North Dakota Medical Association

Checkup

January 2010

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JANUARY 2010

North Dakota Medical Association

Checkup

The mission of the North Dakota Medical Association is to promote the health and well-being of the citizens of North Dakota and to provide leadership to the medical community.

The NDMA Checkup is published quarterly by the North Dakota Medical Association, 1622 E. Interstate Avenue, P.O. Box 1198, Bismarck, ND 58502-1198, (701) 223-9475, Fax (701) 223-9476, e-mail: staff@ndmed.com

SUBMISSIONS: The NDMA Checkup welcomes manuscript, photography and art submissions. However, the right to edit or deny publishing submissions is reserved. Submissions are returned only upon request. Letters to the Editor with name, address and phone number of the author are welcome. All letters are subject to editing.

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PRESIDENT'S *Message*

Kimberly Krohn, MD

Transforming Medical Practice ...One Physician at a Time

I was honored to ascend to the presidency of the North Dakota Medical Association at our Annual Meeting September 25. I feel that I need to share a bit about myself with our membership and to explain the theme for my presidency. But first I would like to thank Immediate Past President Dr. Rob Thompson for his dedication to us. He's been exactly the right physician to lead our organization during the past two years. This position involves a ten-year commitment which Rob has been willing to make and has fulfilled well. He's a political enthusiast with years of experience in health system administration and a real grasp of health care financing issues of a local and global nature. His email address name in my mailbox comes through in all capital letters, and that's how I view this North Dakota physician leader–a real capital letter guy. I am pleased that ROBERT THOMPSON will continue to provide leadership in our congressional liaison work in the area of health reform and other NDMA projects.

I came to North Dakota in 1979 thinking I would live in Minot for about 18 months. I had a new degree in dietetics from Michigan State University, and luckily St. Joseph's Hospital had a clinical dietitian job opening, I was the only applicant, and I was hired! I later obtained a Masters of Public Health degree in Healthcare Administration from University of Minnesota and soon after I graduated prepared my application to the UND School of Medicine. I realized that health care administration was not going to be fulfilling enough; my commitment to clinical care was too deeply rooted. I started medical school when my youngest son started first grade. I was 10 years older than my average classmate. I entered the Minot family medicine residency upon graduation from medical school and joined the residency faculty upon graduation from residency. I am now the director of the Minot residency providing a full scope of family medicine care to my patients and teaching the residents in all health care settings–home visits, nursing home care, outpatient and inpatient care. I have a great team at home which includes my husband John Fishpaw and our three sons. A stronger supporter of our medical school could not be found–I would never have been able to be a physician in Minot, ND without our unique school.

My most important attribute to be your president is that I have enough job flexibility that I believe I will be able to maintain employment and be NDMA president at the same time and I am in that stage of life where family and personal responsibilities will allow it, too. I have been working very hard over the past seven years, since I joined the Council, to be prepared for this moment–but I've had a lot of help. Our AMA Delegate Gaylord Kavlie, former NDMA Presidents Shari Orser, Rob Beattie, and Rob Thompson, and the nominating committee chair who asked me to run for NDMA office, Jack Kerbeshian, have all been great models of leadership and have been kind enough to grace me with their friendship. Bruce Levi, Dave Peske, Annette Weigel, Dean Haas, and Leann Tschider have all helped me to avoid looking foolish on the many opportunities during which it was possible. I have learned many things along the way–what "SGR" means, how to spell Leann's name, and the fact that it stinks to be a woman president because you have to find a long dress to wear to the AMA inauguration ceremony. I have learned how rewarding it is to become an effective participant in our legislative processes and to share the responsibility of improving care for our patients with fellow physicians and other professional partners. But I have a long ways to go and will need the help of our entire membership to represent you most effectively.

It is the tradition that each NDMA president has a "theme" of sorts. My predecessors have all taken the ones that by rights should have been mine–quality, leadership, personal wellness. I've appreciated their dedication to these individual themes. Our organization will be resonating for a long time with the ideals that they each brought

with them. My theme is "transforming medical practice one physician at a time". Some of you in family medicine know that the AAFP has launched an initiative called TransforMed to support family physicians in making the transition to patient-centered medical homes. My theme obviously has to be one that applies to all of our members, so the transformation I'm talking about has to do with providing intelligent, thoughtful leadership in a time of change while "skating to where the puck will be" as far as our clinical systems and elements of care are concerned. As an organization, NDMA can provide support for these transformations. I believe that as physicians, we will need to be open-minded about the following which will be essential components of clinical care now and in the future, united in focus by maintaining the patient as the focus of our clinical systems:

• Health Information Technology for greater communication between doctors, reduction of duplication, and data gathering to monitor quality indicators.

• Prospective chronic disease management

• Transformation of communication systems with patients

• Transformation of outpatient clinic scheduling to enhance access

• Medical information at the point of care.

• Reflective practice that looks at outcomes, not just process

• Change in the structure of practices and practice procedures:

- Eliminating waiting rooms physically and by making them obsolete
- Exploring group visits, evisits, etc.

• Exploring lifestyle balance

• Maintaining relevance in medical knowledge and practice, whether by maintenance of certification or other means

• Leadership knowledge and development in order to guide teams to develop programs/structures to best care for our communities

Our Council has been a hard working one this year. We are strengthened by an incredible staff. Our organization, however, is only as strong as our weakest member, and I hope this year will see us grow in strength, stature, and number. I believe that we will transform our organization together as the organization helps to support our membership in the transformation of their medical practice. I thank all of you for all your contributions to our profession and our organization. I promise in the year ahead to represent you with intensity and integrity. Thank you for joining me in the service of our profession.

New NDMA President Kimberly Krohn, Program Director for the family medicine residency program at the UND Center for Family Medicine in Minot, is shown here with her colleagues at the Center.

