



NORTHERN OHIO PHYSICIAN

FORMERLY KNOWN AS THE CLEVELAND PHYSICIAN

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THE VOICE OF PHYSICIANS IN NORTHERN OHIO

www.amcnoma.org

Introducing the Academy of Medicine of Cleveland & Northern Ohio (AMCNO)

Organizations, like people, can have family trees. The Academy's genealogy goes back more than 180 years to the founding of the Nineteenth Medical District of Ohio in 1824. A copy of our Genealogical Tree (printed on page 3) is from an original drawing found among our historical materials. It traces the succession of the medical society from the first in 1824 to the formation of the Academy of Medicine of Cleveland.

Over the past few years, other changes have been made to alter our genealogical tree. In 1999, the society added the Northern Ohio Medical Association name and became the AMC/NOMA, broadening our focus as a regional organization. The AMC/NOMA was formed in order for the organization to evolve into an independent regional one representing 4,300 physicians in this region and at the Ohio Statehouse.

As part of our recent strategic plan, and to coincide with moving to our new location, the Academy leadership agreed to consolidate our name. There was a lot of discussion about whether or not to retain the "Cleveland" in our name, and after reviewing the long history of the organization it was determined that the name would reflect our roots with the city as well as our extended focus of regional representation.



The new location of the Executive offices of The Academy of Medicine of Cleveland & Northern Ohio in the Park Center Plaza on Rockside Road.

Therefore, as of October 2006, our new name is The Academy of Medicine of Cleveland & Northern Ohio (AMCNO.)

In addition, after some research, it was determined that in order to return to our true roots, the organization should use a logo depicting the practice of medicine. The original medical society logo included the Staff of Aesculapius, long known to represent medicine. Our new logo using this image (pictured above) represents a more contemporary design and is in keeping with our goal of directing the future of medicine in Northern Ohio.

Symbolism of Staffs & Serpents

Serpents and serpent-staffs have long been associated with the healing arts. One modern emblem of medicine, for example, is the single-serpented staff of Aesculapius, the Greek god of healing. According to legend, Apollo was the father of Aesculapius, the Greek god of healing. Physicians today still take the Oath of Hippocrates, which begins with the familiar words "I swear by Apollo, the physician...." Aesculapius had human form and carried a staff with a single serpent wreathed around it, but after his death, caused by a lightning bolt thrown by Zeus, he was depicted by the staff and serpent.

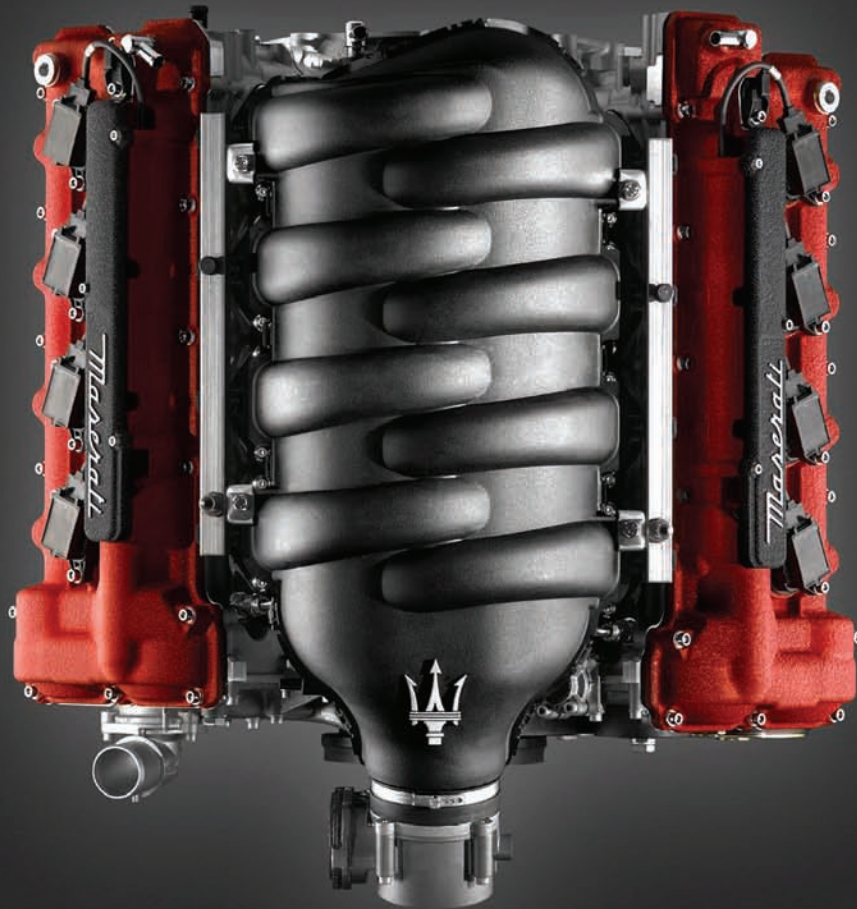
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EXCERPT FROM THE EXECUTIVE

Introducing the AMCNO

(Continued from page 1)

Thus the term, Aesculapian staff. The staff is a rough hewn cypress branch entwined by a single snake, two elements common to the Greek isles. The cypress represents strength and solidity and is perhaps in reference to the unwavering ethic of the physician. The earliest representations of Aesculapius with his serpent staff vary greatly in design. Usually they depict the healer seated, feeding a snake that is rearing before him. The snake is a symbol of many things, but probably embodied Aesculapius' religious connection to the depths of the earth and symbolized his wisdom. Aesculapius was mentioned in the writings of Homer as a mortal physician-hero who performed miraculous acts of healing. Because of his clinical acumen and his skill in combating both disease and death, the ancient writers described him as being "with a serpent," an animal then widely considered to have medicinal powers. So frequently were the staff and snake depicted with Aesculapius that the symbol came to stand for him.



The Caduceus, is also often used as a symbol of medicine, and in fact is used by the Academy of Medicine Education Foundation (see logo at left.) The caduceus

consists of a staff around which are entwined two serpents; at the head of the staff are two outstretched wings, the wings of Mercury. The origin of the Caduceus can be traced back to Greek and Roman mythology. The symbol began as the magical rod of the Greek messenger-god Hermes (or the Roman god, Mercury). Hermes was a diplomat and an ambassador and was believed to be a bringer of peace. The Romans used the Caduceus as a symbol of peace and described a myth in which Hermes (Mercury) threw his rod between two fighting snakes and stopped their battle, at which point they wrapped themselves around the rod. The symbol of the wings came about because of the image of Hermes (Mercury) as a swift messenger. Mercury was worshiped as the god of commerce and of fate, and in Rome the caduceus was viewed as the symbol of trade and commerce. In fact, the caduceus is still used as a symbol of communications and commerce today.



"Genealogy tree" of professional societies from 1824 through the formation of the Academy of Medicine of Cleveland in 1902.

The caduceus and the Aesculapian staff are similar enough in design that the caduceus has on occasion been noted to be an elaboration of the Aesculapian staff. In actuality, both symbols, as noted above, are very old and throughout history have maintained separate identities. The fact remains that the medical community has two well-established symbols – and each brings to mind medicine and the practice of the healing arts. The AMCNO and our foundation are pleased to once again have our organizations proudly utilizing both of these symbols as our logos.



The Academy of Medicine of Cleveland & Northern Ohio (AMCNO) is proud to carry on the rich legacy of organized medicine in Northern Ohio. We will continue to represent you — the practicing physician in this region and continue to fulfill our mission — which is to support physicians in being strong

advocates for all patients and to promote the practice of the highest quality of medicine.

Editor's note: Our new location is Park Center One, 6100 Old Oak Tree Blvd. Ste., 440, Independence, Ohio 44131 (pictured on page 1) There is ample meeting space in the building, and we welcome members coming to visit our new location. Our phone and fax numbers will remain the same. A new Web site domain is expected to be launched by the beginning of the year.

References:

- Journal of the American Medical Association*, Vol. 281, Feb 3, 1999.
- Journal of the International College of Surgeons*, Vol. 37, No. 4, April 1962, by Victor Laughlin B.S., M.D.
- Medicine in Cleveland and Cuyahoga County*, published by The Academy of Medicine of Cleveland, 1977. ■

NORTHERN OHIO PHYSICIAN

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Policy Defines Health IT Guidelines

The AMCNO physician leadership and board of directors have been integrally involved in the discussions surrounding the Northern Ohio Regional Health Information Organization (NEORHIO — see related article on page 8) as well as following key legislation and federal rule changes regarding HIT.

Clearly, the key drivers for the development of an electronic health infrastructure include escalating health care costs, the demand for efficiency, and not least of which the national call to action for patient safety and accountability of quality of care. Since the time when President Bush stated that every American should have an EHR within 10 years, federal and state governments, health care purchasers, payers and others have accelerated efforts to move health care into an electronic environment.

There is a need for access to health care data across the system, yet there is no infrastructure in place to support this at this time in terms of interoperability and the exchange of clinical information.

