaningful use *must be certified*. While policy emerging from ONC will apparently allow for new certifying entities, the Certification Commission for HIT (<http://www.cchit.org/>) is still the only show in town and they have just launched a modular certification path specifically designed to support a modular approach to meaningful use.

ONC has stated that they would like to fund 70 RECs across the country. Some of these are likely to be sub-state, regional RECs, some statewide, and some multi-state. The RECs will be funded in three application waves, the first of which we are in the middle of right now.

Each application cycle is divided into two stages — a short preliminary application and a longer final application. The preliminary applications for the first funding cycle were due on September 8th and notification / invitation to submit a final application in this cycle occurred on September 29th. The 1st cycle final applications are due on November 3rd with funding decisions expected by mid-December, and REC operations to begin in January.

So, what’s happening on the REC front in Ohio? At least three separate preliminary applications from Ohio were submitted back on September 8th — one led by HealthBridge out of Cincinnati, extending well into Indiana and Kentucky and as far north as Springfield; one led by OneCommunity including 58 northern Ohio counties, and; one led by the State itself including the entire state. The OneCommunity proposal — supported by AMCNO — sought to leverage OneCommunity’s existing (and anticipated future) broadband relationships with dozens of rural hospitals in the region, the same hospitals which represent the best way to reach out to, connect with, and support the priority providers targeted by the REC program. Key participants in the Northern Ohio proposal included Better Health Greater Cleveland, Ohio KePRO, and NEO RHIO, and support for the preliminary application came not only from AMCNO, but also from Summa, Mercy (Akron), UHHS, Health Action Council, Medical Mutual, Center for Health Affairs, Akron Regional Hospital Association, Case, Tri-C, Robert Wood Johnson Foundation, Cleveland Dept of Public Health, and others. The State proposal was submitted by a newly formed nonprofit called OHIP (the Ohio Health Information Partnership, see <http://ohipab.pbworks.com/>). OHIP is a subsidiary of BioOhio — <http://www.omeris.org/> — with an independent board that includes three statewide medical and hospital organizations.

Only HealthBridge and OHIP (State) were invited to submit a full application on 11/3. OneCommunity was not, and (as of this writing) is still awaiting specific feedback from ONC regarding its proposal. This is exciting news for Ohio, as there was significant concern that ONC would fund nothing in Ohio this cycle because of conflicting proposals. Presumably, the State and HealthBridge will need to work out the boundaries of their original proposals, as ONC will not fund RECs with overlapping coverage. OneCommunity and many of the supporters of its original proposal — including AMCNO — have been working to support the State’s full application in any way possible, but the process for regional

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Impact of Funding for Regional Extension Centers

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engagement under a State-led REC has yet to be clarified. Specifically, the process for identifying, selecting, and paying

subcontractors who will perform the actual hands-on meaningful use technical assistance work in priority physicians' practices has not been publicly announced.

It's a pretty good bet that both the HealthBridge- and OHIP/State-proposed RECs will be funded.

With any luck, OneCommunity, AMCNO, BHGC and other stakeholders who supported the Northern Ohio proposal will figure out a way to collaborate with the State to ensure that priority providers throughout Ohio receive the best possible REC assistance. At the end of the day, that's all that really matters. ■

"Meaningful Use" for EHR Stimulus Payments – an Update

By Amy S. Leopard, Esq, Walter & Haverfield LLP

As most physicians are aware, the American Recovery and Reinvestment Act of 2009 ("ARRA") provides significant incentives to encourage electronic health record (EHR) adoption in the form of Medicare and Medicaid incentive payments. Beginning in 2011, eligible physicians can receive additional Medicare payments of up to \$44,000 over a five-year period or allowable costs up to \$63,750 over a six-year period under Medicaid. To be eligible, physicians must demonstrate to the satisfaction of the U.S. Department of Health and Human Services (HHS) their "meaningful use" of certified EHR technologies.