North Dakota Medical Association

Annual Meeting Highlights

The 122nd Annual Meeting of the NDMA House of Delegates elected new officers and adopted resolutions including a resolution expressing physician views on national health system reform. Newly-elected NDMA officers are Kimberly T. Krohn of Minot, President; A. Michael Booth of Bismarck, Vice President and Board Chair; Steven P. Strinden of Fargo, Secretary-Treasurer; and Debra A. Geier of Jamestown, Speaker of the House.

At the annual awards dinner, Timothy J. Mahoney of Fargo received the *NDMA Physician Community and Professional Services Award* and Patrick Traynor of Dakota Medical Foundation received the *NDMA Friend of Medicine Award*.

New NDMA Policies Adopted

The NDMA House of Delegates adopts policy through resolutions introduced by District Medical Societies, individual NDMA members, and the NDMA Council. Through the leadership of House Speaker Steven Strinden, the following resolutions were adopted at the meeting:

National Health Care System Reform: A resolution was adopted 1) urging the ND Congressional Delegation as part of health system reform to pursue multiple avenues for Medicare physician and hospital payment reform that address the unfair disparity in Medicare payments to ND as recommended by the joint NDMA/NDHA Medicare Payment Task Force; 2) supporting efforts of Senator Kent Conrad to initiate a CMS demonstration project in ND to pilot rural models of health care delivery that focus on creating an accountable state system of care, assistance for health care infrastructure development, and fair payment for the provision of physician and hospital services; and 3) urging the U.S. Congress to enact meaningful health system reform that ensures access by people in North Dakota to health care and enhances high quality, cost-efficient medical care.

State Health Information Technology Plan: A resolution was adopted urging the NDMA to participate fully in state efforts to develop a state health information technology plan and leverage state and federal resources to support connected and interoperable health information technology systems.

Workers Compensation Coverage for Workers with Preexisting Degenerative Conditions: A resolution was adopted urging the 2011 ND Legislative Assembly to amend the workers compensation statutes to afford workers compensation coverage to workers with preexisting and degenerative conditions.

Cost and Availability of Health Insurance Coverage and Unmet Health Care Needs: A resolution was adopted urging interim committees of the ND Legislative Council, the Commissioner of Insurance, commercial insurers and others to address physician concerns regarding the cost of health insurance and unmet health care needs in the state, including the need for imposing fair contracting standards on commercial health insurers, facilitating more competition in the health insurance market in ND, and recognizing that physician and hospital payments and health insurance premiums of BlueCross BlueShield of ND are much lower than commercial insurers in states

Congressman Earl Pomeroy and Senator Kent Conrad addressed the NDMA House of Delegates on health system reform.

in our region.

Access to Medically-Based Psychiatric Services: A resolution was adopted urging the medical community, including psychiatrists and primary care physicians and the UND School of Medicine & Health Sciences and residency programs and NDMA, to work together with the interim Judicial Process Committee and others to address the availability of medically-based psychiatric services in the state.

Supportive Services for Pregnant Minors: A resolution was adopted urging the interim ND Legislative Council Health and Human Services Committee to consider expanding supportive services for pregnant minors and consider physician views on their experience implementing the new law [NDCC 14-10-19] on minor consent for pregnancy testing, prenatal care and pain management.

Medication Preauthorizations: A resolution was adopted urging Medicare Part D providers to adhere to the following principles in the design of pre-authorization procedures:

1. Physicians should be provided with a streamlined method of submitting a pre-authorization request; long phone hold times should not be used as a method of deterring pre-authorization efforts. If a form is required, it should be readily available without a phone call.

2. Decisions about pre-authorization requests should be produced in a timely manner and should include clear information about appeal processes. Non-physicians should not be making final appeal decisions.

3. Enrollees should be provided with clear information about coverage of medications by their Part D provider.

4. Medications new to the market should not be automatically required to pass through a pre-authorization process without an evaluation of costs and benefits.

5. Appeals because of individual patient characteristics should be available and carefully considered for all enrollees.

The resolution also called on NDMA to consider pursuing legislation similar to Minnesota requiring the use by payors of a uniform pre-authorization or formulary exception form.

Increase in the Number of Family Medicine Residency Positions: A resolution was adopted supporting the expansion of family medicine residency positions in ND through support of both federal and state legislation and/or other policy advocacy to initiate and fund these positions.

Incentives and Disincentives for the Retention of ND-Trained Residents: A resolution was adopted for NDMA to study issues important for the retention of graduating North Dakota resident physicians in positions in the state and to support efforts to retain them; and to support efforts to retain ND-trained residents in the state. The resolution directed NDMA to study and urge appropriate changes in ND medical licensure laws to remove disincentives for residents who are graduates of international schools to remain in the state.

Dr. Thompson led a panel presentation on physician leadership, with Drs. Casey Ryan, Tim Mahoney and Craig Lambrecht.

Dr. Mahoney Recognized for Community and Professional Service

Timothy Mahoney, MD, received the NDMA 2009 Physician Community and Professional Services Award at the annual meeting banquet. The award recognizes outstanding members of the Association who serve as role models, active in both their profession and in their community.

Dr. Mahoney was recognized for his professional and community work spanning over 35 years in North Dakota.

Dr. Mahoney practices medicine at Innovis Health in Fargo, and is the Chief Medical Officer for Divisions & Strategy. Dr. Mahoney played an instrumental role this past year as Deputy Mayor in the flood fight in Fargo. He also serves on the Fargo Economic Development Board, Fargo Family HealthCare Center Board of Directors and Finance Committee, the Board of Fargo-Cass County Public Health, the Greater Fargo Moorhead Economic Development Commission, Fargo-Moorhead Metropolitan Council of Governments, Metropolitan Flood Management Work Group, and the Fargo Native American Commission.

Dr. Mahoney was presented the award by NDMA President Robert Thompson. Thompson said, "Physician leadership is the key to so many of the challenges faced in both the medical community and our communities as a whole. Tim has been an effective leader in working with people to develop solutions and to make a difference for physicians and their patients." Tim's father, James Mahoney, received the NDMA Physician Community and Professional Services Award in 1981.

Pat Traynor and Tim Mahoney were recognized for their service at the NDMA annual meeting.