As the AMCNO reviewed these trends it became apparent that we should establish a policy on electronic medical records to assist the organization in our discussions on these issues into the future. At the September 2006 board meeting the following policy was adopted by the AMC/NOMA:

1. The AMCNO should continue to advocate for and support initiatives that minimize the financial burden to physician practices of adopting and maintaining electronic medical records;
2. That the AMCNO continue to support efforts to define and promote standards that will facilitate the interoperability of health information technology systems;
3. That the AMCNO establish as policy that public and private insurers should not require the use of electronic medical records;
4. The AMCNO will support legislation and other appropriate initiatives that provide positive incentives for physicians to acquire health information.

In addition, the board discussed the issue of how physicians can best choose an EHR vendor. The AMCNO plans to continue to provide articles, links to informational seminars and other items to our members on the topic of EHR.

It was also determined that the AMCNO should provide our members with links to Web sites that can offer background information on EHR such as the Health Information and Management Systems Society (HIMSS) and the Certification Commission for Healthcare Information Technology (CCHIT) Web site rather than trying to rate and rank vendors through AMCNO.

Recommended sources include:

CCHIT – www.cchit.org – CCHIT develops standards and certifies compliance with those standards. CCHIT's mission is to accelerate the adoption of health information technology by creating an efficient, credible and sustainable product certification program.

CCHIT's goals are to: Reduce the risk of HIT investment by physicians and other providers; ensure interoperability (compatibility) of HIT products; assure payers and purchasers providing incentives for EHR adoption that the ROI will be improved quality; protect the privacy of patients' personal health information.

CCHIT has focused its first efforts on ambulatory EHR products for the office-based physician and provider. CCHIT is beginning the process of certification for inpatient EHR products and expects to have certified products available in 2007.

CCHIT CertifiedSM Ambulatory Electronic Health Record (EHR) Products by company

- **Allscripts** (HealthMatics Electronic Health Record 2006)
- **Allscripts** (TouchWorks Electronic Health Record 10.1.1)
- **Cerner Corporation** (PowerChart 2005.02)
- **Community Computer Service** (MEDENT 16)
- **Companion Technologies** (Companion EMR v8.5)
- **eClinicalWorks** (eClinicalWorks Version 7.0 Release 2)

- **e-MDs** (e-MDs Solution Series 6.1)
- **Epic Systems** (EpicCare Ambulatory EMR Spring 2006)
- **GE Healthcare** (Centricity® EMR 2005 Version 6.0)
- **iMedica Corporation** (iMedica Patient Relationship Manager 2005, version 5.1)
- **Infor-Med Corporation** (Praxis® Electronic Medical Records, version 3.4)
- **JMJ Technologies** (EncounterPRO® EHR 5.0)
- **LSS Data Systems** (Medical and Practice Management Suite Client Server Version 5.5 [Service Release 2.1])
- **McKesson** (Horizon Ambulatory Care Version 9.4)
- **MCS-Medical Communication Systems** (mMD.Net EHR 9.0.9)
- **MedcomSoft** (Record 2006 [V 3.0])
- **Medical Informatics Engineering** (WebChart 4.23)
- **Misys Healthcare Systems** (Misys EMR 8.0)
- **NextGen Healthcare Information Systems** (NextGen EMR 5.3)
- **Nightingale Informatix Corporation** (myNightingale Physician Workstation 5.1)
- **Practice Partner** (Practice Partner 9)
- **Sage Software** (Intergy® EHR v3.00)

HIMSS EHR Selector – www.himss.org – there is a fee to use this item but the Web site also contains a wealth of other information regarding EHR and the physician practice.

KLAS – www.healthcomputing.com – KLAS helps healthcare providers make informed technology decisions by offering accurate and impartial vendor performance information. KLAS independently monitors vendor performance through the active participation of healthcare organizations. Research results are offered through: A free directory of vendor and product information; free online access to vendor ratings for participating providers and in-depth published reports, discounted for participating providers. KLAS offers basic satisfaction information free in exchange for satisfaction survey participation.

The AMCNO will continue to work with the NEORHIO on the regional project as well as continue to offer our members information and background on EHR implementation. Staff contact: Elayne R. Biddlestone, (216) 520-1000, ext. 321. ■

Board Questions Care Issues in Retail Clinics, Sets Policy in Response

Another issue meriting the attention of the AMCNO board has been the rising incidence of clinics offering medical services opening up in grocery stores and pharmacies across the state. Letters were sent out by the board to CVS, Minute Clinic, Inc., and the Ohio Department of Health expressing specific concerns we felt warranted review and evaluation. These included supervision of the clinics by a licensed physician, medical records retention, privacy issues associated with HIPAA, self-referral implications; public health concerns and medical liability among others. Of chief concern for the AMCNO is continuity of patient care.

Responses received by the AMCNO board outlined that the clinics located in our state were operating under appropriate laws, however, if physicians in the community were to become aware of any healthcare related risks or lack of appropriate referrals, these matters should be referred to the appropriate state agency. The AMCNO board determined it would be prudent to have a policy in place regarding these store-based clinics as they continue to proliferate in our area and elsewhere. Therefore the following policy was adopted in September:

1. It is the opinion of the AMCNO that any individual, company, or other entity that establishes and/or operates store-based health clinics should adhere to the following principles:
 - a. Store-based health clinics must have a well-defined and limited scope of clinical services, consistent with state scope of practice laws.
 - b. Store-based health clinics must use standardized medical protocols derived from evidence-based practice guidelines to insure patient safety and quality of care.
 - c. Store-based health clinics must establish arrangements by which their health care practitioners have direct access to and supervision by M.D.s/ D.O.s consistent with Ohio law.
 - d. Store-based health clinics must establish protocols for ensuring continuity of care with the practicing physicians within the local community; including a defined referral system to assure that patients are seen in follow-up by their primary care physician; physician practices or other facilities for appropriate treatment if the patient's conditions or symptoms are beyond the scope of services provided by the clinic.
 - e. Store-based clinics should encourage patients to establish care with a

primary care physician (PCP) to ensure continuity of care.

- f. Store-based clinics must clearly outline their policy on payment for services including types of health care coverage accepted by the clinic.
- g. Store-based health clinics must clearly inform patients in advance of the qualifications of the health care practitioners who are providing care, as well as the limitation in the types of illnesses that can be diagnosed and treated.
- h. Store-based health clinics must establish appropriate sanitation and hygienic guidelines and facilities to insure the safety of patients.
- i. Store-based health clinics should be encouraged to use electronic health records as a means of communicating patient information and facilitating continuity of care.

2. The AMCNO continue to monitor the effects of store-based clinics on the healthcare community in Northern Ohio.

The AMCNO would like our members to keep us apprised of how the presence of these clinics in our community have affected your patients and/or your practice. Please send in any comments/concerns to the Practice Management Department.

UPDATE: MinuteClinic, a subsidiary of CVS Corp., and the American Academy of Family Physicians (AAFP) agreed in October to use the Continuity of Care Record Standards (CCR) developed by AAFP as a way to secure patient-approved personal health records (PHRs) between retail clinics and family physician practices. Family physicians and MinuteClinic practitioners will use CCR standards to make certain that the PHRs provided to MinuteClinic patients are transferable, interoperable and consistent prior to an anticipated national rollout. ■

Call for 2007 AMCNO Honorees

The AMCNO invites you to nominate an individual who is a member of the AMCNO who you believe is deserving of special recognition by the Academy. Any physician who wishes to nominate an individual for one or more of these awards should send the information below to 6100 Oak Oak Tree Blvd., Suite 440, Cleveland, Ohio, 44131. You may also Fax your nominations to Elayne Biddlestone at (216) 520-0999 OR you may call her at (216) 520-1000 to provide your honoree nominations over the phone. Deadline for submission: 12/31/06

• **JOHN H. BUDD, M.D. DISTINGUISHED MEMBERSHIP** – This award is bestowed upon a member of the AMCNO who has brought special distinction and honor to the medical profession, to our community and to our physician association as a result of his or her outstanding accomplishments in biomedical research, clinical practice or professional leadership. Often, such an individual has already gained national and/or international recognition because of the importance of his or her contributions to medicine.

• **CHARLES L. HUDSON, M.D. DISTINGUISHED SERVICE** – Awarded to a physician whom the AMCNO deems worthy of special honor because of notable service to and long activity in the interest of organized medicine.

• **CLINICIAN OF THE YEAR** – Awarded to a physician whose primary contribution is in clinical medicine and whose service to his/her patients over many years has reflected the highest ideals and ethics of, and personal devotion to, the medical profession.

• Your Name: _____

• Your Nomination: _____

• Nominated for the following award: _____

Please include an explanation as to why you are nominating this individual

At a board meeting of the AMCNO earlier this year, Mr. Richard Whitehouse, new executive director of the State Medical Board of Ohio was queried by board members regarding the issue of out-of-state expert witnesses who come into Ohio and provide their testimony. Board members felt strongly that Ohio should have a mechanism to sanction these "experts" if they should act unethically. It was noted at that time that HB 215 contained a section specific to expert witnesses. The Bill set forth that a physician from another state who testified as an expert witness in Ohio in any action against a physician for injury or death, whether in contract or tort, arising out of the provision of or failure to provide health care services, is to be deemed to have a temporary license to practice medicine in Ohio for the purpose of providing such testimony and is subject to the authority of the State Medical Board of Ohio.