We expect the Centers for Medicare and Medicaid Services (CMS) to propose a formal definition of "meaningful use" by year end through the rulemaking process and to adopt a final rule in early 2010. In the meantime, physicians are anxious to make timely decisions for selecting and upgrading their current EHR systems and maximizing their likelihood of eligibility. Here's what we know so far.

Definitions Under Way

CMS will determine eligibility under two steps: first, the EHR technology used must be certified. Second, physicians must demonstrate their use and exchange of health information by:

- using a certified EHR technology in a meaningful manner, including appropriate e-prescribing;
- connecting the certified EHR technology for the electronic exchange of health information to improve quality of health care (e.g., promoting care coordination); and
- meeting clinical quality measures established by HHS.

We have informal guidance already for both steps. The HHS Office of National Coordinator (ONC) received recommendations this summer from two federal advisory committees that solicited public input on certification standards and a roadmap for how providers might be eligible for incentive payments. EHR vendors have had a few months to study the criteria and standards recommended by the ARRA HIT Standards Committee in order for a technology to be considered "certified." Many expect that CMS will make only minor changes in these standards when it proposes rules.

For "meaningful use," the ARRA HIT Policy Committee recommended an evolving definition, with the bar raised each year to 'ramp up' providers over time. See HIT Policy Matrix at www.healthit.hhs.gov/meaningfuluse. The HIT Policy Matrix focuses on how EHR technology should be used to meet broad health policy goals under ARRA and identifies specific care goals for providers that advance the following priorities through measurable clinical conditions and use of EHR technology.

- improving quality, safety, and efficiency and reducing health disparities
- engaging patients and families;
- improving care coordination;
- improving population and public health; and
- ensuring adequate privacy and security protection for personal health information.

The provider goals escalate over time, beginning in 2011, and increase in scope and complexity in 2013 and 2015, with the intention of improving the quality of care, and the health care delivery system as a whole, as demonstrated by the achievement of measurable outcomes. The progression begins in 2011 with the initial goal of electronically capturing in coded format and reporting health information and using that information to track key clinical conditions. In 2013, the meaningful use objectives expand toward guidance and support of care processes and care coordination. Finally, in 2015, the objectives focus on achieving and improving performance and supporting care processes and on measuring key health system outcomes.

In the Meantime

Ideally, physicians want to make sure that over the term of the software license, all versions of the software are certified as necessary to allow eligibility for Medicare incentives beginning January 1, 2011 and continue until all payments have been received. This is difficult without a final definition available, but frankly, vendors who are in the market for the long-term must license software meeting these evolving standards in order to stay in the health care market.

Several EHR vendors have come out with "guarantees" that their software products will meet requirements for meaningful use. Read these statements carefully. Most guarantees are limited to whether the software will be considered a "certified EHR technology," (and not whether the physician will be considered a "meaningful user"), or are really a credit on the vendor's fees if the physician is not eligible (not a guarantee of stimulus funds). Limitations include dollar amounts and placing responsibility squarely on the physician for HIPAA privacy and security compliance and as well as meeting any quality goals that are based on outcomes.

Nonetheless, the guarantee programs are a signal from vendors that they intend to stay in the market and evolve as necessary to support practices over the period of eligibility — an important commitment to obtain given the problems inherent with switching vendors midstream to maintain your incentive payments. Physician practices should be in a dialogue with their vendors to understand the level of commitment to the road ahead, the flexibility of the software product to potential changes, and the available support to assist physician practices through the journey. Stay tuned for further updates on this topic.

Amy S. Leopard heads the health care practice group at the law firm of Walter & Haverfield LLP and may be reached at aleopard@walterhav.com. This article present general information regarding legal developments and does not constitute legal advice for a particular set of facts. ■

A Year-end Tax Plan

By Philip Moshier, CFP, CRPC, Financial Advisor with Sagemark Consulting, affiliated with Lincoln Financial Advisors

With just a couple months left, it's time for you and your financial planner to implement some tax strategies. These six tips can take the bite out of tax time.

The first changing of the leaves heralds the transition to fall, the start of school, football season, and sweater weather.

