



December 2009

MIAMI MEDICINE

The Official Publication of the Dade County Medical Association

LOOK WHAT'S INSIDE:

Money Talks	2
President's Page	3
Signature Requirements	5
Medical Information Technology.....	7
Preventing Malpractice Claims Entailing Misdiagnosis of Cancer ...	9
Increase the Profitability of Your Medical Practice	11
Changes that Affect your Practice	13

MEMBER BENEFIT!

\$ Money Talk \$

with Thomas Kosky & Harris Kerker

As we are currently living in extraordinary economically challenging times that are impacting not only our lifestyles but our professions as well, the DCMA is taking the initiative to better educate its membership in the finance related areas.

Over the next year, the DCMA will be sponsoring a series of seminars that will be available free of charge to our members. These seminars will be conducted at the DCMA conference center on the 2nd Tuesday of each month beginning in January 2010 and each month thereafter. These seminars will be conducted from 6:30–7:30 p.m. followed by a question and answer session. Refreshments at 6:00 p.m.

These seminars will cover finance and finance related topics ranging from investment and portfolio management to estate and insurance planning. The schedule is as follows:

- | | | |
|---------------|----------------------------|---------------------------------|
| • Session #01 | January 12 th | Retirement Planning |
| • Session #02 | February 9 th | Asset Protection Part 1 |
| • Session #03 | March 9 th | Asset Protection Part 2 |
| • Session #04 | April 13 th | Pension Planning Part 1 |
| • Session #05 | May 11 th | Pension Planning Part 2 |
| • Session #06 | June 8 th | Insurance Planning Part 1 |
| • Session #07 | July 13 th | Insurance Planning Part 2 |
| • Session #08 | August 10 th | Investments Part 1 |
| • Session #09 | September 14 th | Investments Part 2 |
| • Session #10 | October 12 th | Alternative Investments |
| • Session #11 | November 9 th | Investments – Perils & Pitfalls |

The seminar facilitators and speakers are Thomas Kosky and Harris Kerker who are Principals with the Asset Planning Group, Inc. with offices in Dade and Broward counties. Their combined experience is in excess of 50 years in the financial planning field. In addition to Messrs. Kosky and Kerker, guest speakers who are experts in the finance related fields will be brought in on occasion to discuss the economy and economic trends.

Mr. Kosky has taught graduate finance classes in the Saturday Healthcare Executive MBA Program at the University of Miami for more than 20 years where he currently teaches a course in investment and portfolio management. Mr. Kosky has also sat on the editorial boards of two healthcare publications – Physician’s Money Digest and Dentist’s Money Digest where he published in excess of 200 finance related articles.

We look forward to your participation!
Please call the DCMA at 305 324-8717 to register.

Seminar Series

Retirement Planning

(1 session)

- The financial planning process
- Estimating how much will be required at retirement to sustain one’s lifestyle needs through life expectancy

Asset Protection

(2 sessions)

- Creditor protection in Florida
- Exempt vehicles
- Divorce

Pension Planning

(2 sessions)

- Qualified vs. non-qualified plans
- Defined contribution 401(k) plans
- Defined benefit plans
- Traditional vs. Roth IRAs

Insurance Planning

(2 sessions)

- Life insurance – variable, universal and term life insurance contracts
- Disability insurance
- Long-term care insurance
- Variable & fixed annuities

Investment Vehicles

(2 sessions)

- Stocks & bonds
- International investing
- Asset Allocation
- Portfolio Construction
- Risk assessment

Alternative Investments

(1 session)

- Risk vs. reward Involved with non-traditional types of investment vehicles

Perils & Pitfalls of Investing

(1 session)

- “Caveat Emptor” – let the buyer beware



Frank R. Maderal, M.D.

President, Dade County Medical Association

MESSAGE *from your* PRESIDENT:

by Frank R. Maderal, M.D.

A Lot To Think About

Where do I begin. There is so much going on with health care and it's all still unclear. It is difficult to decide whether to be for or against many of the issues. I'm just going to comment on some of them.

The Florida Medical Association leadership has come out mostly against a public option, yet in Miami-Dade County we have a large percentage of the population that wants to buy insurance but can't because they are individuals who work for themselves, work for companies that don't offer health insurance, or they have pre-existing conditions. The insurance industry will never take care of these people unless they are forced to, or there is some sort of "option" whether public or a private cooperative, or something that will group these people and help them negotiate.