In a follow-up letter to Mr. Whitehouse's visit, the AMCNO board sent a letter strongly suggesting that the OSMB consider setting up a defined complaint process through the state board on expert witnesses, because these testifying physicians, resident Ohioans or not, are subject to licensure through the OSMB. The AMCNO believes some sort of sanctioning process should be in place if such testimony were offered irresponsibly or unethically. The AMCNO also pointed to recent rules promulgated by the Mississippi State Board whereby expert witnesses could be fined or sanctioned for providing inappropriate expert witness testimony.

In his response to the AMCNO, OSMB Director Whitehouse indicated that the language contained in Chapter 4731 of the Ohio Revised Code implies that the provision of expert testimony does constitute the practice of medicine and further allows the Medical Board to take action against a physician pursuant to Chapter 4731 of the ORC. The letter to the AMCNO further states that the OSMB has statutory authority to pursue action against a physician in situations involving expert testimony, however, based upon the relative lack of complaints the board has received to date within this area, the State Board does not feel that further statutory changes are a priority at this time.

We would like to sincerely thank Mr. Joe Farchionne and his associate for providing the thorough and thoughtful clarification of these issues to our members in the article to follow.

Medical Malpractice by the Medical Expert

By Joseph Farchione, Esq.; Stuart Baker, Esq.; Sutter, O'Connell & Farchione

"Gentleman of the Jury, there are three kinds of liars: the common liar; the damned liar; and the scientific expert." These words, first prophetically sounded by Judge William L. Foster in 1898, remain pertinent to today's debate regarding experts and medical malpractice¹. All malpractice actions involving physicians require a plaintiff to present the testimony of a physician familiar with the standard of care who is willing to articulate a theory as to why you were below that standard. What makes the judicial system different than the real medical world is that while you are entitled to a jury of your peers, that jury will not be made up of your colleagues with whom you review and debate cases in mortality and morbidity conferences or review, debate and critique articles for peer review publications. The usual checks and balances that accompany your day to day professional life do not exist in the courtroom. Instead, a jury of your "peers" is made up almost exclusively of non-medical citizens, perhaps some without even a high school education. In a courtroom, a medical expert is faced with no checks and balances other than your attorney's cross examination.

Has anything really changed since 1898?

We stood in the Judge's chambers packed like sardines amongst several attorneys. Halfway through the Plaintiff's direct examination of their so-called expert, we requested a sidebar based on the standard of care testimony just elicited. "It is a complete fabrication Your Honor, it is entirely inconsistent with any national standard of care, let alone, ours here in Ohio. Their expert cannot point to one text or published article to support his opinion. In fact, every published article and book, including the expert's own book, is entirely contrary to the testimony offered. He should be precluded from further testimony on this topic and his testimony should be stricken." The Judge reclined in his chair, glanced in our direction and stated: "That, counsel, is what cross examination is for." With that, our impromptu meeting was adjourned, and the opposing expert reassumed the stand to deliver the most medically unsound and fraudulent testimony ever uttered².

Even though the jury ultimately saw through the expert's deceptive testimony, he still collected his fee, which of course was a rather large sum, with impunity. And while our office entertained the idea of filing sanctions against opposing counsel, what we really wanted was to hold the "expert" physician responsible for his testimony. It is always easy to rally against trial attorneys for presenting this type of testimony, but, unless a physician is willing to say that the care was below the standard of care, then there is no case to present to the jury. The real issue is the medical expert. In the past, there were few options that packed the

type of punch we were looking to deliver. That is, until now.

On June 14, 2004 Governor Taft signed into law House Bill 215 (HB 215), as a part of his five-point plan to stabilize Ohio's volatile medical malpractice insurance market. The bill, designed to curb the escalation of insurance rates, amended one section of the Ohio Revised Code, repealed another and enacted four new sections.

HB 215 also contained what at first appeared to be an innocuous provision granting out-of-state physicians a "temporary license to practice medicine" in Ohio when appearing as a testifying expert. Under this provision, now enacted as R.C. § 2323.421³, licensure arises from that physician's role as an expert witness in a medical malpractice action. This is based on the proposition that offering expert medical testimony in a trial court constitutes the practice of medicine. The significance of this is that R.C. § 2323.421 places the temporary licensee under the authority of the State Medical Board of Ohio and the disciplinary provisions of Chapter 4731 of the Revised Code. Since an out-of-state physician providing expert testimony in Ohio is considered to be practicing medicine with a temporary license, they can now be disciplined for certain expert testimony⁴.

What types of testimony would fall under the umbrella of discipline?

The discipline contemplated is contingent upon the violation of any of thirty seven identified reasons. While the majority of these sections do not have practical application for out-of-state physicians

who are providing expert testimony, two sections arguably apply.

First, a physician who provides “false, fraudulent, deceptive or misleading statement[s] [...] in relation to the practice of medicine and surgery, osteopathic medicine and surgery, podiatric medicine and surgery, or a limited branch of medicine [...]” is subject to discipline⁵. Since expert testimony is considered the rendering of medical care, the argument can be made that “false, fraudulent, deceptive or misleading statements” associated with an expert’s opinion falls within the purview of disciplinary action.

“In the past, there were few options that packed the type of punch we were looking to deliver. That is, until now.”

Another potential offense is when a person obtains or attempts to obtain “money or anything of value by fraudulent misrepresentations in the course of practice⁶.” All experts get paid, and some rather handsomely. Under this section, it is arguable that being paid by providing fraudulent testimony could lead to discipline.

Does that mean anytime there is a defense verdict or an expert whose testimony you believe is flimsy, at best, should be investigated and sanctioned? No. Ohio law narrowly defines a false, fraudulent, deceptive or misleading statement as one:

[T]hat includes a misrepresentation of fact, is likely to mislead or deceive because of a failure to disclose material facts, is intended or is likely to create false or unjustified expectations of favorable results, or includes representations or implications that in reasonable probability will cause an ordinarily prudent person to misunderstand or be deceived⁷.

These statutes were clearly not designed to discipline physicians whose testimony amounts to nothing more than a difference of opinion. Rather, they were designed to discipline physicians for truly egregious testimony.

What types of penalties can be imposed?

The state medical board has the authority to discipline a physician in a number of ways including: (1) limiting, revoking or suspending an individual’s license to practice; or (2) reprimanding or placing the individual on probation⁸.

Why all the “could” be disciplined and “arguably” subject to discipline?

The Academy of Medicine Cleveland and Northern Ohio Medical Association were very proactive in investigating this potential avenue of redress. In response to a letter from AMCNO, the State Medical Board of Ohio reported that to date no complaint

has been filed under these provisions. Therefore, the sections cited and arguments proposed have not yet been tested. However, in that same letter to the AMCNO, the State Medical Board of Ohio recognized that medical experts are subject to discipline as they are indeed practicing medicine with a temporary license.

How can I file a complaint?

First and foremost, you should consult with your defense counsel or personal counsel. This process while a viable recourse was established to provide a check and balance on testimony that goes beyond the bounds of a difference of opinion. Abusing the process by filing non-meritorious complaints serves no one.

The State Medical Board of Ohio currently has a confidential complaint process. A complaint form may be obtained at www.med.ohio.gov.

Conclusion

“The complex motivations that lead to this nefarious practice [of providing false testimony] are probably inherent in the human condition [and] are not easily altered⁹.” While juries for the most part do make the correct decision when faced with testimony that has crossed the line, a defense verdict does not dissuade these experts, both in-state and out-of-state, from continuing this

irresponsible practice of medicine. In the past, theories and opinions that would never be espoused in the presence of medical peers for lack of foundation, scientific or otherwise, could be easily presented in a courtroom to a lay jury. With the enactment of HB 215, there is now a check and balance that can take an expert’s testimony out of the courtroom and into the halls of the State Medical Board of Ohio. Used properly and with discretion, this tool can and should be used to eliminate medical malpractice by experts.