And while not nearly as exciting, it's also time to think ahead to tax time, while you can still take specific steps before the year's end to help minimize your tax bill — and improve your long-term financial situation.

It's important to understand your tax obligations, as well as what opportunities you might have to reduce your tax bill before the year ends.

So, consider the following six steps, and consult your financial planner to help determine which moves might suit your individual circumstances.

Maximize retirement-account contributions. Putting money aside for retirement is obviously a wise move — and it can have significant tax advantages. Pretax contributions to a 401(k) plan effectively decrease your taxable income. For 2009, you can deduct traditional 401(k) contributions of up to \$16,500, with an additional \$5,500 deductible "catch-up" contribution if you are 50 years old or older. Your contributions to a traditional individual retirement account (IRA) may also be tax-deductible, depending on your income and whether you or your spouse has a workplace retirement plan.

Contributions to a Roth IRA are not tax-deductible, but the earnings in such accounts grow tax-free, which can be a powerful argument for establishing one. Regardless of which type of IRA you hold, you can contribute up to a maximum of \$5,000, with an additional \$1,000 catch-up contribution if you are 50 or older.

Harvest capital losses. Investment losses are no fun. Unfortunately, you may be sitting on many of them this year. The upside is that realized losses can bring benefits at tax time. Within your taxable accounts, consider selling investments that

have experienced relatively large losses and aren't essential to your portfolio strategy. You can use the capital loss to offset any taxable capital gains; beyond that, you can offset up to \$3,000 in ordinary income. Additionally, you can carry forward any losses to future years. If you follow the investing mantra of selling losers while letting winners ride, you may find yourself looking forward to many years of offsetting capital gains.

Donate appreciated securities to charity. If you're charitably inclined, you can take advantage of gains on a stock you've owned for more than a year by donating it to a qualified charity. You can then deduct the security's full market value — and you'll be exempt from paying capital gains tax on the appreciation.

Prepare for the alternative minimum tax (AMT). The AMT was created in 1969 to ensure that wealthy taxpayers don't escape taxation altogether by using lots of deductions, but the income cutoff was never adjusted for inflation. As a result, more middle-income Americans are subject to this tax each year. If you have gross income of \$100,000 or more, a large family, or a significant capital gain, you may be hit by the AMT. Tax planning to minimize your AMT liability means using a totally different set of tools from those you would employ to mitigate conventional tax consequences. Consult your tax advisor if you think you may be at risk.

Take advantage of Section 179 deductions for business equipment. If you own a small business, it may be worthwhile to invest in new equipment before year's end. Depending on the way you categorize equipment purchases for tax purposes, you may be eligible for the Section 179 deduction for equipment you buy — and install — in 2009. If you qualify, you can deduct up to \$250,000 worth of equipment purchases right away, rather than claiming depreciation deductions for them slowly over several years — as long as

your business purchases less than \$800,000 worth of equipment in all of 2009.

Make energy-efficient home improvements. The federal economic stimulus package expanded the tax credits available for many energy-saving upgrades. You can receive a tax credit worth 30% of the cost — up to \$1,500 — for installing certain windows, doors, insulation, roofing, water heaters, and HVAC systems. These credits are available through 2010, so if you're inclined to procrastinate on any item on this list, this is the one to choose.

Your financial planner will have further advice about steps to take now to reduce your 2009 tax bill.

Talk to your financial planner about:

- Reviewing your income statements to pay out year-end bonuses to maximize business deductions and allow for transfer of monies at current low income tax rates
- Reviewing malpractice insurance needs and costs.
- Adding a deferred compensation program to your benefit plans. This will allow for larger deferrals of income, especially in upcoming higher tax years.
- Having year-end income tax projection prepared to make certain they will not be subject to underpayment penalties and discover planning opportunities to lower individual taxes.
- The use of 529 plans. Physicians may consider 529 plans for themselves and their spouses. Assets held in 529 plans are secure from creditors (and law suits) and grow tax-deferred. If monies are disbursed and not used for educational purposes there is a penalty on the interest earned.
- Investing in an annuity to provide income security similar to a pension plan. Monies grow tax-deferred.
- Planning ahead for your 2010 taxes ■