Buried somewhere in the health care bill is a move to have Medicare pay physicians equally across the country. The higher reimbursement we receive in Miami-Dade County due to higher overhead will be gone or reduced. This is not an issue for the rest of Florida, we in Miami-Dade County will have to lobby and fight this issue by ourselves. This is a perfect example of why we need the Dade County Medical Association. We have asked the Florida Medical Association to state their position on this for our members to know. We believe that our overhead costs are greater and therefore we need our fair higher reimbursements.

Alternative insurance or "option" may be left to the individual states to establish. This will mean that our state and county medical associations need to get involved in the planning early on. This is another example of why our recent successful lobbying will be so important in the near future. This is why we need continued membership and membership in the Dade County Medical Association Political Action Committee.

Will tort reform be included in the health care bill? Will the Medicare SGR formula which calls for yearly cuts and is "fixed" on a yearly basis be finally terminated? Mentioned in the health care

bills are accountable care organizations. These organizations would need sufficient primary care physicians to care for at least 5000 beneficiaries. These organizations would get a global fee to later pay for care including doctors. Sadly at present the only entities that can quickly organize such a group are hospitals and some corporations such as those that employ hospitalists, etc. There are no primary care groups which are owned by the group members in Miami-Dade County - at least not larger than 3 or 4.

No one knows what the final health care bill will contain. There are a lot of different players pushing their interests.

Some physicians may choose to work for a salary and enjoy their practice with little administrative headaches. Those who decide to keep their independence will need to develop a small niche practice or consolidate into a larger group with better negotiating, investing and development capabilities. Until the health care future is clearer, we should not become over dependent on one hospital or one payer, etc.

It's going to be very interesting over the next few weeks. The Dade County Medical Association will try to keep you informed and we will continue to represent our members.

Finally please look at the many companies that advertise in our magazine, and those listed on our web site - miamimed.com. Many offer services to our members at a discount or reimbursement back to the practice (see page 11 in this issue of Miami Medicine). We try to associate only with reputable established vendors. Many have a long relationship with the Dade County Medical Association. Our group practice uses several of these companies and we are very satisfied with their work.

Frank R. Maderal, M.D.

President, Dade County Medical Association



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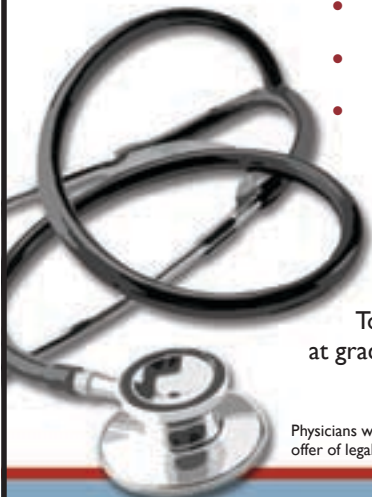
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from **PATRICIA C. HANDLER**

Executive Vice President, DCMA

**IMPORTANT INFORMATION
REGARDING MEDICARE
CLAIMS PAYMENTS**

Signature Requirements Clarification

First Coast Service Options Inc. (FCSO) has seen a significant increase in the number of CERT errors related to the lack of a legible signature in medical record documentation. The CERT contractor confirmed that the Centers for Medicare and Medicaid Services (CMS) and the Office of Inspector General (OIG) have clarified that providers of Medicare services must comply with the signature legibility requirements outlined in the Internet-only manual, Publication 100-08, Chapter 3, Section 3.4.1.1 B:

- *Medicare requires a legible identifier for services provided/ordered. The method used shall be hand written or an electronic signature (stamp signatures are not acceptable) to sign an order or other medical record documentation for medical review purposes. (The only exception is that facsimiles of original written or electronic signatures are acceptable for the certifications of terminal illness for hospice.)*

The legible identifier (signature) requirement applies to documentation for **any** service performed and billed to Medicare. The purpose of a rendering/treating/ordering practitioner's signature in patients' medical records, operative reports, orders, test findings, etc., is to support that the services have been accurately and completely documented, reviewed and authenticated.