1. See: Milunsky A: Commentary. Lies, Damned Lies, and Medical Experts: The abrogation of Responsibility by Specialty Organizations and a Call for Action, *J of Child Neurol* 2006; 18:413-419 citing Foster WL: Expert Testimony. *Harvard Law Rev* 1898:XI:169-186.
2. The expert had testified before the jury that a frozen section “must be obtained every time” during this particular surgery in order to meet the standard of care. However, the expert had authored a textbook on surgery that was published for medical colleagues not lay people that was literally a step-by-step instruction manual for this particular surgery. No where in the fourteen (14) listed steps was a frozen section mentioned as a consideration, let alone a mandatory requirement.
3. R.C. § 2323.421 provides: A person licensed in another state to practice medicine, who testifies as an expert on behalf of any party in this state in any action against a physician for injury or death, whether in contract or tort, arising out of the provision of or failure to provide health care services, shall be deemed to have a temporary license to practice medicine in this state solely for the purpose of providing such testimony and is subject to the authority of the state medical board and the provisions of Chapter 4731, of the Revised Code. The conclusion of an action against a physician shall not be construed to have any effect on the board’s authority to take action against a physician who testifies as an expert witness under this section.
4. It should be noted that while the subject of this article is out-of-state physicians who provide expert testimony, the potential sanctions for certain expert testimony should also apply to in-state expert physicians.
5. R.C. § 4731.22(B)(5)
6. R.C. § 4731.22(B)(8)
7. R.C. § 4731.22(B)(5)
8. RC § 4731.22(B)
9. Milunsky A: Commentary. Lies, Damned Lies, and Medical Experts: The abrogation of Responsibility by Specialty Organizations and a Call for Action, *J of Child Neurol* 2006; 18:413-419. ■



Brian Keaton, MD, provides a NEORHIO update to the AMCNO Board of Directors at their September meeting, posing pertinent questions regarding realistic implementation issues for physicians in our area.

NEORHIO Update

Dr. Brian Keaton, an emergency physician from Summa Care working on the NEORHIO project, presented an update on the NEORHIO to the AMCNO board of directors in September 2006. Dr. Keaton stated that the strongest case for health information exchange stems from the reality that more than two million adverse drug events and 190,000 hospitalizations per year could be prevented using HIT. In addition, the use of computerized physician order entry could reduce error rates by 55 percent, while EHR can produce a savings of \$78 billion to \$112 billion annually. He further stated that full adoption of computerized physician order entry (CPOE) in the ambulatory setting could generate an annual savings of \$44 billion.

The benefits of connectivity include avoidance of duplicate testing; effective case management, enable e-prescribing, enhanced medication reconciliation, enhanced security and public health and enhanced research. Dr. Keaton noted that a RHIO is an organization that seeks to enable the exchange and use of health information in a private and secure manner for the purpose of promoting the improvement of health quality, safety and efficiency in a defined geographic community. Further, a RHIO is a politically entity that enables HIE though a trusted neutral party focused on community good, not competition. The RHIO is meant to be an entity that provides infrastructure and enables partnerships to improve quality in their markets. Collaboration is critical to the success of the RHIO — bringing together nontraditional partners; healthcare competitors; the business community, patients and the medical community.

Dr. Keaton briefly outlined for the board the NEORHIO mission. NEORHIO is an inclusive, multi-stakeholder collaborative dedicated to improving the quality, safety

and efficiency of healthcare in Northeast Ohio through the use of information technology and the secure exchange of health information. The goals of the NEORHIO are to make all necessary healthcare information available to patients and providers where it is needed; provide a secure, confidential, patient-controlled environment for HIE; provide opportunities for patients to participate in their healthcare and reduce duplicative testing, and barriers to cost-effective health care. The NEORHIO is also intended to enable public health functions such as biosurveillance, effective disease prevention and chronic disease management, enable healthcare research using de-identified data; reduce disparities in healthcare and provide transparency to enhance quality assessment and value comparison.

Substantial work has been completed over the last five months to help define the vision, mission, governance, financing and application strategy for NEORHIO. The effort has expanded both in terms of geographic and stakeholder representation (including the AMCNO.) Funds have been raised via contributions from member organizations to enable a detailed planning process which is in its early stages. NEORHIO is working to design a business plan that will serve as a blueprint for growth and a tool to attract the funds to become operational. NEORHIO has selected eHealth Initiative, an organization whose mission is to drive improvement in quality, safety, and efficiency of healthcare through information and information technology, representing one of the nation's most experienced RHIO consultants, to provide oversight, guidance, and support throughout the business plan development process.

The first deliverable is a "CEO" business plan to include proof of concept/feasibility, a staged proposal with cost and return on investment data (options and associated risk/benefits) a governance model, a funding model and an operational model. Potential

NEORHIO projects include: results delivery, medication reconciliation, hosted EHRs, — prescribing, linking emergency rooms, care management, personal health records, community computerized physician order entry, and others. The NEORHIO initial project is data-sharing from hospitals to clinical caregivers beginning with emergency rooms.

The bottom line of the project? Healthcare will become connected and NEORHIO will enable Northeast Ohio to remain competitive. The NEORHIO effort has leaders and involved participants, however, the return on investment is a difficult sell. Dr. Keaton encouraged the AMCNO board and the physician members of the AMCNO to become involved in the project.

Key questions posed by Dr. Keaton to the board and to our members:

- What does the "future state" look like to you?
- How can NEORHIO bring "value" to physicians?
- What would physicians be willing to pay for?

Editors Note: Members of the AMCNO interested in the NEORHIO project should contact Ms. Elayne R. Biddlestone at the AMCNO offices. If you would like to respond to the questions posed by Dr. Keaton at the board meeting — email your answers to ebiddlestone@amcoma.org. ■

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Technology Donations to Physicians: New Health IT Rules in Play

By Amy S. Leopard, Walter & Haverfield LLP

Solo physicians and small groups have been slow to adopt electronic health information based largely on the barrier of start-up costs. Health and Human Services (HHS) Secretary Mike Leavitt recently launched new exceptions to the Stark physician self-referral rules and safe harbors under the Antikickback statute that ease restrictions on health information technology (IT) provided to referring physicians if certain conditions are met.

Background

HHS has previously excluded from the Stark rule a hospital's provision of IT wholly dedicated to hospital services furnished to hospital patients. So, a treatment portal into a hospital's IT system is considered acceptable, but if this technology also has any independent functionality above and beyond patient treatment (e.g., physician billing functions), the physician would need to pay fair market value for the license. Interestingly, the new rule provides some additional guidance, outlining key areas that explicitly relate to patient treatment without independent value. These areas include transmitting test results, diagnosis codes, medical history and prescription information.

The new e-prescribing rules allow both software and hardware donations, but may have fairly limited utility due to the requirement that the technology be used solely to transmit and receive prescriptions. The new rules for electronic health records (EHR) allow health plans and entities that bill Medicare and federal health care programs for designated health services (DHS) to more easily provide EHR software that has value to the physician. Both sets of rules were effective October 10, 2006.

Eligible EHR Technology

First, the donated software must be necessary and used predominantly to create, maintain, transmit, or receive electronic health records and must include an electronic prescribing component. The software cannot duplicate equivalent technology the physician already possesses.

EHR software also must be interoperable at the time of donation, meaning data can be exchanged accurately, securely and consistently with other applications and networks in different settings such that the clinical or operational purpose and meaning of the data are preserved without alteration. Software is deemed interoperable if it has been certified by a body recognized by HHS.

Although industry standards for what is considered interoperable are amorphous and evolving, several things are clear: (i) the software package must communicate with products of other vendors, (ii) it must contain or interface with an E-prescribing component that meets Medicare Part D electronic standards, and (iii) donors cannot disable interoperability or impose barriers to compatibility with other e-prescribing or EHR systems — i.e., lock-in donor referrals through a closed system. Beyond that, HHS advises parties to consult industry standards to determine whether the software is “as interoperable as feasible given the prevailing state of technology” at the time of donation.

Certain related technology and training services may be donated as well, such as Internet connectivity (including broadband and wireless access), secure messaging, and training and help desk support services. While EHR functionality must predominate, the software can include ancillary administrative functions which relate to the care and treatment of individual patients (e.g., scheduling, billing, and clinical support). The EHR rules prohibit donations of hardware, storage devices, core functionality other than EHR, such as payroll packages or software that focuses primarily on billing and practice management, staffing to migrate hard copy to electronic formats, and software or items and services used primarily for personal business or unrelated to medical practice (separate research or marketing support).

Eligible Donors

Eligible donors under the safe harbor are health plans and those who deliver health care and bill federal health care programs, including hospitals and group practices, pharmacies, surgery centers, labs, dialysis and imaging centers, home health agencies and medical equipment suppliers, nursing facilities, and prescription drug plans. HHS declined to extend safe harbor protections to pharma and device manufacturers donations, preferring to rely on the facts and circumstances in an individual case over bright line rules.

Donors cannot select recipients or set the level of donation using criteria relating directly to the volume or value of referrals or other business between the parties. In a move demonstrating flexibility on the manner in which recipients are selected, HHS will allow donors to select eligible physicians on any reasonable and verifiable manner that indirectly relates to referrals, including such criteria as medical staff membership, size of the medical practice as measured through total patient encounters, RVUs, hours worked, or prescriptions written.

Conditions for Physician Participation:

So what must a physician do to be eligible for EHR donations? Before receiving a donation, the physician must pay at least 15% of the donor's cost, which could be a significant savings over paying the full price at retail or using existing exceptions that require a license at fair market value. Healthcare organizations are considering how to account for those costs on an incremental basis that appropriately considers physician use rather than an allocation methodology that attempts to fully load hospital system development costs in the license fees. The cost sharing amount for homegrown software and add-ons can be derived using a reasonable and verifiable cost allocation method, but the parties must document all costs and technology and the level of physician contribution in a written agreement.