The Academy of Medicine Education Foundation (AMEF) Co-Sponsors Local Symposium

The Consortium for Healthy and Immunized Communities (CHIC) and Boonshoft School of Medicine hosted a one day CME credited immunization symposium on September 25th at Windows on the River in Cleveland. This conference was made possible through grants from Every Child by Two, **The Academy of Medicine Education Foundation (AMEF)** Wyeth Pharmaceuticals, Merck and CHIC membership.

The symposium titled "Reflections of Change" drew participants from around the state. Nationally renowned speakers, included: Dr. Lance Rodewald, the Director of the Immunization Services Division of the CDC who spoke on new immunization resources and community partnerships, Dr. Sylvania Ng from Infectious Disease Associates in Cincinnati discussed the impact of shingles, Dr. Ari Brown, pediatrician and author of *Baby 411* from Capital Pediatric Group of Austin, Texas advised the audience on successful ways to address parental concerns on immunizations, Dr. Jane Seward, Deputy Director for the National Center for Immunization and Respiratory Diseases at the CDC, presented on notable recent vaccine preventable disease outbreaks. Frankie Milley, Founder and Executive National Director of Meningitis Angels, gave a personal account on the loss of her son to meningitis and her work on legislation to mandate the meningitis vaccine. In addition to these excellent speakers, 26 practices throughout the state were recognized by the Ohio Department of Health for their efforts in 2008 for maintaining and improving their immunization rates through the use of AFIX (Assessment, Feedback, Incentives, eXchange). For additional information on CHIC and /or to join, please visit www.chicohio.com. ■



AMEF

Academy of Medicine Education Foundation

Include AMEF in Your Charitable Giving Plans

AMEF uses funds to provide medical scholarships to assure that our medical schools continue training physicians to meet the need of patients in the future. In addition, your donation may assist with other worthwhile foundation activities that support public health and education initiatives. Look for AMEF's annual newsletter, *Foundation Facts*, in your mail soon and remember your profession in your giving plans

Academy of Medicine Education Foundation 2010 Scholarships

Scholarship applications can be obtained from the registrar or financial aid offices of eligible schools. **The filing deadline is January 31, 2010** for medical students meeting AMEF scholarship eligibility criteria:

1. AMEF awards scholarships each year to Third and Fourth year medical students (MD/DO) who are or were residents of Cuyahoga, Summit, Lake, Geauga, Ashtabula, Lorain or Portage counties, and who demonstrate an interest in organized medicine, leadership skills, community involvement and academic achievement.
2. AMEF scholarships will be awarded to Third and Fourth year medical students attending the following institutions: Case Western Reserve University School of Medicine, Cleveland Clinic Lerner College of Medicine, Northeastern Ohio Universities College of Medicine and Ohio University College of Medicine. ■



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Pelvic Floor Disorders

By John Eric Jelovsek, M.D., Assistant Professor of Surgery, Cleveland Clinic Lerner College of Medicine at Case Western Reserve University

Pelvic floor disorders include urinary incontinence, pelvic organ prolapse, fecal incontinence, and other sensory and emptying abnormalities of the lower urinary and gastrointestinal tracts.¹ Recent U.S. population-based estimates demonstrated that the prevalence of women having at least 1 pelvic floor disorder was 23.7%, with 15.7% of women experiencing urinary incontinence, 9.0% of women experiencing fecal incontinence, and 2.9% of women experiencing pelvic organ prolapse.¹ The prevalence rises to 51% in women in ambulatory clinical populations and the annual incidence of surgery for POP ranges from 1.5 to 4.9 cases/1000 women years. Increasing age and parity appear to be the strongest risk factors with each subsequent birth imposing an incremental risk (12.8%, 18.4%, 24.6%, and 32.4% for 0, 1, 2, and 3 or more deliveries) while overweight and obese women were more likely to report at least 1 pelvic floor disorder compared to normal weight women.¹

Pelvic organ prolapse (POP), a type of pelvic floor disorder, is defined as the downward descent of the pelvic organs, which results in a protrusion of the vagina and/or the uterine cervix, and does not include rectal prolapse. The International Continence Society (ICS) developed a standardized definition for POP in 1996. This quantification method, referred to as the Pelvic Organ Prolapse Quantification (POPQ) exam, determines prolapse by measuring the descent of specific segments of the reproductive tract relative to the vaginal hymen duringValsalva.