Physicians Recognize J. Patrick Traynor as Friend of Medicine

J. Patrick Traynor received the NDMA "Friend of Medicine" Award. The Award formally acknowledges non-physician citizens of the state who "have distinguished themselves by serving as effective advocates for health care, patient services, or the profession of medicine in the state of North Dakota."

Under Mr. Traynor's leadership since 2000, the Dakota Medical Foundation has adopted a dynamic results-oriented strategic planning process and an aggressive grant-writing program which has secured over $12 million since 2002 to measurably improve health and access to healthcare services.

The Foundation's efforts have included placement of automated external defibrillators in local police and rural first responder vehicles to provide immediate medical treatment to victims of cardiac arrest. The Foundation provides many health career scholarships, and continues to support prescription assistance allowing individuals to obtain life-sustaining medications. As an advocate for children's health, under Pat's leadership, the Foundation sponsors a children's mental health program that facilitates the development of community children's mental health resources and education, and improves access to screening, diagnosis and treatment for children with mental health issues.

Mr. Traynor also spearheads important health programs, including a crucial program to ensure an adequate supply of physicians, nurses, and other medical personnel to serve our region and the 'Covering Kids and Families Initiative,' that connects uninsured North Dakota children and families to free/low-cost healthcare coverage.

Pat was nominated for the award by the First District Medical Society.

Expand J-1 Waiver Opportunities in North Dakota: A resolution was adopted for NDMA to study J-1 waiver opportunities and their utilization in ND; and to support efforts to allow J-1 waivers to be used for academic positions.

State Tobacco Prevention and Control Program: A resolution was adopted supporting the comprehensive tobacco plan "Saving Lives, Saving Money: ND's Comprehensive State Plan to Prevent and Reduce Tobacco Use," and the essential goals of decreasing the number of people who start using tobacco products, increasing the number of tobacco users who quit, and eliminating exposure to secondhand smoke; and supporting the ongoing tobacco prevention and control efforts and funding of Measure 3.

Governor Hoeven Speaks to NDMA

In addition to the business of medicine that took place in the House of Delegates, Governor John Hoeven spoke at the NDMA luncheon. The Governor spoke on a number of topics, addressing health system reform specifically and talking about the health information technology initiative underway through the HIT Advisory Committee he appointed under legislation enacted by the 2009 ND Legislative Assembly.

"Real reform," said Governor Hoeven, should include:

- Real tort reform.
- Enhanced competition for purchasing healthcare insurance.
- Transparency in billing.
- Portability.

- Eliminate or reduce denial of coverage for preexisting conditions.
- Promote the purchase of healthcare insurance through tax credits.
- Insure disenfranchised children, and work to bring already eligible children into the existing SCHIP program.
- Create a cohesive information technology system for healthcare information to create efficiency and save costs.
- Promote meaningful wellness and prevention programs.

Excellent presentations were also heard by attendees on physician leadership in North Dakota and the impact of generational change on the practice of medicine.

Dr. Thompson is recognized for his two terms as NDMA president.

SAVE THE DATE!

The 2010 NDMA Annual Meeting will be held in Fargo on Thursday-Friday, September 9-10.

Involved in a Medical Audit? Contact NDMA!

Dean Haas, General Counsel

This article summarizes physician (and hospital) appeal rights in four audit situations: Medicare Recovery Audit Contractor audits (RAC); Medicaid Integrity audits (MIC); Blue Cross Blue Shield North Dakota audits (BCBSND); and Workforce Safety and Insurance audits (WSI). Your NDMA is a primary source for you to turn when audited; we offer legal services enabling your organization to create an "appeals team," and the necessary paperwork to file an initial appeal.

Medicare Recovery Audit Contractor (RAC) Audits

The Recovery Audit Contractor program, created by the Medicare Prescription Drug, Improvement, and Modernization Act of 2003, was designed to find and correct "inappropriate payments," for Medicare services. A vast majority of the Medicare denials relate to hospital charges; the financial health of hospitals may depend upon their ability to fight to keep income to which they are entitled. According to many legal experts, medical providers who hire attorneys to dispute payment denials frequently prevail; the RAC auditors, paid a contingency fee from the 'overpayment,' may well decide to spend their time and resources on the cases in which providers do not vigorously contest their determinations. And the statistics bear this out. Although CMS reports that only 5% of determinations were overturned on appeal, only 11.3% of the RAC determinations were appealed. Though the number of appeals was small, 44.2% of the appealed claims were decided in the provider's favor. And the denial categories seem promising: almost half of the improper payments were attributed to incorrect coding, 32% for medically unnecessary service or setting, and 9% to no or insufficient documentation.

The RAC in our Region D is Health Data Insights, and its website recently approved by CMS–with which providers should be familiar–is www.racinfo.healthdatainsights.com/ HDI's website contains a list of new issues approved by CMS. The audit 'look back' period is three years. The audits focus on diagnosis related groups (DRG) compliance, unreasonable 'units' billed (Medicare rules prohibit billing units until half or more of the time for the next unit has passed–HDI identified billing excessive units relating to administration of neulasta, bronchoscopy, IV hydration, blood transfusions, and 'untimed codes'), and bundling (HDI is currently focused on urological bundling, wheelchair bundling, and knee orthotic bundling). The audits will eventually also be expanded to questions of medical necessity.

Clearly, physicians and other medical providers must establish a systematic appeal process for RACs and ensure that they respond to record requests and make their filings within the required timeframes. There are a number of things providers must do internally to ensure that they can subsequently hand off the case to their attorneys. Providers must: 1) ensure that they focus on clinical documentation; 2) monitor problematic areas that are currently, or likely to be, subject to review; 3) implement a RAC team; 4) establish record management protocols; and 5) monitor government websites.