Many donors will likely inquire of the physician as to existing technology utilized to document that the donation is not duplicative. This type of request is reasonable and protects both parties, but HHS does not expect the parties to hire technical experts here and allows for upgrades that enhance functionality or make the software more current and user friendly as not being duplicative. Finally, physicians cannot make the donation a condition of doing business with the donor, and donors cannot loan funds to a physician or finance physician payments.

The new rules sunset on December 31, 2013 — just in time to meet the President's ambitious goal of electronic health records that improve patient safety and quality care for all Americans by 2014. Despite vagueness in some aspects of the new rules, HHS is moving to remove financial impediments to IT adoption. Stay tuned as Congress debates further expansion and additional funding sources for this goal consistent with privacy and security principles.

Amy S. Leopard is a partner in the health law practice at Walter & Haverfield LLP. This article presents general information regarding legal developments and does not constitute legal advice. ■

LEGISLATIVE UPDATE

By Michael Wise, AMCNO Lobbyist

For political junkies, and I am a recovering one, the fall of 2006 has everything. There is national intrigue, significant turnover due to term limits, and a majority party that may soon swap positions with the minority party. *The Plain Dealer* recently ran (Oct. 8) an excellent election preview. Special thanks to them for allowing me to share some of that material here.

Based on polls and fund-raising, the closest race appears to be the re-election of Republican U.S. Sen. Mike DeWine. The longer range issue is whether Democrats or Republicans will hold the pencil when legislative districts are redrawn.

In the race for Governor, Democrat Ted Strickland has polled ahead of Republican Ken Blackwell all summer. The latest polls show the race narrowing but Strickland still has a double-digit lead.

Meanwhile, Republican State Auditor Betty Montgomery is very likely to become Ohio's next attorney general in her race against Senator Marc Dann. Franklin County Treasurer Richard Cordray, a Democrat, has a large lead over County Auditor Sandy O'Brien in the contest for Ohio Treasurer.

In the legislature, state Senate President Bill Harris' caucus cannot lose control of that chamber. The GOP runs the Senate 22 to 11 and only half of the 33 Senate seats are on the ballot. The best the Democrats could do here is win four GOP-held seats. That would prune Harris' caucus to 18, but Republicans would still run the Senate 18-15. In Ohio's 99-member House, GOP Speaker Jon Husted's 60-seat caucus may lose a few seats to Rep. Joyce Beatty's 39-member Democratic caucus. A worst case scenario for the Speaker is likely a 56-43 majority.



At a recent political event (from l to r) Dr. and Mrs. James Sechler, former State Senator Grace Drake and Judge Robert Cupp share a moment.

The two statewide elected executive offices that remain close are the Secretary of State and Auditor offices. Aiming to become Secretary of State are Columbus Democrat Jennifer Brunner and Cincinnati Republican Greg Hartmann. Competing for Auditor are two Greater Clevelanders, Democrat Barbara Sykes, of Akron, and Republican Mary Taylor, of Green.

What is perhaps more important to AMCNO, the Secretary of State and Auditor are members, with the Governor, of the Apportionment Board. This Board draws Ohio's state House and Senate districts. The party that runs the board draws the districts to suit its own interests.

The GOP has ruled the Apportionment Board since 1990. If Democrat Strickland becomes Governor, Democrats must elect only Brunner or Sykes to control the pencil that draws the lines. The flip side for Republicans would be that they must elect both Hartmann and Taylor if they want to keep running the redistricting show.

Reports filed in October suggest that Brunner and Hartmann (rivals for Secretary of State) and Sykes and Taylor (competing for Auditor) are, in terms of on-hand campaign cash, reasonably matched.

As far as statewide ballot issues, it appears, as this goes to print, that there will be five: 1) BWC Reform, 2) Minimum Wage increase, 3) Expansion of legalized gambling, 4) Constitutional Amendment to limit smoking, and 5) Broad Statutory change to virtually ban smoking.

AMCNO is pushing for a NO vote on Issue 4 and a YES vote for Issue 5. (see article, page 11).

NOMPAC has endorsed both Judge Bob Cupp and Judge Terrence O'Donnell for the Ohio Supreme Court. You will see in your 2006 Election Guide that AMCNO is providing more information about judicial races. For the first time, those of you living in Cuyahoga County will see a list of recommended candidates for the Cuyahoga Court of Common Pleas. Further, on October 24, 2006, AMCNO will team up with my firm, McDonald Hopkins, to raise money for two of those Common Pleas candidates (Judge Dick Ambrose and Judge Joan Synenberg).

We hope, in future Voter Guides, to expand our judicial recommendations to all of Northeastern Ohio.

NOMPAC is also endorsing Senator Coughlin in his bid for reelection, as he has been an incredibly knowledgeable and supportive friend to physicians.

The Ohio General Assembly has been on recess since June. We continue to push SB 88 and we also continue to meet with legal practitioners to refine the language in the Bill. Special thanks to AMCNO's medical/legal liaison committee and its members; Joe Farchione, Pat Murphy, Bill Meadows, George Moscarino, Mark Jones, John Mulligan, Bob Tucker and Michael J. Jordan. This committee has been very helpful on SB 88 and other legal issues that affect physicians.



AMCNO lobbyist Mike Wise provides an update of recent legislative activities to AMCNO members from the Akron area earlier this fall.

The General Assembly will reconvene Nov. 14 and work through December, when this legislative session will conclude. AMCNO will be tracking and advocating for a number of Bills and I will provide a full report in the next issue.

One issue that has developed over the summer concerns specialty hospitals (see news brief p. 11). On Aug. 8, a federal moratorium on specialty hospitals expired. Medicare has issued a report that appears more political, in an attempt to satisfy both the hospital and physician communities. The Ohio Hospital Association (OHA) asked for an emergency rule from Gov. Taft specifying to be classified as a hospital, the institution must have a 24-hour ER. Governor Taft would not issue the Rule. He offered three public hearings, and two to date have been held on limited service hospitals. The OHA believes physician-owned hospitals are

LEGISLATIVE ACTIVITIES

a conflict of interest and they are looking to come up with a new definition of hospital. The AMCNO will lobby this issues as well over the next few months.

Please make sure to vote Nov. 7. We hope that you find our Election Guide helpful as you strive to make informed choices.

United We Stand

Of critical importance this year is the smoke-free public places law, or Issue 5, supported in earnest by the Academy and its members. Indeed, we are proud to have partnered with the SmokeFreeOhio Initiative since its introduction last fall, and will continue through Election Day, Nov. 7 by staffing area polling places with physicians and medical students delivering the SmokeFree message to voters. And this year's AMCNO Voting Guide featured an advocacy section on the statewide Issue, in addition to candidates. During a recent press conference on the subject, community and civic leaders including Elayne Biddlestone, EVP/CEO of the AMCNO, stood united in opposition to Issue 4, the tobacco industry-backed proposal also on the ballot that would actually create a constitutional amendment permitting smoking and superceding the SmokeFreeOhio law, should it pass. **Vote YES on SmokeFreeOhio's Issue 5 and Vote NO on Issue 4 the "Smoke Less Ohio" Pro-Smoking Ohio Constitutional Amendment!**

End to Moratorium on Doctor-Owned Specialty Hospitals

The federal moratorium on the enrollment of new physician-owned specialty hospitals in the Medicare program ended when the Centers for Medicare & Medicaid Services (CMS) presented to Congress a mandated plan on physician investments in specialty hospitals. This ended a phase in which Congress had prohibited CMS from issuing Medicare provider numbers to new specialty hospitals whose owners also refer patients to the hospitals. The release of the CMS report means that Medicare has opened the door for new specialty hospitals. However, the government will be paying closer attention to how they behave. "Specialty hospitals often achieve high levels of service, but especially under current payment methods, there have been questions about whether they focus on profitable patients rather than quality care," said CMS Administrator Mark McClellan, MD, recently. To address these concerns, CMS will require specialty hospitals



(l to r) Tim O'Brien, MD, Director of the MetroHealth Cancer Care Center; Michael Nochomovitz, MD, President and Chief Medical Officer, University Hospitals Medical Practices; Delos Cosgrove, MD, President and CEO, Cleveland Clinic; Elayne Biddlestone, EVP/CEO of the Academy of Medicine of Cleveland & Northern Ohio and Scott Frank, MD, Shaker Heights Health Director, representing the medical community at the American Cancer Society press conference to highlight the health consequences of smoking and the difference between the competing issues on our statewide ballot.

— and eventually all types of hospital — to publicize any investment and compensation arrangements they have with physicians or risk fines of up to \$10,000 per day. Based on such disclosures, CMS and the Office of Inspector General might decide that some referring doctors are reaping disproportionately high returns from their investments and are therefore not eligible for exceptions to federal laws against physician self-referral, Dr. McClellan said. CMS also will be taking steps to level the financial playing field between specialty hospitals and community facilities. By adjusting Medicare reimbursements to reflect hospitals' costs and severity of patients' illnesses more accurately, CMS hopes to reduce the financial incentives that some specialty facilities might have to focus on healthier, more profitable patients. For more information on the rules, visit www.cms.hhs.gov/apps/media/press/release.asp?Counter=1937.