Pathophysiology and Natural History

Pelvic organ prolapse appears to be multifactorial. It is likely caused by direct acute or chronic injury to the pelvic floor by any combination of previously mentioned risk factors combined with an individual's genetic predisposition to develop and/or repair damaged pelvic floor structures when trauma occurs. Trauma from vaginal delivery can result in direct injury or compression injury to pelvic connective tissue, nerves, vasculature, or muscles of the pelvic floor. Supportive ligaments may be stretched, torn, or broken, resulting in displacement of the pelvic viscera during straining or secondary to gravity. Up to 80% of women will have EMG evidence of deinnervation-reinnervation injury of the pelvic floor muscles after vaginal delivery. Finally, changes in the levator muscles may result in a widened genital hiatus. This allows for displacement of the pelvic viscera through the vaginal opening.

Signs and Symptoms

Most women are not aware of prolapse that is above the hymen. As the prolapse worsens, they feel as if something is falling out, a feeling of a bulge or protrusion from the vagina, the need to splint or press on the

vagina to empty their bladder or bowels, or that they can no longer wear tampons. Urinary urgency, frequency, difficulty emptying bowels, straining at defecation, or fecal incontinence is also common. Urinary incontinence may occur at early stages of POP. However, most women with severe prolapse are continent because prolapse of the anterior vaginal wall kinks and may obstruct the urethra. In fact, this obstruction may mask urethral incompetence and urinary incontinence may result once the prolapse is replaced in its normal position after placing a pessary or surgery.

Diagnosis

The diagnosis and severity of POP are determined by physical exam. The patient is typically examined in the lithotomy position. A standing position may be used if the initial position does not reproduce the patient's symptoms or complaints. A vaginal retractor, such as the posterior portion of a disassembled, Graves speculum, aids visualization. This allows for the examiner to retract one portion of the vagina into its normal anatomic position while asking the patient to strain to allow for the non-retracted segment(s) to protrude. Rectal exam may facilitate identifying a rectocele. Staging of prolapse is described by the International Continence Society using the POPQ system as the distance of the prolapsed segment relative to a fixed anatomic landmark, the hymen. Terms such as cystocele, enterocele, and rectocele have been replaced by anterior, apical, or posterior vaginal wall prolapse due to the uncertainty as to the visceral structures on the other side of the bulge.

Management

The most important component to consider when treating a patient with pelvic organ prolapse is to determine if their symptoms result in some physical and/or social limitation

that results in a worsening quality of life. Asymptomatic patients with Stage I or II POP (≤ 1 cm beyond the vaginal hymen) should be counseled regarding observation. Symptomatic patients with advanced POP may consider observation as long as consideration is given to adequate bladder emptying which may predispose her to urinary tract infection with resultant sepsis and risks of severe vaginal mucosal erosions with resultant infection.

Non-surgical therapies are indicated when observation is no longer a consideration, the patient does not want surgery, or surgery would involve above average risks. It is also indicated in women in whom the degree of symptom distress does not coincide with physical exam findings of prolapse. Pelvic floor muscle exercises have been shown to mildly improve urinary and fecal incontinence episodes and may improve symptoms of prolapse.