And in order to properly work up appeals to challenge denials in the appeals process, providers should also employ or retain certified coders–CMS is requiring RACs to use certified professional coders in their reviews, so if the medical practice or facility doesn't have certified coders, they won't be able to talk peer-to-peer and won't have the experts available to help the attorneys present the case. Because the RACs employ RNs and a medical director, many medical providers employ nurse auditors in the business department to review rejected front-end claims edits. Medical necessity issues will likely require physician involvement.

The process begins as the RAC identifies potential cases for review through proprietary analysis of the Medicare claims file. There are two types of review–an automated review (without records) and a complex review (review of medical records by non-physicians). The provider's records must be delivered to the RAC within 45 days–and records may be provided via paper, or on CD/DVD. The RAC has 60 days to review the record and notify the provider of the outcome of the review. There is an opportunity to engage in a 'discussion period' with the RAC, outside of the formal appeal process. Engaging in the discussion period does not stay running of the time to file the formal appeal petition.

The Appeals Process

A provider should retain legal counsel in the appeals process, and must also be prepared to retain expert witnesses. Your NDMA is contemplating the extent to which it may have the ability to assist; at a minimum, we can help review the initial case and assist proper filing for review, and refer to private counsel, if necessary.

The first level of appeal is redetermination. 42 CFR §§ 405.940-958. Providers must file a written request for redetermination within 120 calendar days from receiving the initial determination. A provider may forestall recoupment if the appeal is filed within 41 days. When filing the request for redetermination, the provider must explain why it disagrees with the contractor's determination and should include any evidence that it believes should be considered by the contractor in making its redetermination. The RAC contractor has 60 days to transmit notice of its redetermination decision, which is extended an additional 14 days if the provider submitted additional evidence after filing the redetermination request. The notification must include a description of the procedures that a party must follow in order to request reconsideration.

The second level of appeal is reconsideration with a qualified independent contractor, (QIC) as defined by 42 CFR §§ 405.902-968. Providers must file this request within 180 calendar days, or within 60 days to avoid immediate recoupment. Providers must submit a full presentation of evidence at this stage, including reasons for disagreement with the initial determination and redetermination, which must include any missing documentation identified in the notice of redetermination. It is important to note that absent good cause, the provider's failure to submit evidence in the reconsideration filing precludes consideration of the evidence in later stages of the appeal. The QIC has 60 days to transmit notice of its decision, which is extended an additional 14 days if the provider submitted additional evidence after filing the request for reconsideration. If the QIC fails to act in a timely manner, the provider may request an Administrative Law Judge (ALJ) hearing. Reconsiderations are simply record reviews, but medical necessity reviews must be performed "by a panel of physicians or other appropriate health care professionals, and be based on clinical experience, the patient's medical records, and medical, technical, and scientific evidence of record."

The third level of appeal is the ALJ hearing. 42 CFR §§ 405.1002-1063. The request must be filed within 60 days following receipt of the QIC's reconsideration decision. ALJ hearings are generally conducted by video-teleconference, or in person if the technology isn't available or if the ALJ offers to do so upon request of a party. CMS or its contractors may participate in the ALJ hearing without necessarily joining as a party, but may also join as a party. Discovery is only permitted if CMS elects to participate in the hearing as a party. The provider has a right to present evidence (but absent good cause, only records presented to the QIC will be admitted), including through witnesses, and written and oral argument. The evidence must be submitted before the hearing, and written arguments must be provided to all parties at the same time as presented to the ALJ. An ALJ generally has 90 days to act (180 if the appeal was escalated to her because the QIC had failed to act). The ALJ's decision must provide findings of fact, conclusions of law, and the reasons for the decision, based upon the evidence in the record and offered at hearing, which is a recommended decision directed to the Medicare Appeals Council. Though bound by national coverage decisions and CMS rulings, unlike the QIC, the ALJ is not bound by local coverage decisions.

The fourth step is the Medicare Appeals Council

(MAC), the Appeals Board of HHS. 42 CFR §§ 405.1102-1110. A MAC review must be filed within 60 days of receipt of the ALJ's decision. A MAC review is also available if the ALJ doesn't issue a timely decision. The MAC review is de novo (a new review not bound by previous decisions), but the review is limited to the exceptions raised by the party requesting review. However, the MAC may also review any ALJ decision on its own motion–sometimes through a referral by CMS or its contractors–and if it does do, may review any "error of law material to the outcome of the case," or matter presenting a "broad policy or procedural issue that may affect the public interest."

The fifth and final step in the appeals process is judicial review in federal district court. 42 CFR § 405.1136. The appeal must be filed in the district where the party resides, and within 60 days of receipt of the MAC decision. As usual in administrative law, the findings of fact made by HHS are conclusive if supported by substantial evidence.

Old Claims

An issue currently being litigated is whether the ALJ's and MAC have jurisdiction to consider challenges to re-opening 'old' claims–Medicare regulations place restrictions on the permissible timeframe to reopen initial determinations, limiting contractors to re-examine claims over a year old, or with good cause, four years. 42 CFR § 405.980. The Medicare Appeals Council decided that ALJ's and the MAC do not have jurisdiction to consider challenges to a reopening that might violate the timeframes. *Critical Care of North Jacksonville v. First Coast Service Options, Inc.,* (February 29, 2008). A California provider filed an action in federal district court in March 2009, alleging that the RAC unlawfully reopened 'old' claims submitted by the hospital. NDMA will keep you abreast of developments.