The CERT contractor is rigorously enforcing the CMS requirement that all medical records subject to medical review must include a legible identifier (signature). Documentation that

is submitted with an illegible signature, initials, an unauthenticated electronic signature, no signature, or an unsigned typewritten signature will be denied and assigned a CERT error. This error will produce an overpayment and a subsequent recoupment of funds.

Physicians, non-physician practitioners, and other health care providers who bill Medicare contractors must remember:

- A legible signature is required on **all** medical records subject to medical review.
- Prior to submission for medical review, every medical record should be audited to ensure that the beneficiary's name, the date of service, and the signature of the provider of services are on the records.
- If the provider's signature is illegible, a signature legend/log identifying the author associated with the illegible signature or initials should be submitted with the records. This applies to records submitted to any Medicare contractor, including the Medicare Administrative Contractor (MAC) and the CERT contractor.
- Electronic signatures should be safeguarded against misuse (such as password protected) and should be easily identifiable as electronic, rather than typewritten, signatures.

Providers should ensure that their offices and/or billing departments are aware of these guidelines.

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Bernd Wollschlaeger, M.D., FFAFP, FASAM

Medical Information Technology

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How Do You Find A User-Friendly Electronic Health Record?

The Meaningful Use And EHR Certification Quagmire

The push for Electronic Health Record (EHR) implementation is gaining momentum and speed. The Health Information Technology (HIT) Extension Program, included in the American Recovery and Reinvestment Act of 2009, contains an economic stimulus package to offset costly EHR implementation and will provide financial incentives for those physicians who demonstrate meaningful use of a certified EHR program in their practice by January 2011. Therefore, physicians' offices are being bombarded with offers by EHR vendors promising to meet all of those demands, guaranteeing increased reimbursement by the set deadline. As a veteran EHR user, I caution my fellow colleagues not to fall prey to those offers but to sit down and consider the following.

There is a big difference between EHR functionality and usability! What's the difference? Functionality is what a system can do. Usability is how easily you and your staff can apply and implement all those capabilities. According to an article posted on amednews.com we should "pay less attention to the bells and whistles and more to whether physicians and support staff can figure out how to make them work. Determining what usability means to you will require a hard look at not only the system but also your practice — how it works now, how you want it to work, and how ready and able employees are to adapt to technology." Furthermore, we should be aware that if "all of the EHR's functionalities aren't being used by the majority of people in the office, the practice is not realizing the system's full potential." I always advise my clients to avoid searching for the PERFECT system but to focus on the essential functionalities, which can be applied in the daily practice. In addition, we have to pay close attention to definitions contained in the "meaningful use" matrix and the upcoming changes in the EHR certification process.

Meaningful use describes the electronic documentation required to enhance quality/efficiency and actual data exchange among payers, providers and patients. The definition of meaningful use will be codified in a December 2009 Notice of Proposed Rulemaking. We will not have the final meaningful use criteria until Spring 2010 after a period of comment. The August 2009 recommendations for meaningful use describe 9 data exchanges, multiple sending and receiving modalities all parties need to participate. They include: ePrescribing, sending reminders to patients, checking insurance eligibility, submitting claims, providing patients with an electronic copy of their record, providing patients electronic access to their records, capability to exchange key clinical information (e.g., problem list, medication list, allergies, test results) among care providers and patient authorized entities, capability to submit data to immunization registries, and the capability to provide syndromic surveillance data to public health agencies.

Given the extensive scope, limited time, and resources, it is hard to fathom that all EHR providers will meet the 2011 deadline to implement all 9 data

exchanges among payers, providers and patients in time for Stimulus funding. I expect an incremental approach to introduce all of the described features over the course of 2-3 years. The EHR selection and purchase decision should take this into consideration and I highly recommend involving your entire staff in this process to assess and test the usability of the complex functionality features. Remember, that certification only describes the features of a product and NOT its practical application!

EHR vendors always point out that they are CCHIT (Certification Commission for Health Information Technology) certified but it means nothing if those features are hard to find, difficult to learn, and too time-consuming in their application. Meaningful use implementation exceeds the current EHR vendor's service capability and as physicians we must collaborate to meet those challenging goals.