Legislators Listen to Physician Concerns

On Sept. 8, the AMCNO held another in a series of Legislative Breakfast meetings, this one at Fairview Hospital. There to address the many physicians in attendance were Sen. Dale Miller and Rep. Mike Foley, both democratic legislators representing Cleveland-area residents, along with AMCNO lobbyist Mr. Michael Wise. The meeting was wrought with questions and thoughtful exchanges between those gathered, as most of the physicians present not only practiced at Fairview but resided in areas around the district as well.

President Paul Janicki, MD, began the meeting with an overview of recent advocacy and public health work being done by the AMCNO, especially on the legislative front

with respect to our continuing work on alternative dispute resolution for medical negligence claims. He noted that the news of liability premiums leveling off has had less of an effect on those practicing in NE Ohio than the rest of the state. Mr. Wise then delivered a synopsis of the mandatory arbitration model laid out in SB 88, the AMCNO-backed legislation that passed the Ohio Senate earlier this year.

Discussions went on and ranged from Medicare payment cuts and insurance company policies to healthcare quality issues and patient concerns. The meeting concluded with a more in-depth look at how the legal system functions with regard to medical cases as Dr. Janicki moderated, then summed up, the benefits of meeting such as this. The legislators seemed pleased to hear directly from the physicians at the meeting about issues affecting them, and in fact were urged to take a close look at SB 88 when the General Assembly reconvenes. *If you are interested in the AMCNO organizing a breakfast meeting with legislators at your hospital, call Elayne Biddlestone for more information (216) 520-1000.* ■



From (l to r) Rep. Mike Foley, Cristiana Boieru, MD; President Paul Janicki, MD; Adnan Mourany, MD; Sen. Dale Miller and Luis Llerena, MD, following the breakfast meeting between legislators and physicians organized by the AMCNO.

New Ohio State Medical Board Rules Governing the Termination of the Physician-Patient Relationship

By John T. Mulligan

The Ohio State Medical Board has recently enacted a rule (Ohio Administrative Code Section 4731-27-01) governing the termination of a physician-patient relationship. This rule deals with the following situations: where a physician leaves a practice due to retirement or some other reason; where the physician sells his or her practice; where the physician simply desires to terminate a particular physician-patient relationship while continuing to practice; and where the patient terminates the physician-patient relationship. The rule became effective September 30, 2006.

The rule provides that a physician-patient relationship is established when the physician provides services to a person to address medical needs, whether by mutual or implied consent, or provided without consent pursuant to a court order.

Once the "relationship is established," a person remains a "patient" of the physician until the relationship is terminated as provided under the rule.

Generally, the rule provides that in order to terminate a physician-patient relationship, a physician must mail to the patient via both regular mail and certified mail, return receipt requested, a letter containing at least the following information:

- (a) A statement that the physician-patient relationship is terminated;
- (b) A statement that the physician will continue to provide emergency treatment and "access to services" for up to thirty days from the date the letter was mailed, to allow the patient to secure care from another physician; and
- (c) An offer to transfer records upon the patient's signed authorization to do so.

The rule does not require the physician to explain why the relationship is being terminated. The physician must maintain in the patient's record a copy of the letter, the original certified mail receipt, and the original certified mail return receipt.

With respect to the requirement to retain the original certified mail return receipt, sometimes this is not possible, for example, because the patient refused to sign for the certified letter. The rule does not address this possibility, nor does it provide what the

physician is to do if the letter comes back indicating that the address is incorrect.

The rule does not define what is meant by "access to services." Presumably what this means is that the physician must afford the patient the same degree of "access" that the patient would have had had the patient not been terminated by the physician.

One problem with this new rule is that unless and until the physician-patient relationship is terminated, a person "remains a patient." In theory, that relationship would continue forever until it was terminated either by the physician or by the patient. This creates a question of what affirmative duties to the patient the physician has during this period, even where the physician may not have any contact with the patient, or where the patient might not consider the physician to be his or her "physician." It may take court cases to answer this question.

There are no exceptions to the requirement that a physician provide "access to services" in situations in which the patient has not paid for prior services, or in which the patient has been abusive of the physician or the physician's staff, or is not following the recommendations of the physician.

Under the rule, the requirements with respect to patient notification of termination do not apply in the following circumstances:

- (1) Where the physician rendered medical services to the patient on an episodic basis or in an emergency setting, and the physician could not reasonably expect that related medical service will be rendered to the patient in the future. An "emergency setting" means only an

- emergency department (presumably, of a hospital) or an urgent care center; or
- (2) Where the physician has formally transferred the patient's care to another physician who is not in the same group practice; or
- (3) Where the physician is leaving a practice, selling a practice, or retiring and has done all of the following:
 - (a) Mailed a notice, sent by regular mail addressed to the last known address, to all patients seen by the physician within the immediately preceding three years;
 - (b) Published a notice in the newspaper of greatest circulation in each county in which the physician has practiced and in a local newspaper that serves the immediate practice area; and

The leadership of the AMCNO has closely followed this issue since first requested to submit written comments to the OSMB earlier this year.

Our first letter dated March 3, deconstructed much of the verbiage contained in the proposal, imprecise terms such as a 36-month termination rule as well as the narrow definitions of termination rules time lines. The AMCNO asked the OSMB why there was even a perceived need to place this into a rule that has a force of law. It would seem that the AMA Opinion on this matter should be sufficient. The termination rules clearly would create a situation where a physician could be responsible for the care of a patient for up to 30 days after terminating their care. The AMCNO noted "we could not help but wonder why, except for the ethical obligations to provide continuing care when a case has been undertaken, that physicians should be saddled with a patient like this?"

To this, the executive staff attorney for the OSMB replied in writing April 3 that the Medical Board's Minimal Standards Committee had reviewed AMCNO comments which "assisted the members in developing amended language" and "also assisted the board staff in redrafting" those relative to terminating patient relationships. But upon even further review of the amended rules, the AMCNO board wrote again to the OSMB with additional comments considering these revisions.

Members interested in more detailed information on these actions may call Ms. Elayne Biddlestone at (216) 520-1000 or their AMCNO board of directors district representative.

LEGAL CONCERNS

(c) Posted a sign in a conspicuous location in or on the façade of the physician's office.

(2) The physician maintains documentation in the patient records of the patient's action terminating the relationship.

with respect to the ongoing obligation of a physician to a patient who has not been properly "terminated" as a patient or who otherwise has a right of "access" to services.

The required notices and sign must advise the patients of their opportunity to transfer or receive their records. For patient records remaining in the physician's possession once the physician is no longer seeing patients, the notices must provide contact information for obtaining the records.

In summary, this new rule provides some clear requirements in an area which in the past has not had clear rules. Unfortunately, the rule imposes new burdens on physicians, may present complications in situations in which a physician is involuntarily leaving a group, and creates a potential legal issue

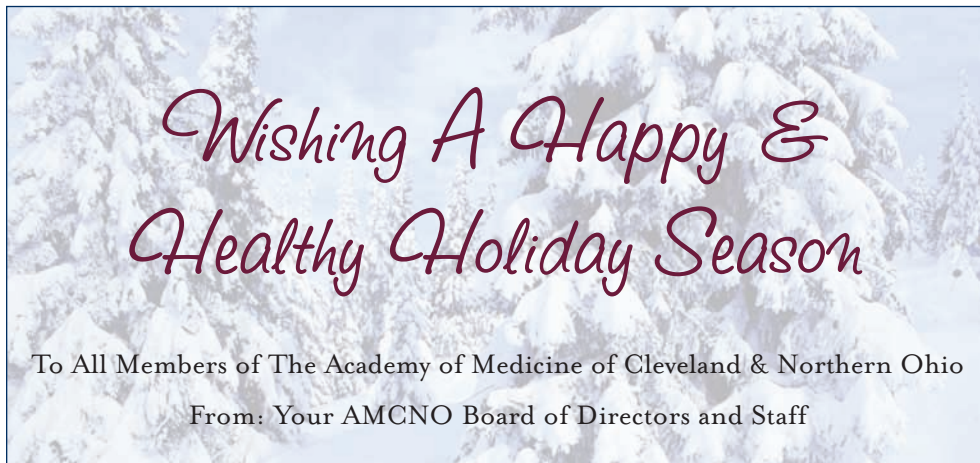
Mr. Mulligan of McDonald Hopkins, Co. LP focuses on representation of professional practices and general businesses. In the past, he has served as the manager of the firm's Health Law Department and as a member of the Board of Directors. ■

The rule defines a physician who is "retiring" from practice as one who does all of the following:

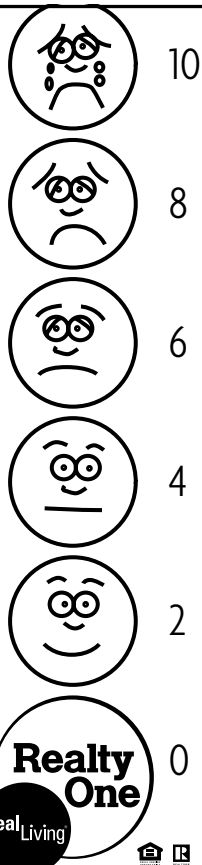
- (1) Relinquishes all clinical privileges; and
- (2) Terminates professional liability insurance or converts it to "tail" coverage only.