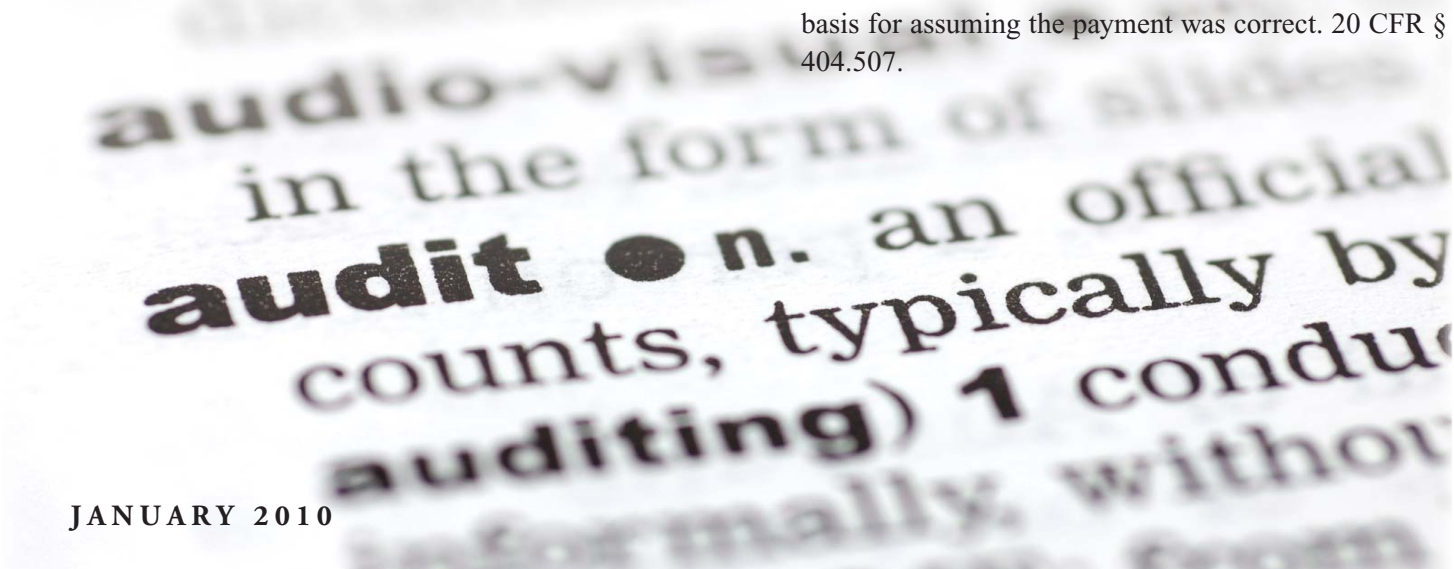
The Treating Physician Rule

The treating physician rule may assist providers in cases of medical necessity, which reflects the common sense idea that the treating physician is in the best position to understand the patient's medical requirements. The rule has been accepted in the Eighth Circuit (the federal appeals court for North Dakota): "[t]he treating physician rule premised, at least in part, on the notion that 'the treating physician is usually more familiar with a claimant's medical condition than are other physicians.'" *Thomas v. Sullivan*, 928 F.2d 255, 259 n.3 (8th Cir. 1991). Where applied, the treating physician rule provides greater weight to the opinion of the treating physician, which will prevail absent substantial contradictory evidence.

Waiver of Liability and Provider Without Fault Defenses

Under the waiver of liability defense, providers might be entitled to payment for claims deemed not reasonable and necessary by CMS and its contractors during the audit, if the provider did not know, and could not reasonably have been expected to know, that payment would not be made. 42 U.S.C. § 1395pp. For example, in situations where a provider receives an overpayment demand, if the provider had previously been subject to claims reviews or Medicare audit where similar claims were approved, then these decisions can be used to demonstrate that the provider did not have reason to know that payment would not be made in a same or similar case. Waiver of liability generally only applies to determinations that a service was not medically necessary.

Similarly, a provider without fault defense is available if the provider had exercised reasonable care in billing for and accepting payment, had complied with all pertinent regulations, made full disclosure of all material facts, and on the basis of the information available, had a reasonable basis for assuming the payment was correct. 20 CFR § 404.507.



Provider without fault arguments might be based on communications disseminated to the provider community generally, or to the provider specifically. For example, if a provider had a favorable conversation with a Medicare contractor regarding a specific matter, the provider should *contemporaneously* document the call in writing, so if the claim is subsequently denied, it can argue that it was without fault, having relied on the representation that payment would be made.

Extrapolation

Finally, CMS has the authority to audit a small sample of providers' medical records, and if it finds an overpayment, extrapolate the overpayment to the provider's entire patient population. If an extrapolation is flawed, it may be successfully challenged, bringing the total dollars at issue to the 'actual' alleged overpayment, rather than the much larger extrapolated overpayment–big numbers are frequently at stake. 42 U.S.C. § 1395ddd, limits extrapolation to cases involving "a sustained or high level of payment error; or documented educational intervention has failed to correct the payment error." Currently, the RAC's are not utilizing extrapolation. If they do in the future, providers challenging the validity of the extrapolation must engage the services of a qualified statistician expert witness to testify regarding the sample chosen and statistical extrapolation performed.

Medicaid Integrity Contractor (MIC) Audits

Medicaid Integrity audits are expected to recover more in 'overpayments' than the CMS RAC program for Medicare. North Dakota's July 2009 Medicaid Provider Bulletin notes that CMS awarded the audit contract to Health Management Systems (HMS); the first audits are being conducted now.

The MIC audit process is unique compared to other forms of CMS Audits such as RAC. The appeals process is managed at the State level and will vary from one state to the next. Also, unlike the Medicare RAC auditors, MIC auditors currently are not bound by limits on the number of claims records they can request in each audit. And also unlike the Medicare RAC program, the Medicaid Integrity Program does not have restrictions on how far it can 'look back,' to identify overpayments, though generally the Medical Integrity Program expects to follow state policies with regard to look back periods–in North Dakota the look back period is six years. MIC audits are conducted in distinct steps with each managed by a different type of MIC Audit Contractor.

The Review MICs are contracted to review actions of entities that provide Medicaid items or services. They are tasked with evaluating risks to the Medicaid programs, in terms of both financial risks and risks related to quality of care. They are also looking for indications of potential fraud, waste and abuse. Providers will most often be selected for audits based on data analysis by the Review MICs. They also will be referred to the Audit MICs by State agencies. The Division of Fraud Research and Detection will utilize algorithms to help the Review MICs identify Medicaid providers whose billing activities indicate the potential for inaccurate payments. Providers will be ranked in terms of risk, to help prioritize MIC audits.