With the establishment of Regional Extension Centers (RECs) health care providers will be supported with direct, individualized and on-site technical assistance in selecting a certified EHR product that offers best value for the providers' needs; achieving effective implementation of a certified EHR product; enhancing clinical and administrative workflows to optimally leverage an EHR system's potential to improve quality and value of care, including patient experience as well as outcome of care; and, observing and complying with applicable legal, regulatory, professional and ethical requirements to protect the integrity, privacy and security of patients' health information. The Extension Program expects all Regional Centers to be operating at full capacity by the end of December 2010. In addition, it is expected that by the end of December 2012, the Regional Centers will be largely self-sustaining and their need for continued federal support in the remaining two years of the program will be minimal. Your DCMA is supporting the establishment of a South Florida REC and by December 11, 2009 we will know if the South Florida REC Collaborative will receive the grant funding necessary to start such a service in our community, too. I will keep you posted.

I look forward to reading your comments and suggestions on our blog at <http://miamimedblog.blogspot.com/> or send me a tweet at <http://twitter.com/dadedoc>.

Next month: Practical EHR Solutions for your office.

Disclosure: The author is a practicing family physician, addiction specialist and computer consultant. In addition, he is a founder and managing partner of VirtualMed, LLC (www.virtualmed.com)

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This is a unique program and will prove successful to the extent our Members utilize this program. Below is the list of attorneys who are on the panel, including their specialty and telephone numbers. If you have any questions or comments on this program, please do not hesitate to contact J.A. Ziskind, Esq. at (305) 577-4888.

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**By Cliff Rapp, LHRM
Vice President, Risk Management
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Cliff Rapp is a licensed healthcare risk manager and Vice President for Risk Management of First Professionals Insurance Company, a leading professional liability insurer. Mr. Rapp is widely published and a national speaker on loss prevention and risk management.

First Professionals Insurance Company is Florida's Physicians Insurance CompanySM and the endorsed carrier for professional liability insurance by 22 county medical societies, 15 specialty societies, and two statewide associations in Florida.

The information below does not establish a standard of care, nor is it a substitute for legal advice. The information and suggestions contained here are generalized and may not apply to all practice situations. First Professionals recommends you obtain legal advice from a qualified attorney for a more specific application to your practice. This information should be used as a reference guide only.

According to the American Cancer Society (ACS), cancer is the second leading cause of death in the United States. The ACS has projected that over 565,000 Americans will die annually from various forms of cancer. Misdiagnosis of cancer is one of the most prevalent types of medical errors and accounts for a significant portion of all medical malpractice indemnity paid. Implementing fundamental risk management measures can easily prevent the majority of such claims.

Lung Cancer

Lung cancer is the leading cause of cancer death for both men and women. It accounts for almost 29% of the total cancer deaths in the US. A recent study conducted by the Physician Insurers of America (PIAA) found that communication issues were the most prevalent root cause of lung cancer claims. Failure to respond to an abnormal x-ray and inadequate follow-up were frequent contributing factors to the misdiagnosis of the disease.

The most prevalent root cause of diagnostic error involving lung cancer claims is communication. More than 64% of malpractice claims involve some aspect of inadequate, inappropriate or faulty communication. Approximately one-half of claims involve the failure to respond to abnormal x-rays.

Colorectal Cancer

Colorectal cancer is the third most common cause of cancer deaths for both men and women. While there are a number of non-controllable risk factors (age, personal history of inflammatory bowel disease, polyps and race), there are also several controllable factors that patients can and should be counseled about such as diet, smoking and alcohol usage, as well as the management and control of diabetes and obesity. Although screening tests for colorectal cancer are readily available and have been found to be effective in the early detection and treatment of this form of cancer, screening for colon cancer lags significantly behind the testing done for other cancer forms. The Center for Disease Control (CDC) has found that only 42.5% of adults in the United States over the age of 50 have undergone sigmoidos-

copy or colonoscopy within the past 10 years or had utilized a fecal occult blood test (FOBT) within the preceding year. Almost 60% of the over-50 population has not received proper screening. The CDC estimates that 60% of colorectal cancer deaths could be prevented if everyone over the age of 50 were screened regularly. An analysis of PIAA closed claim data involving colorectal malpractice claims reveals that the most prevalent presenting symptom is rectal bleeding, followed by abdominal pain.