Pessaries are offered to patients who want to reduce their symptoms and do not want surgery, or are not candidates for surgical management due to other medical conditions. Most patients, including sexually active women, can be instructed on self-inserting, removing, and cleaning a pessary; although patients who are unable to manage a pessary themselves are seen several times a year for an exam, removal, and cleaning of the pessary. Pessaries can be successfully fitted in up to 75% of women with prolapse. The majority of patients (92%) who are successfully fitted report being satisfied at two months follow up. The majority of patients who choose to use a pessary can be fitted with either a ring with support or a Gelhorn pessary. A number four ring with support pessary is a good starting size and type of pessary for women with a normal genital hiatus and/or good perineal support. Women with a wide genital hiatus or poor perineal support may require a Gelhorn pessary; although these pessaries are more difficult to insert and remove for the patient.

Surgery for POP can be divided into two groups, restorative or obliterative. Restorative approaches should be performed in women who wish to maintain sexual function after surgery. Restorative approaches are then divided into route of access. There are two major routes of access, vaginal and abdominal.

(Continued on page 18)

Pelvic Floor Disorders

(Continued from page 17)

Abdominal procedures may also be conducted using open, laparoscopic, or robotic approaches. Most surgery for POP in the United States is performed through the vaginal route. The vaginal route has the advantages of less overall reoperation rate, less complications, shorter hospital stay, quicker return to daily activities and lower cost when compared to the abdominal approach. Overall anatomic outcome appears to be similar between abdominal and vaginal approaches. Although, there is data to suggest that the recurrence rate of the anterior and apex of the vagina may lower in women undergoing surgery via the abdominal route, this increased efficacy of an abdominal route appears to be at the expense of a higher complication rate.² Furthermore, although the laparoscopic and robotic routes result in shorter hospital stay, shorter recovery times, less pain, and comparable efficacy to the open route, no evidence exists that this route is more efficacious and safer than the vaginal route.²

The most important part of surgery for POP appears to be resuspending the apex of the vagina. The best available evidence supports the use of the following procedures to surgically correct the vaginal apex: the high uterosacral ligament suspension, iliococcygeus fascial fixation, Mayo culdeplasty, and sacrospinous ligament suspension. Several series demonstrate that objective cure of prolapse is estimated to be between 70-90%. Each procedure has its own limitations and since there are no good comparative trials, the procedure type should be individualized to the patient and the skills of the surgeon. The uterosacral ligament suspension allows for more normal anatomic placement of the vaginal apex and allows for increased vaginal length. However, it requires intraperitoneal entry, which may be difficult when performing without concomitant hysterectomy, and there is a significant risk of ureteral obstruction between 2 and 11%. Use of intraoperative cystoscopy has been shown to reduce the risk of injury during this procedure to less than 1%. The sacral colpopexy is currently the procedure of choice when an open, laparoscopic, or robotic abdominal approach is preferred. Cure rates range from 78 to 100% using this approach. Sacral colpopexy involves placing two strips of permanent mesh on the anterior and posterior vaginal wall and suturing the opposite ends to the anterior longitudinal ligament of the sacrum. This procedure

appears to have comparable success when performed by the laparoscopic approach. However, the laparoscopic approach requires a relatively high level of technical skill with advanced laparoscopic procedures; therefore, many surgeons will elect to use a robotic-assisted approach to decrease the learning curve required for suturing when using the laparoscopic approach.

Procedures for the anterior vaginal wall include: anterior colporrhaphy and paravaginal repair. Currently, anterior colporrhaphy is the vaginal procedure of choice in surgically correcting anterior vaginal wall prolapse. Unfortunately, this is also the area with the highest objective recurrence rate. Success is reported ranging from 40 to 100%. Some surgeons have suggested placing a mesh material in this area of the vagina to lower the recurrence rate of anterior vaginal wall prolapse. Although several randomized trials have demonstrated superior objective success when augmenting anterior repairs using polypropylene mesh, most patients who receive the traditional non-mesh augmented repairs appear to be equally satisfied as the mesh groups. Furthermore, most studies demonstrate that patients who have mesh placed can expect to experience an increased risk of complications associated with the mesh including erosion, fistula, and new onset pelvic pain that require additional operations. It is also worth noting that the U.S. Federal Drug Agency released a warning on the use of mesh in the vagina in October 2008. Surgeons who choose to use vaginal mesh should be adequately trained on the use of these products and patients should be thoroughly counseled during the informed consent process and given copy of the FDA release.