The Audit MICs are contracted to conduct claims audits based on the findings and recommendations of the Review MICs, or by referral from the state agency. CMS will ensure that its audits don't duplicate state audits of the same providers. Audit MICs have the authority to request copies of records, often via a letter. They also have the authority to request interviews with office personnel and have access to facilities. Requested records must be made available to the Audit MICs within the requested timeframes. In North Dakota, providers will generally have up to thirty days before the start of an audit to provide initial documents to the Audit MICs.

After completion of the audit, the Audit MIC is expected to prepare a draft audit report. The report will be shared with the state Medicaid agency for review and comment, specifically to ensure that the state's Medicaid policies were appropriately interpreted by the MIC, and then shared with the provider who will have thirty days to comment and submit additional supporting information. CMS will take these comments into consideration and will prepare a draft report, which will again be reviewed by the state for comment. After taking the state's comments into consideration, the Audit MIC will submit a final report to the state. The appeals process described in the next section begins when the provider is given notice of the final audit report.

Unlike other forms of CMS Claims audits, the State, not the auditor, will pursue the collection of any overpayments in accordance with State law. But the Audit MICs will be available to provide support and assistance to the State throughout the adjudication of the audit.

Audit and Appeals Strategies

In contrast to the RAC audits, the MIC audit process

offers valuable opportunities to resolve the matter prior to the formal appeal. First, an "entrance conference" may be an opportunity for the provider or entity to gain an understanding of why it was targeted by the Audit MIC. This may provide valuable insight into what the Audit MIC is looking for with regards to the records request and can help providers respond with all of the relevant information to aid the Audit MIC in its decision. The opportunity to comment on the audit report and submit additional information before finalization is another valuable opportunity for providers.

As with any third party payor audit, an effective compliance plan is the best defense. Because providers are chosen for audit based on the identification of aberrant billing practices, providers should perform a self-assessment or hire an independent auditor to determine whether their claims will be considered outliers. Some examples of aberrancies that have been identified by the Medicare Program Integrity Program for audit are: services after death, duplicate claims, bundling, and outpatient claims during inpatient stay. A recent GAO report indicated that 90 percent of all Medicaid payment errors were related to insufficient or lack of documentation. Thus, providers should expect documentation related to Medicaid services to be carefully scrutinized. Other sources of payment errors identified in the GAO report were pricing errors and payment of non-covered services.

Provider's Hearing/Appeal Rights for Medicaid Billings

A North Dakota provider's appeal rights are governed by N.D.C.C. § 50-24.1-24, which states that a 'provider' (defined as an individual or entity that furnished medical services or supplies pursuant to a provider agreement with the department), may request a review of denial of payment for services provided to an eligible individual. The written request must be filed within 30 days of the department's denial of the claim, and include a statement of the disputed items, and basis for the dispute. Then, within 30 days of its review request, the provider must provide all documentation, including exhibits (i.e., the informal hearing 'record'), and written arguments that support its demand, along with "a computation and the dollar amount that reflects the provider's claim as to the correct computation and dollar amount for each disputed item." The provider may obtain an "informal conference," (which opportunity should be seized), but it doesn't appear that there are any rights to a formal (oral) hearing to present live witnesses to testify. If a provider deems such an

opportunity to be essential, please contact me–as your NDMA legal counsel, I'd appreciate an opportunity to help–because an argument may be made that due process requires an oral component in order to reduce the incidence of error, or to present witnesses.

In an effort to ensure an unbiased decision-maker, the legislature requires that the hearing officer must be an individual who had not been involved in the initial denial. The department's final decision is due within seventy-five days of receipt of the notice of request for review, and must conform to the requirements of the Administrative Practices Act, N.D.C.C. ch. 28-32. The factual findings of the Department are accorded deference, as the court

merely inquires whether a reasoning mind could have made the finding on the evidence. *Steen v. Department of Human Services,* 1997 ND 52, ¶ 9, 562 N.W.2d 83.

Disputing Decisions of BlueCross BlueShield of North Dakota

Opportunities to dispute BlueCross BlueShield of North Dakota decisions are limited by contractual provisions that allow BCBSND to set the terms of the debate, by the carrier's convoluted grievance and appeal procedures, and the rather limited legal protections afforded medical providers by state law. As is well-known, provider contracts generally allow BCBSND to make decisions that providers cannot dispute. One such pernicious practice contained in the managed care contract grants to BCBSND the "right to offset… from future payments," without providing any notice or opportunity to protest. While North Dakota law defines 'medically necessary care' in terms of a 'reasonably prudent physician,' it also allows the insurer to set the terms of coverage, as N.D.C.C. § 26.1-04-03(17) provides that "[t]his definition does not preclude an entity from establishing a definition of 'medically necessary care' for determining which services are covered by the health plan.") In this regard, the Blues' provider contracts generally define "medically appropriate and necessary care" as that which is "determined by BCBSND," which may allow the carrier to determine what is medically necessary under the criteria, and provide BCBSND to unilaterally determine whether the services are 'covered.' Similarly, BCBSND's definition of "medical management" place additional conditions upon "medically appropriate and necessary care," e.g., that the care be "high-quality," provided in "a cost-effective" manner, but neither term is defined in the contracts.

Dispute Resolution through BCBSND Grievance and Appeal Procedures

Provider contracts generally contain rather vague dispute resolution language, merely encouraging informal dispute resolution through meeting by the parties' respective executive staff. In fact, BCBSND's 'formal' grievance and appeal policies seem to be purposefully vague–"the carrier's" grievance manual provides for several levels of review, including "inquiries, complaints, grievances, and appeals," and provides different procedures to resolve each. BCBSND's dispute appeal and grievance manual provides for "appeals," which are broken down into two broad categories: medical appeals (including expedited medical appeals for emergency services), and nonmedical appeals. Nonmedical appeals are assigned to BCBSND's medical management and network consultants for resolution.