Breast Cancer

Breast cancer accounts for 15% of all female cancer deaths. It is among the most prevalent and expensive types of medical malpractice claims, accounting for 13% of all malpractice claims. Because of its prominence, the PIAA has commissioned several studies of malpractice claims involving breast cancer. The most recent study indicated that 75% of claims involved premenopausal and perimenopausal women, categories generally considered to be less likely candidates for breast cancer. Sixty-eight percent of the patients were under the age of 50.

Most diagnostic errors involving breast cancer are due to the misinterpretation of mammography, inadequate medical record documentation, system failures within the practitioner's office, and communication failures. A majority of the cases indicated a reliance on negative or equivocal mammography. One noteworthy caveat brought to light by the PIAA breast cancer studies is that biopsy should follow suspicious findings. A prevalent root cause for delay in diagnosis is the failure to recommend biopsy for suspicious findings. In nearly 30% of cases, further diagnostic pursuit was not pursued in the face of a diagnosis of fibrocystic disease. Although the patients in these studies were ultimately diagnosed with breast cancer, more than one-half of the patients received a negative mammogram report following the initial presenting examination.

Prostate Cancer

Prostate cancer is the second most deadly form of cancer in males in the U.S. accounting for 10% of all male cancer deaths. Significant risk factors include age (50+), race (African-American), family history of prostate cancer, and high-fat dietary habits. Screening tests for prostate cancer (PSA, DRE) are known to be effective in detecting prostate cancer in its early stages. Although the use of these tests on a widespread basis has become controversial, patients should be given information about these tests. Screening and diagnostic efforts should be well-documented. To prevent claims involving diagnostic error entailing prostate cancer, document the patient's personal and family history. Conduct physical exams with specificity. Patients that are noncompliant with recommendations for consultations, additional testing or procedures should be asked to sign an informed refusal form. Most importantly, ensure adequate follow-up and recall of high-risk patients.

For more information regarding this and other medical professional liability insurance risk management issues, please contact the risk management consultants at First Professionals Insurance Company at (800) 741-3742, ext. 3016, or send an e-mail to rm@fpic.com.

Case Summary

Consider the case involving a 62-year-old male with severe cardiac disease that was hospitalized for pacemaker implantation. A postoperative x-ray to verify pacemaker placement revealed nodular densities, warranting additional investigation. However, the patient was discharged by his PCP before the cardiologist had an opportunity to review the radiology report. The report was faxed to the cardiologist's office, but not yet filed in the chart when the patient presented for a post-op exam. Because the patient's cardiac condition was stable, no additional follow-up appointments were scheduled. The radiology report was filed without having been reviewed by the cardiologist. The patient was subsequently diagnosed with lung cancer 15 months later, expiring three months after the diagnosis. Suit was filed against the PCP and the cardiologist for the failure to diagnose.

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by Jeffrey I. Shavitz, Executive Vice President of Charge Card Systems Inc.

Our research shows that medical practices tend to find themselves engulfed in daily issues and, consequently, the attention to credit card transactions and the corresponding costs are not being adequately and properly addressed. By working with thousands of medical office managers and hospital administrators around the country, we have enlightened them to the hidden fees of credit card processing and how a few simple tricks and education will increase your office's profitability.

The acceptance of credit cards helps to alleviate the monetary constraints being placed on healthcare industry practitioners. However, it is important to avoid the pitfalls associated with taking a credit card for payment. Just like we need to maintain our health by exercising regularly, medical practices must exercise their financial acumen when analyzing whether they have the best "credit card program" for their particular organization.

Yes, the word "program" is critical as there are different programs and solutions depending upon the needs of an organization. What is your rate is the most common question we hear when speaking with practices. Yet the base rate is only part of the equation. The credit card industry has numerous "hidden costs" which can, and will, inflate credit card costs. Unfortunately most medical offices are unaware of the potential pitfalls and how the additional fees are adversely affecting the bottom line.

Did you know that there are different rate structures based upon how a practice is set-up? Similar to when you started your practice, you may have spoken with your accountant to determine the benefits of establishing your business as a Subchapter S, C, LLC or a partnership. In the same regard it is vitally important that your processing account be set up properly. Different rate structures exist depending upon how a transaction will be conducted. For instance, are the majority of your transactions swiped (card and cardholder present) or manually entered (card and cardholder not present)? Did you know that there is a higher fee structure for manually entered transactions?