Posterior colporrhaphy (vaginal rectocele repair) is currently the procedure of choice for posterior vaginal wall prolapse. Success rates range from 62-100%. Vaginal rectocele repair has been compared to transanal rectocele repair and shown to be superior in anatomic results. Currently, it is not recommended to use mesh augmentation in the posterior wall as most data fails to document any benefit and may, in fact, cause harm.³

Obliterative procedures include the LeFort colpocleisis and partial and total colpectomy. These procedures should be performed in women who no longer wish to remain sexually active. They are useful for elderly patients or those with concomitant medical problems increasing the risks for perioperative complications. Success rates range from 91-100%.

Common Mistakes in the Management of Pelvic Floor Disorders and Pelvic Organ Prolapse

Finally, it is sometimes useful to know some of the common decision making mistakes when treating pelvic organ prolapse and these are listed below:

- *Pelvic organ prolapse to the vaginal hymen must be treated.* In general, pelvic organ prolapse to the vaginal hymen is considered normal pelvic floor support in up to 40% of parous women and should only be treated in patients who also experience bothersome symptoms such as the feeling of a bulge or protrusion.
- *Pelvic organ prolapse beyond the hymen must be treated.* Although most women will elect to be treated if they present to your office with advanced prolapse, a patient who is asymptomatic or has non-bothersome pelvic organ prolapse does not need to be treated and can be closely observed. Patients should be cautioned against urinary retention and taught to perform maneuvers to reduce their prolapse if needed.
- *Treatment for advanced pelvic organ prolapse is hysterectomy.* Failure to reestablish support for the apex of the vagina is the most common reason for surgical failure, even after hysterectomy, and has resulted in historically high failure rates for surgery. Surgeons with training in the treatment of pelvic floor disorders recognize this "keystone" in the surgical treatment of pelvic organ prolapse and will usually perform some suspension procedure for the apex of the vagina along with the bladder or rectum.

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. ■

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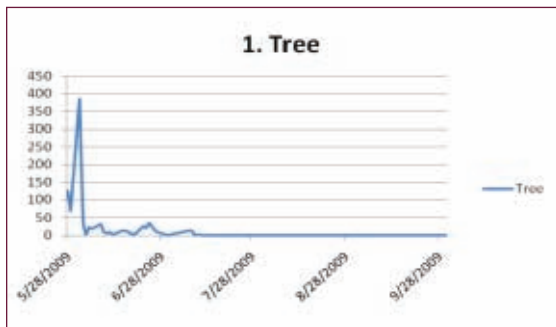
AMCNO ACTIVITIES

AMCNO Pollen Line – 2009 Recap

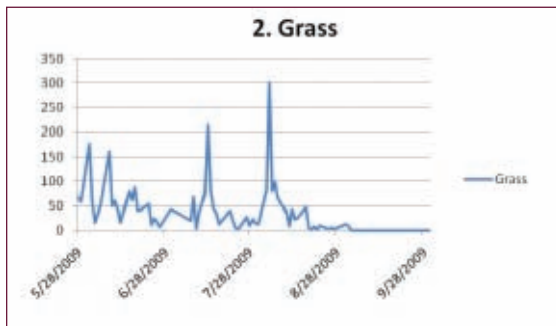
By Amy L. Marks, DO, Allergy Immunology Associates Inc.

The daily pollen measurements serve as an allergy thermometer for patients who suffer from seasonal allergies. Pollen measurements are the degrees on that thermometer which enables physicians to be exact on their recommendations to patients who suffer from disorders such as allergic rhinitis, allergic conjunctivitis as well as asthma.