A patient will be considered to have terminated the physician-patient relationship if both the following requirements are met:

- (1) The patient terminated the relationship, either verbally or in writing, or has transferred care to another physician for the same or related condition; and



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Pollen Line: A Season in Review

By Arthur Varner, MD

The 2006 pollen season started out fast and furious. The highest tree pollen levels observed in Cleveland for many years triggered severe spring hay fever symptoms the first few weeks of May. It was quite different from the year before when the snow of April 24, 2005 abruptly ended the tree pollen season before it started.

By the middle of May bad weather returned with 10 days of rain and dreariness. But this did halt the tree pollens and muted the increase in grass pollen which had started sooner than normal due to the nice weather in the first weeks of May. Overall, the grass pollen season was mild to moderate, but seemed to linger a little longer than usual. Interestingly, we saw a second grass pollen season late in the summer, but levels never got high enough to cause significant symptoms.

The ragweed started out strong and peaked as usual around Labor Day. While the levels were certainly higher than last year, the mildest season ever recorded in Cleveland thanks to remnants of all the hurricanes of last year, the ragweed season was mild to moderate and most patients on a good medication regimen and/or immunotherapy did fine. In talking with other allergists around the state, all seem to have noted milder ragweed symptoms over the

last couple of years. There has been speculation that with global warming, pollen counts would increase but such is not the case here in Ohio with ragweed. Possible explanations include less agriculture with urban sprawl but also new drug-resistant crops allowing the use of potent weed killers that decrease the number of ragweed plants.

The mold season started earlier than normal in mid-June and was moderate to high through the rest of the summer and fall. Not as many people are sensitized to molds but those who are had a difficult summer. Unfortunately, mold allergy is associated with both hay fever as well as asthma, sinusitis, and headaches.

At this time patients who did not do well controlling their symptoms this summer should consult with an allergist for testing and a better medication regimen for next year. Now is a good time to start immunotherapy as most

patients on allergy shots did very well this summer, even during the severe tree pollen season. Forecasts for next year's counts are difficult but as of now an el Niño weather pattern is strong in the Pacific. This means mild winters for us and increased mold counts as we will lack constant snow cover. Also, we generally see warmer and drier springs which means the possibility of an early and severe tree and grass pollen season.

It has been a pleasure reporting the counts for the AMCNO *Pollen Line*. Have a great winter, Go Bucks, and see you in the spring.

Editor's Note: Our sincere gratitude to Dr. Varner for not only conducting the pollen counts but also for making them available to the public daily via our call-in pollen line and Web site from May through October. This is the second year Dr. Varner committed to this endeavor and the 48th of the public service program itself. ■

It's Time For Your Financial Check-Up

Thanks in large measure to the work of health care professionals like you, Americans are enjoying longer, healthier lives than ever before. Plan to make the most of the coming years. Retirement planning is like preventive medicine, build a nest egg now and be more comfortable later.

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Speaker's Bureau Showcases Medical Expertise

For the second year in a row, **Bernard Stulberg, MD**, delivered a well-received presentation on joint replacement to seniors in Tri-C's ENCORE program, this time at the Corporate College West location. ENCORE is sponsored by the Tri-C Department of Gerontology and attended by local seniors in their continuing education series.

The Sept. 20 engagement included a discussion about one of the most common causes of knee pain — osteoarthritis. Dr. Stulberg provided information on conservative treatments such as steroidal and nonsteroidal anti-inflammatory drugs as well as detailed information on total knee replacement — what the surgery entailed and the techniques involved in the procedure. Specifically the computer-assisted surgical monitoring was conferred, which is meant to enhance longevity of knee replacement through more precise surgical implantation and intraoperative evaluation. Dr. Stulberg is Director of the Joint Reconstruction Center at the Cleveland Orthopaedic and Spine Hospital at Lutheran.

The AMCNO works collaboratively with Tri-C's East and West campus programs as part of our own Speaker's Bureau, which provides physician speakers to the community on a range of medical topics. Members interested in similar presentations should contact Sara Lieberth at (216) 520-1000. ■



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Anthem Continues Audits on NE Ohio Physicians

Close to 1,300 NE Ohio physicians have been subjected to a professional audit performed by Healthcare Comprehensive Solutions (HCS) on behalf of Anthem. If you are subjected to an audit you may expect the following to occur:

After completion of the initial audit, the audit results are sent back to the physician outlining the results and providing information on the appeals process. The physician is then notified of his/her appeal rights and has 30 days to submit an appeal in writing along with supporting documentation to HCS.

Upon receipt of an appeal, HCS is supposed to assign a different auditor to perform the appeal review and the results of this review are to be sent back to the physician. If the physician continues to dispute the audit findings, the AMCNO strongly suggests that physicians request a peer-to-peer conference with the Medical Director of HCS. Currently, HCS is utilizing the CMS 1995/1997 E/M Guidelines for these types of discussions.

Anthem has stated that these audits are based solely on correct coding and supporting documentation and in no way questions the level of care provided by the physician. Anthem has indicated that this is being done to ensure that the level of code billed is supported by appropriate documentation. However, there appears to be some question on the part of physicians undergoing these

audits as to how Anthem reviews "risk." Some physicians have expressed concern that if the reviewers for Anthem merely assess the risk under medical decision-making based on the eventual established diagnosis, it may not reflect the overall medical decision-making work done for each patient.

The AMCNO strongly suggests that if you are subjected to an Anthem audit that you copy the Medical Director for Anthem in the Northern Ohio region (Dr. Thomas Weisman) and request a peer-to-peer review of the claims by HCS. The AMCNO would also be interested to learn from our members if you have experienced any problems/issues due to these audits by Anthem. Please email any comments/questions to ksnider@amcnoma.org. ■

Flu Vaccine Availability & Billing Update

FFF Enterprises currently has the GSK Fluarix influenza vaccine in stock and available through its physician contract initiative. All physicians who need the product right away may place an order for immediate delivery. In May, the company launched MyFluVaccine, a Web-based influenza vaccine ordering and planning tool that offers providers real-time order status and guarantees vaccine delivery by a pre-selected date. Call 800-843-7477 or visit www.fluvaccine.net to place an order.

PalmettoGBA of Ohio has prepared a packet for health care providers who mass immunize their patients against influenza and pneumonia. The packet contains instructions on how to submit claims using the roster billing method. If you have questions regarding this, the Medicare Part B Provider Contact Center's toll free line is (877) 567-9232 and is available Mon. thru Fri., 8 a.m. till 4:30 p.m. To access the roster billing packet or to download a Word version of the roster billing form, click visit www.palmettoGBA.com ■

The Center for Health Industry Solutions of Cuyahoga Community College

Offers Discounted Classes for AMCNO Members & their Staff

Interested parties will need an exclusive AMCNO course number to register and obtain the discount. For course numbers, call Linda Hale of at (216) 520-1000, ext. 101, or e-mail lhale@amcnoma.org. For course information visit www.corporatecollege.com. Classes are offered at Corporate College East or West (CCE) (CCW) and the Unified Technology Center (UTC).

Medical Terminology/Anatomy & Physiology

CEU: 3	HRS: 30	
Jan 17 - Feb 26	CCE - TBD 6:00p - 8:30p	MW
	UTC - TBD	MF
Jan 22 - Mar 2	9:30a - 12:00p	
	CCW - TBD	TR
Jan 23 - Mar 1	6:00p - 8:30p	
	CCE - TBD	TR
May 1 - Jun 7	6:00p - 8:30p	

AAPC Professional Medical Coding Curriculum

CEU: 8.1	HRS: 81	
Mar 20 - Jun 19	CCE - TBD 6:00p - 9:00p	TR

Certified Medical Coder (CMC) by PMI

CEU: 2.8	HRS: 28	
Apr 11 - May 9	CCE - TBD 8:30a - 4:30p	W

Case Scenario Workshop – Coding for Physician Services

CEU: 0.4	HRS: 4	
Feb 21	CCE - TBD 8:00a - 12:00p	W

Cardiology Coding Lab – Diagnostic & Interventional Coding

CEU: 0.4	HRS: 4	
Apr 17	CCE - TBD 8:30a - 12:30p	Tues

Compliance and Advanced Chart Auditing

CEU: 0.4	HRS: 4	
Mar 14	CCW - TBD 8:30a - 12:30p	W
	CCE - TBD	R
Apr 12	8:30a - 12:30p	
CEUs - AAPC Pending, PMI - 4		

CPT Coding Workshop by PMI

CEU: 0.6	HRS: 6	
Mar 7	CCE - TBD 8:30a - 3:30p	Wed

ICD-9-CM Coding Workshop by PMI

CEU: 0.6	HRS: 6	
Feb 14	CCE - TBD 8:30a - 3:30p	Wed

CPC Certification Exam Review

CEU: 0.5	HRS: 5	
Feb 24	CCE - TBD 9:00a - 2:45p	Sat

Urology Coding for the Physician's Practice

CEU: 0.3	HRS: 3	
Apr 17	CCE - TBD 1:30p - 4:30p	Tues

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Year-End Tax Planning Strategies

By Philip G. Moshier, CFP

As the end of the year approaches, it is a good time to review your tax planning strategies. You are now in a position to explore various opportunities that may save taxes for this year, next year, or both. Compiled below is a checklist of possible actions that may help you to save taxes if you act before year-end.