Visa and MasterCard maintain different rate structures for different types of cards and based upon how a transaction is processed. Credit card companies present these rates in different forms i.e. qualified, mid-qualified, non-qualified. Credit card companies also have other fees such as batch fees, debit fees, annual fees, voice verification fees, address confirmation fees, etc., I think you can understand the point.

In addition to discount rates there are transaction fees. Not having a transaction fee does not necessarily ensure the best rate structure. Companies will "bundle" their rate, combining the discount rate and the transaction fee to give businesses the appearance of a better rate

structure. However, in situations such as this the discount rate will be much higher, which could adversely affect the bottom line. Don't get caught up in the game of not having a transaction fee, it may not make sense for your practice.

Many credit card companies will offer a low introductory rate, which to a layperson will seem unbelievable. However, what will be unbelievable will be the "downgrades" or penalties that a practice will be paying, without even realizing it, because there are so many additional issues that have to be addressed besides a low base rate. In order to run your practice in a financially astute manner, you must know your "effective rate" (takes into consideration all charges) vs. your "base rate", which is the initial rate discussed with your credit card company.

Other issues that are rarely raised is how long until your money is deposited into your bank account – , 12, 24, 48 or 72 hours? Why should you have to wait three days to get your money, doesn't 12 hours sound better? When is your discount fee taken, daily or monthly? Think about the savings on interest, the float of your money plus increased cash flow if your fees were removed at the end of the month? It certainly adds up and these issues will help greatly with your cash management.

Finally, it is important to note that switching processors is not a difficult task. In most cases there is no fee to switch and it typically involves filling out a 2-page application. Why not start saving money today for your practice? It is a much better investment to spend your money on improving your practice vs. wasting money on the high and hidden costs of your credit card processing fees.

Jeffrey Shavitz is a Founder of Charge Card Systems, Inc., which is a DCMA Vendor of Choice and is the merchant services provider for the DCMA. CCS is a nationally-recognized credit card processing company with its corporate headquarters in Boca Raton, FL. CCS has a division, CCS Medical that has been working with medical offices, hospitals and specialty practices throughout the United States since its inception. Mr. Shavitz can be contacted at jshavitz@chargecardsystems.com 1 800 878-4100 or 561-338-4452 or by visiting www.chargecardsystems.com.

Note from the Editor: Charge Card Systems, Inc. is a DCMA Vendor of Choice. DCMA members who convert to Charge Card Systems, Inc. for their credit card transactions are eligible for up to \$300 towards their 2010 membership dues. CCS offers a no cost, no-obligation rate analysis and \$500 cash if they can't save you money. "Switching to CCS was seamless and we're happy to be realizing the savings" said Patricia Handler, EVP of the DCMA.

Top 10 Reasons for Physicians to Asset Protect

10. \$8,570,000: the verdict in Seminole County, Florida for failure to timely diagnose tuberculosis meningitis in a 5-year-old female, resulting in brain damage. Incident Date: September/1995; Trial Date: February/2007.
9. \$30,000,000: the verdict in Broward County, Florida for failure to timely perform a C-section, resulting in severe mental deficiency and paraplegia of newborn. Incident date: May/1991; Trial Date: April/ 2008.
8. \$35,206,000: the verdict in Broward County, Florida for failure to timely diagnose fetal distress and perform a C-section to prevent oxygen deprivation, resulting in severe mental deficiency and paraplegia. Incident Date: January/2000; Trial Date: June/2008.
7. 43%: the recovery probability for medical malpractice claims reported in Florida from 2002 through 2008. (Recovery Probability is the share of plaintiff verdicts to the total number of verdicts rendered for a specific liability.)
6. 42%: the percentage of medical malpractice combined plaintiff and defense verdicts in Florida which are due to an allegation of failure to timely diagnose or an allegation of negligent surgery.
5. 16%: the percentage of the total number of combined plaintiff and defense verdicts in Florida which are in the category of medical malpractice, second only to vehicular liability.
4. \$1,417,745: the median award for medical malpractice verdicts in Florida.
3. \$6,169,796: the mean award for medical malpractice verdicts in Florida.
2. The duty to protect your family's financial future. Rest assured, you will sleep better.
1. Once a claim is brought against you, it is too late to protect your assets!