Although N.D.C.C. § 26.1-36-42(1) requires that carriers have grievance procedures for resolving complaints by both covered persons and medical providers, "including access to and availability of services, quality of care, choice and accessibility of providers, and network adequacy," the statutes don't give physicians and other health care providers a legal cause of action to enforce the statutes. However, "[t]he procedure must be approved by the insurance commissioner." N.D.C.C. § 26.1-36-42(2). The Commissioner has approved BCBSND's grievance policies, even though the appeal steps are convoluted.

Utilization Review Appeals

N.D.C.C. § 26.1-26.4-02(8) defines utilization review as "a system for prospective, retrospective, and concurrent review of the necessity and appropriateness in the allocation of health care resources and services that are subject to state insurance regulation and which are given or proposed to be given to an individual within this state."

Preferred provider contracts must "[i]nclude mechanisms, subject to the minimum standards imposed by chapter 26.1-26.4, which are designed to review and control the utilization of health care services and establish a procedure for determining whether health care services rendered are medically necessary." N.D.C.C. § 26.1-47-02(1)(b). BCBSND's grievance procedure appears to be in general compliance with N.D.C.C. § 26.1-26.4-04(1), which sets minimum standards that utilization review agents must follow, including notification of the determination to the enrollee or other appropriate individual in accordance with timelines set by federal law. See 29 U.S.C. 1133 and 29 CFR 2560.503-1.

Medical appeals under BCBSND's grievance procedure–which include medically appropriate and necessary service questions–provides a peer review mechanism in which the peer review is conducted by a medical consultant "within the same specialty or similar specialty as the Health Care Provider." This limited peer review mechanism in the Blues' grievance procedure is required by N.D.C.C. § 26.1-26.4-04(2), which provides that "[a]ny determination by a utilization review agent as to the necessity or appropriateness of an admission, service, or procedure must be reviewed by a physician or, if appro-

priate, a licensed psychologist, or determined in accordance with standards or guidelines approved by a physician or licensed psychologist." Unfortunately, BCBSND's grievance manual doesn't say whether a finding made by the peer reviewer is final and binding on BCBSND, but N.D.C.C. § 26.1-26.4-04(10) provides that the findings of the physician trained in the relevant specialty are a "final determination."

Unfortunately, the statutes don't give medical providers an express legal remedy for violations of the utilization review statutes–and an implied private cause of action is difficult to establish, *see Trade 'N Post, L.L.C. v. World Duty Free Americas, Inc.,* 2001 ND 116, ¶ 11, 628 N.W.2d 707. Rather, the Insurance Department is tasked with oversight of alleged violations of utilization review procedures by convening hearings under the North Dakota Administrative Agencies Practices Act, and may issue cease and desist orders or assess monetary penalties. *See* N.D.C.C. § 26.1-26.4-05. If you believe your rights are violated, please contact NDMA immediately.

External Review

N.D.C.C. § 26.1-36-44 requires carriers like BCBSND to "establish and implement an independent external review mechanism to review and determine whether medical care rendered under the line of insurance was medically necessary and appropriate to the claim as submitted by the provider." An "independent external review," is defined as "a review conducted by the North Dakota health care review, inc., another peer review organization meeting the requirements of [federal law], or any person designated by the commissioner." It is unfortunate that the external review mechanism in N.D.C.C. § 26.1-36-44 has not been utilized; this is primarily because the statute is vague, and *imposes the costs of the process on the non-prevailing party.* Moreover, BCBSND may contend that its payment denials or reductions were not accomplished via utilization review, in which case the provisions don't come into play. But if the claim denials or reductions are accomplished through 'utilization review,' the medical provider is entitled to an external review proceeding, but under recent amendments to the statute, must first exhaust the carrier's internal appeal processes. There is no judicial review of such external review decision, as the statute provides that it is binding on the parties. As in the other audit circumstances, please contact NDMA if you believe that your claims have been denied through a utilization review process.

Corrective Action Plans; Provider Credentialing and Profiling

BCBSND provider contracts generally address credentialing and provider profiling in a vague way, requiring the provider to coordinate with all BCBSND credentialing requirements as determined unilaterally by BCBSND in its policies. But any Corrective Action Plan (CAP) must be conducted in compliance with N.D.C.C. § 26.1-36-41. Under the statute, BCBSND must "consult with the practitioner and provide a reasonable time of not less than six months within which to modify the practitioner's practice pattern." Only if "the excessive or inappropriate practice pattern continues," may the entity "impose reasonable sanctions on the practitioner, terminate the practitioner's participating contract, or designate the practitioner as nonpayable."

N.D.C.C. § 26.1-36-41 contains standards that apply to carrier profiling of a "practitioner's practice pattern," including description of the criteria, data, sources, and methodologies used to compile the practice profile; and basic due process guarantees (notice and opportunity to be heard). Regarding notice, the statute requires that the adverse decision be communicated "in writing, as to the manner in which the practitioner's practice is excessive or inappropriate." The statute also provides that "[i]f considered for sanction, termination, or nonpayable status, the affected practitioner must first be given the opportunity to be present and to be heard by a committee appointed by the entity which must include at least one representative of the practitioner's specialty. The entity may not impose sanctions on a practitioner, terminate a practitioner, or designate a practitioner as nonpayable in the absence of the committee's recommendation to do so." Although the statute doesn't create a private cause of action, it does require the insurer to "negotiate in good faith." NDMA is here to help if you are subjected to a CAP.

Workforce Safety and Insurance (WSI) Medical Audits

Unlike the legal procedures that govern other payors' reductions or denials of medical billings, WSI "managed care" decisions are not subject to judicial review. The purpose of N.D.C.C. § 65-02-20, which provides for WSI's "managed care program, including utilization review and bill review," is "to effect the best medical solution for an injured employee in a cost-effective manner." The statute directs WSI to promulgate administrative rules, and

allows aggrieved parties, including the medical provider, to request binding arbitration, which decision is final.