- Increase the amount you set aside for next year in your employer's health flexible spending account if you set aside too little for this year. Don't forget you can set aside amounts to get tax-free reimbursements for over-the-counter drugs, such as aspirin and antacids. Also, new rules allow your plan to permit a grace period after year-end for using remaining amounts.
- If you have any capital gains or losses from sales of stock or other capital assets, or you have stock or other capital assets that are ripe for sale, it may be advisable to meet to discuss how you can best coordinate timing your gains and losses to minimize tax on your gains and maximize the tax benefit from your losses.
- It may be advantageous to arrange with your employer to defer your bonus until 2007.
- If you own an interest in a partnership or S corporation you may need to increase your basis in the entity so you can deduct a loss from it for this year.
- Consider using a credit card to prepay expenses that can generate deductions for this year.
- You may want to pay contested taxes to be able to deduct them this year while continuing to contest them next year.
- You may be able to save taxes this year and next by applying a bunching strategy to "miscellaneous" itemized deductions.
- Those facing a penalty for underpayment of estimated tax may be able to eliminate or reduce it by increasing their withholding.
- Self-employed individuals should consider setting up a self-employed retirement plan.
- You can save gift and estate taxes by making gifts sheltered by the annual gift tax exclusion before the end of the year.

You can give \$12,000 in 2006 to an unlimited number of individuals but you can't carry over unused exclusions from one year to the next.

- Depending on your particular situation, you may also want to consider deferring a debt-cancellation event until 2007, electing to deduct investment interest against capital gains, and disposing of a passive activity to allow you to deduct suspended losses.
- Sign up for the "catch up" provision in your retirement plan of \$5,000 if you are over age 50.

These are just some of the year-end steps that can be taken to save taxes. Please remember this information is provided as informational. A financial planner can work with you and your tax advisor to tailor a particular plan that will work best for you.

Don't forget the Academy of Medicine Education Foundation in your charitable efforts this year. Contact Linda Hale at the AMCNO for donation details. ■

12 Publication Title **Cleveland Physician**

13 Issue Date for Circulation Data Below **Sept/Oct 2006**

Extent and Nature of Circulation		Average No. Copies Each Issue During Preceding 12 Months	No. Copies of Single Issue Published Nearest to Filing Date
a. Total Number of Copies (Net press run)			
(1) Paid/Requested Outside County Mail Subscriptions Based on Form 3541 (Include advertiser's proof and exchange cost)		2300	2300
(2) Paid In-County Subscriptions Based on Form 3541		145	124
(3) Paid/Requested Outside and In-County (Include advertiser's proof and exchange cost)		1705	1460
b. Paid and Requested Circulation			
(4) Sales Through Dealers and Carriers, Street Vendors, Counter Sales, and Other Non-USPS Paid Distribution		—	—
(5) Other Classes Mailed Through the USPS		—	—
c. Total Paid and Requested Circulation (Sum of 1b(4) and 1b(5))			
		1850	1784
d. Free Distribution (Sum of 1c(1) and 1c(2))			
(1) Outside County as Stated on Form 3541		68	77
(2) In-County as Stated on Form 3541		352	389
e. Other Classes Mailed Through the USPS			
		—	—
f. Total Free Distribution (Sum of 1d(1), 1d(2), and 1d(3))			
		420	466
g. Total Distribution (Sum of 1c and 1f)			
		2270	2250
h. Copies not Distributed			
(1) Total (Sum of 1g and h(1))		30	50
(2) Return to Publisher (Sum of 1g and h(2))		2300	2300
(3) Other (Sum of 1g and h(3))		82%	79%
i. Total (Sum of 1g and h)			
		2300	2300

14 Indication of Statement of Ownership (Publication required. Will be printed in the issue of this publication. Publication not required.)

15 Signature and Title of Editor, Publisher, Business Manager, or Owner **Elyse R. Biddlestone** Date **10/10/06**

Instructions to Publishers

1. Complete and file one copy of this form with your postmaster annually on or before October 1. Keep a copy of the completed form for your records.
2. In cases where the stockholder or security holder is a trustee, include in items 10 and 11 the name of the person or corporation for whom the trustee is acting. Also include the names and addresses of individuals who are stockholders who own or hold 1 percent or more of the total amount of bonds, mortgages, or other securities of the publishing corporation, in item 11, if none, check the box. Use 30 characters if more space is required.
3. Be sure to furnish all circulation information called for in item 10. Free circulation must be shown in items 10a, b, and c.
4. Item 10b, Copies not Distributed, must include (1) nonpaid copies originally stated on Form 3541, and returned to the publisher; (2) estimated returns from news agents; and (3) copies for office use, leftovers, spoiled, and all other copies not distributed.
5. If the publication has previously authorized as a general or requester publication, this Statement of Ownership, Management, and Circulation must be published. It must be printed in any issue in October or, if the publisher is not published during October, the first issue printed after October.
6. In item 10, indicate the date of the issue in which this Statement of Ownership will be published.
7. Item 17 must be signed.

Failure to file or publish a statement of ownership may lead to suspension of Periodicals authorization.

PS Form 3526, October 1999 (Revised)

United States Postal Service

Statement of Ownership, Management, and Circulation

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2 Issue Date **9.30.06**

3 Filing Date **9.30.06**

4 Issue Frequency **Six (6)**

5 Annual Subscription Price **\$36.00**

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8 Complete Mailing Address of Owner (Do not include ZIP+4®)

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PS Form 3526, October 1999

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!

Group Membership Opportunities Touted at Local Hospitals

During the last several months, the AMCNO has participated in medical executive/staff meeting agendas to discuss group membership opportunities in the only regional organization dedicated to the issues of NE Ohio physicians. In this time, Board of Directors representatives have presented at Marymount, Lakewood, Huron, Parma, Lake and Fairview Hospitals and most recently the AMCNO met with the Summit County Medical Society members. The established corporate/group membership category was created to address the changing needs of our local medical environment. With dues at a significant discount, corporate membership is available to medical partnerships, group practices, incorporated medical societies, and hospital medical staffs. If you would like the AMCNO to present at your Med Exec meeting, call Membership Coordinator Linda Hale at (216) 520-1000. ■



President Paul Janicki, MD, discusses the many benefits of membership for hospital groups to interested physicians at Lakewood Hospital recently.



Just prior to his Medical Staff meeting, Huron Road Hospital Chief of Staff John Erkins, MD, chats with Dr. George Kikano regarding organized medicine in our region.

"Tracking Trends Impacting the Practice of Medicine"

March 9, 2007

Embassy Suites Independence, Ohio 10 am – 3:30 pm

The 2007 AMCNO Annual CME Seminar will address ongoing developments in pay-for-performance programs, electronic health records and their associated technology as well as the implications on today's practicing physician.



Academy Responds to Crain's on Liability Rates

In a published letter-to-the-editor of *Crain's Cleveland Business* last month, President Paul Janicki, MD, counters that the "stabilized" medical liability rates reported for the state have had little effect on practicing physicians in NE Ohio. The original article, "Docs Find Relief at Last" (*Crain's Cleveland Business*, Sept. 11) cited insurance statistics and a representative of the state medical association making the case that medical liability rates have abated to the extent that Ohio is now a better place to practice medicine than in recent years. Dr. Janicki, however, offered insights into the

"reality" of medicine in the Northern Ohio area. "Physicians in our region continue to lose ground in the struggle to pay medical liability rates. We continue to hear from our members that medical liability is still their number one expense and their number one practice issue," he wrote. The efforts of organized medicine, he said, and particularly AMCNO's work to get meaningful dispute resolution legislation passed, would do more to bring the type of "relief" doctors in this area of the state need. Read the full text of the Academy's response at www.amcnoma.org ■

Residents Learn Business of Medicine

The Academy of Medicine of Cleveland & Northern Ohio presented our annual seminar, "Preparing for the Business Aspects of Practicing Medicine" for third and fourth year residents Oct. 4 at HealthSpace Cleveland. The agenda's content and speakers targeted specific issues these young physicians will face entering today's healthcare marketplace. Residents from several area hospitals were on hand to learn about employment contracts, liability coverage, asset management, estate planning, starting a practice, and tax concerns from a lineup of expert guest speakers. Sponsored by the AMCNO in collaboration with Hilb, Rogal & Hobbs; McDonald Hopkins, Sagemark Consulting;



Richard Cause of Walthall, Drake & Wallace LLP delivers sound advice on the tax considerations in forming a partnership to the resident attendees at this year's seminar.

Squires, Sanders & Dempsey, and Walthall, Drake and Wallace LLP. ■

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