All data was obtained from Jury Verdict Research, 2009 Florida Verdict Survey.



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A note from the new CEO:

Physicians Advantage has undergone exciting changes over the past several months with new ownership, new management and a renewed commitment to excellence in our products and our client relations. The goal of the new management team is to provide you with the most comprehensive and personalized asset protection, estate planning and financial planning available in the market today.

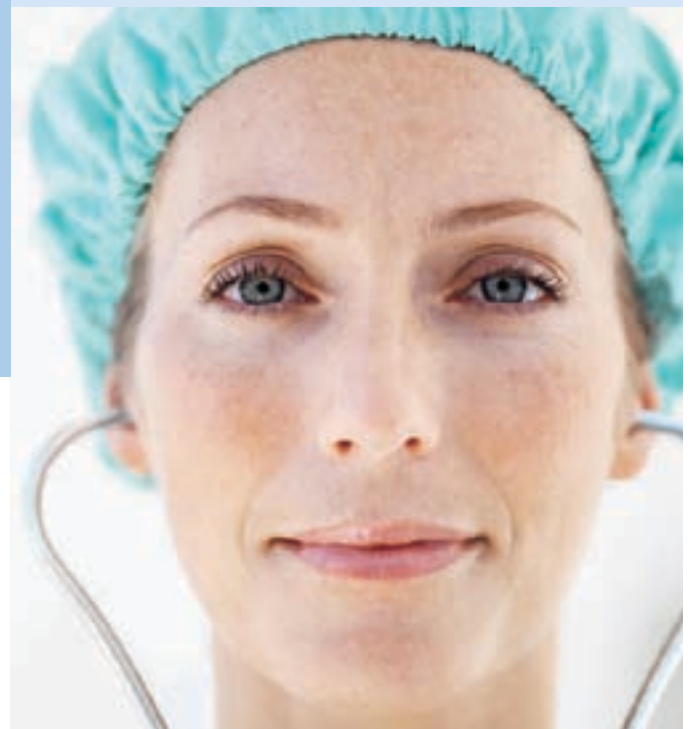
Our flagship program – CAPS+ (Comprehensive Asset Protection Solutions) – provides a team of attorneys, accountants and financial planning experts at a fixed rate to address the specialized needs of physicians. This is a great way in which to get your financial house in order to fully protect the success you have worked so hard to achieve. I look forward to publicly announcing other great products and services in the very near term!

We are proud to have the exclusive endorsement of the Florida Medical Association for asset protection and related services. Our team of professionals at Physicians Advantage is ready to assist you.

P. Butler Ball
Chief Executive Officer



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NEW HIPAA BREACH NOTIFICATION RULES¹

These significant changes affect your practice

By Sharon Roberts, PharmD, JD & Jean Acevedo, LHRM, CPC, CHC, CENTC

As of September 23, 2009, all businesses regulated by HIPAA and any business that offers products or services that use with protected health information are required to:

- **Notify individuals when their health information has been breached;**
- **Update their HIPAA policies and procedures; and**
- **Train employees on updated procedure including what to do if a breach occurs.**

Who is affected by the new HIPAA breach notification rules?

The new rules generally apply to HIPAA regulated entities and business associates. Regulated entities include most health care providers, health plans and health care clearinghouses.

What is considered a breach?

The term "breach" is defined in the rules as the acquisition, access, use or disclosure of protected health information, in a manner not permitted under the privacy regulations, which compromises the security or privacy of protected health information. A breach will compromise security or privacy if it poses a significant risk of financial, reputation or other harm to the individual. The rules state that determining whether there is a significant risk of harm to an individual will require assessing several factors, such as who impermissibly used the information, and the type and amount of the information.

Do all breaches require notification?

No. Regulated entities and business associates must do the following to determine whether notification is required under the HHS rules:

- Determine whether there has been an impermissible use or disclosure under the HIPAA privacy rules
- Determine whether the impermissible use or disclosure compromises the privacy or security of protected health information. For example, if a physician's office faxes patient information to hospital A when the information should have gone to hospital B, there may be less risk of harm to the individual, since the recipient entity is obligated to protect the privacy and security of the information it received in the same or similar manner as the entity that disclosed the information.
- Determine whether any exceptions apply
- Determine whether the breach involves unsecured protected health information

When is notice of a breach required, and to who?