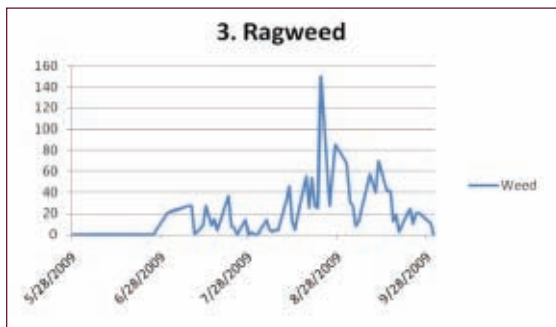
The AMCNO pollen counts, measured by a Rotorod Aeorallergen device, are available daily throughout the pollen season. Knowing the start and end of the pollen season and the daily levels allows physicians to start seasonal medications and guides patients' outdoor activities. The 2009 pollen season was indeed robust.



Tree pollen season was severe starting in mid-April lasting thru late May with a rapid decline. This is demonstrated in Graph 1. The winter precipitation and quick warm-up in early spring lead to early pollination of the trees with a rapid increase in pollen during the warm weeks Cleveland experienced in April and May.



Grass pollen season was less predictable. The counts were elevated early in May with two peaks, one in mid-June followed by a second in early August. Grass pollen sufferers had a long season. The two peaks were likely secondary to the humid air and high temperatures of greater Cleveland. The first peak represents the typical pattern seen with grass pollen in mid-July. The second peak in early August occurred with the week of extreme heat and humid air. Temperatures reached the mid to high 90s. These peaks are demonstrated in Graph 2.



Ragweed pollen season was moderate compared to the rather high pollen counts of the 2008 ragweed season. The height of ragweed pollen, as expected, was in mid to late August with a decline through September. The rather rapid decline in temperatures at the end of summer and cool start to fall kept the ragweed pollen low through the end of September. This is demonstrated in Graph 3.

Since early October, Cleveland has experienced rain, high winds, cool and damp air. This climate allows for high mold levels especially as the leaves begin to fall harboring the moisture and mold. High mold counts are expected. A prolonged frost will mark the end of the pollen season. The predicted cold winter with heavy snow will likely give rise to rather severe 2010 pollen season. The AMCNO Pollen Line will resume pollen counts in April and continue to be the allergy thermometer for the greater Cleveland area.

Editor's note: The AMCNO gratefully acknowledges Robert W. Hostoffer, D.O., Theodore H. Sher, M.D. and Haig Tcheurekdjian, M.D., of the Allergy/Immunology Associates Inc. and thanks them for their assistance with the AMCNO pollen count. ■

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AMCNO ACTIVITIES

Residents Join the AMCNO

The Academy of Medicine Cleveland & Northern Ohio (AMCNO) welcomed new residents this summer from the Cleveland Clinic Foundation, Fairview Hospital, Huron Hospital, MetroHealth Medical Center, South Pointe, St. John Westshore, St. Vincent Charity Hospital and University Hospitals. In all, more than 400 new physicians joined the



Residents at the Cleveland Clinic orientation line up to sign up for AMCNO membership.

AMCNO as resident members. Membership entitles these new physicians to many benefits including receiving weekly updates on all manner of health care related news as well as legislative and regulatory updates under review by the Ohio General Assembly

and the United States Congress, legislative representation at the state house by AMCNO lobbyists, listing in the membership directory, seminars, publications and opportunities to serve on AMCNO committees and more.

Welcome to all new resident members!

Do you know of a resident or medical student interested in free AMCNO membership? Direct them to apply online at www.amcnoma.org Click on BECOME A MEMBER. ■



Residents at the Metro resident orientation fill out the AMCNO membership application.



Winners of the AMCNO raffle prizes are all smiles at the medical student picnic.

More than 50 students, faculty, friends and family attended this year's medical school picnic of Case and the Lerner College of Medicine October 4th. The annual event, held at Squire Valleevue Farm in Hunting Valley, offers students a late summer retreat of food and outdoor fun including volleyball, soccer and tug-o-war games. The AMCNO hosts a raffle awarding prizes of gift certificates to popular local eateries. During the festivities, AMCNO membership staff enrolled new medical student members into the organization. Welcome new AMCNO medical student members!

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