Notice to the Individual

If there is a breach, a regulated entity must notify individuals as soon as possible, but no later than 60 days after discovery of the breach. A breach is considered discovered on the first day it is known to any member of the regulated entity's workforce (other than the person who committed the breach), or the date it would have been known if the regulated entity exercised reasonable diligence. Notice must be sent to the individual's last known address, or by e-mail if the individual agrees and the notice must be written in plain language and contain:

- A brief description of what happened, including the date of the breach and date of discovery
- The types of PHI involved (such as whether full name, SSN, date of birth, home address, account number, diagnosis, disability code, or other types of information were involved)
- Any steps individuals should take to protect themselves from potential harm
- A brief description of steps the regulated entity is taking to investigate, mitigate losses and protect against further breaches
- Contact information for individuals to ask questions, including a toll-free telephone number, e-mail address, website, or postal address.

The regulation provides the following example of a breach: *For example, a covered entity, due to a lack of reasonable safeguards, sends a number of explanations*

of benefits (EOBs) to the wrong individuals. A few of the EOBs are returned by the post office, unopened, as undeliverable. In these circumstances, the covered entity can conclude that the improper addressees could not reasonably have retained the information. The EOBs that were not returned as undeliverable, however, and that the covered entity knows were sent to the wrong individuals, should be treated as potential breaches.

Notice to the Media

The new rules also require regulated entities to notify the media where the breach involves more than 500 residents in a state. The notice must be made to prominent media outlets serving the state, include the same content as the individual notice, and be provided within the same timeframe (i.e., 60 days).

Notice to HHS

The new rules require regulated entities to notify the Department of Health and Human Services (HHS) of any security breach, based on the number of individuals involved.

- When a breach involves 500 or more people, the rules require a regulated entity to notify the Secretary of HHS immediately.
- When a breach involves less than 500 people, the rules require a regulated entity to maintain a log of security breaches and submit it to HHS on an annual basis.

Five Essential Steps Regulated Entities Should Take.

Step 1 - Establish Breach Notification Procedures and Update Policies. Regulated entities, which include physicians who submit claims electronically, need to establish procedures to determine when a breach has occurred, who will prepare individual notifications, and when a breach will trigger a requirement for notice to the media or immediate notice to HHS;

Step 2 - Amend the HIPAA privacy and security policies to incorporate information on the security breach notification rules;

Step 3 - Maintain Breach Incident Log to record security breaches, which the regulated entity must file with HHS within 60 days after the end of the year. A log is required for breaches affecting fewer than 500 individuals;

Step 4 - Train staff regarding the 60-day breach notification date that will be triggered from the date a breach is discovered by anyone in the regulated entity's workforce. Employees must understand how to report it. Training may include building awareness through policies, postings and formal instruction; and

Step 5 - Revise your Business Associate Agreements regarding the timing for a business associate to notify the regulated entity of a breach by the business associate, what information should be reported, and which party will issue the required notifications. If your Business Associate doesn't notify you in a timely manner, there may not be time for you to investigate the breach and take required actions within the maximum of 60 days allowed.

How much time do Regulated Entities have to prepare?

Although the new rule was implemented as of September 23, 2009, HHS has stated it will not impose penalties until February 22, 2010.

¹ **Federal Register** / Vol. 74, No. 162 / Monday, August 24, 2009.

Article written by Sharon Roberts, RPh, PharmD, JD., and Jean Acevedo, LHRM, CPC, CHC, CENTC. Ms. Roberts is a former State of Florida, Department of Health Inspector, and is now a practicing healthcare law attorney and pharmacist in Palm Beach County, FL, who specializes in regulatory healthcare practice with the law firm of Strawn & Monaghan, P.A. She can be reached at 561-278-9400. Learn more about Ms. Roberts and her firm at www.healthandregulatorylaw.com. Ms. Acevedo is the founder of Acevedo Consulting Incorporated; a coding and compliance consulting firm in Delray Beach, FL. She can be reached at 561-278-9328. Learn more about Ms. Acevedo and her firm at www.AcevedoConsultingInc.com.

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