N.D. Admin. Code § 92-01-02-46, provides the procedures governing most medical billing disputes (those relating to managed care under N.D.C.C. § 65-02-20). On the other hand, "[d]isputes not arising from managed care follow the reconsideration and hearing procedures provided by North Dakota Century Code section 65-01-16." In this rare case, a *medical provider can obtain a hearing with the right to judicial review; the likely context would be successful intervention in a claims determination.* While it is unclear whether a medical provider may intervene in a pending proceeding, if a physician or hospital is involved in a matter involving significant dollars or issues, and wishes to pursue the matter, please contact me, because you may have legal remedies to recover for medical services rendered to a North Dakotan injured at work.

Regarding the normal case of a medical audit, N.D. Admin. Code § 92-01-02-46 begins by defining restrospective review as the procedure "provided for disputing the denial of payment for a medical service charge based on failure to request prior authorization or preservice review." Requests for retrospective review must be made in writing, within thirty days after the notice that payment for the service is denied, addressed to the WSI claims analyst assigned to handle the claimant's claim rather than to the managed care vendor. N.D. Admin. Code § 92-01-02-46(1),(2). But a medical provider disputing a utilization review decision must first exhaust the internal dispute resolution procedures provided by the managed care vendor or the utilization review department. A request for binding dispute resolution must be filed within 30 days of the final recommendation of a managed care vendor.

Other audits that do not involve pre-authorization and retrospective review have similar rules. A medical provider disputing a denial or reduction of a service charge arising from bill audit and review must file a written request for binding dispute resolution within thirty days after the date of WSI's remittance advice reducing or denying the charge. N.D. Admin. Code § 92-01-02-46(4). Of course, the request must contain information to identify the claimant and claim, the specific code and date of service in dispute, the reasons the reduction or denial was incorrect, and the relief sought. The rule also provides opportunity to submit "any supporting documentation." WSI provides a 'records-only' review, and "*may*" request peer review by medical providers. If WSI elects to request this review by medical service providers, "at least one … must be licensed of certified in the same profession as the medical service provider whose treatment is being reviewed, or by an external expert in medical coding or other aspects of medical treatment or billing, to assist with its review of the request." WSI does not have a time deadline in which to issue its decision.

Since WSI is not required to consult medical providers about its decision, its internal review mechanism seems particularly subject to internal bias against medical providers. Additionally, the absence of judicial review is troubling, as there may be no check against arbitrary decision-making. It may be that a successful constitutional challenge to N.D.C.C. § 65-02-20 can be launched on the theory that it violates the constitutional guarantee to open access to the courts, N.D. Const. Art. I, § 9. As in the case of the other audit scenarios, NDMA should be your first source of contact to assist you in preparing your WSI medical audit strategies.

NDMA Briefings

By Bruce Levi, Executive Director

Health System Reform –The Good, the Bad, and the Ugly

With national health care reform being debated in Congress, our NDMA goal over these past many months has been to work very closely with our ND Congressional Delegation on Medicare payment and health system reform issues. We appreciate the continued dialogue with the Delegation and staff and their listening to our views on the potential impact of reforms on North Dakota patients, physicians and our state's healthcare system.

We have also kept state leaders apprised, including interim legislative committees and the Governor's office.

Our various national and state specialty societies, the AMA and other physician organizations have taken varying strategic positions on health system reform as this process has continued to move forward – as we now are down to two bills in Congress, HR 3692 which was passed narrowly by the House along with a companion bill, HR 3961, which would provide a "permanent" fix to the Medicare physician SGR formula, and HR 3590 which was passed on Christmas Eve.

Now that both the House and Senate have passed bills, a process for negotiating a reconciliation of the two bills will occur, likely in a conference committee through January and into February.

Your NDMA leadership realizes and respects the diverse perspectives of ND physicians on this controversial debate. We see the current debate as an opportunity to ensure that geographic inequity is replaced by quality and cost efficiency as the basis for incentives in the Medicare payment system. We see the debate as an opportunity to test models for health system delivery that recognize our strengths in North Dakota or provide new resources for improving the care provided patients in our state.

At the same time, with concerns over the economic viability of the various proposals and efforts to constrain medical practice, we are watching the debate with both guarded optimism and concern, and weighing in as necessary.

NDMA Advocacy

In September, the NDMA House of Delegates adopted a ten-page resolution setting forth NDMA priorities and principles on health system reform, many of those principles built through the work of our Medicare Payment Task Force convened by Senator Kent Conrad with ND hospitals, which began its work early in 2008. We have repeatedly gone back to these priorities in reviewing proposals throughout the fall months, including active opposition to a public insurance option tied to Medicare rates and a Medicare "buy-in" program tied to existing Medicare rates.

On December 14, NDMA sent a letter to Senators Conrad and Byron Dorgan, expressing general concerns with the Senate bill, HR 3590, and specific provisions which NDMA opposes, as well as areas of support.

The Senate bill does not include a Medicaid "buy in" or public option. While many of the points in NDMA's December 14 letter to Senators Conrad and Dorgan were satisfactorily addressed, many were not.

These amendments include the following significant changes:

• The 10 percent payment bonus for primary care and general surgery in underserved areas will no longer be offset by cuts in other physician services to maintain budget neutrality.

• A "Frontier States" amendment was included through Senator Dorgan that places a 1.0 floor on the physician practice expense geographic adjuster (GPCI) and a 1.0 floor on the hospital wage index for qualifying states (ND, SD, Montana and Wyoming).

• The proposed tax on elective cosmetic surgery and medical procedures was eliminated.

• The proposed enrollment fee for physicians who participate in Medicare and Medicaid was eliminated.

Frontier State Amendment Addresses Medicare Payment Disparity

Throughout the process, NDMA has advocated for our Delegation to work to establish parity for ND physicians and hospitals in the Medicare payment system. In our rural states the geographic practice cost indices (GPCIs) lower payments as much as 32% below other states for professional codes and as much as 60% lower for technical fees.

The "frontier states" amendment now included in the Senate bill would establish a 1.0 floor on the physician practice expense geographic adjuster (GPCI) and a 1.0 floor on the hospital wage index. The floors would only apply in states in which 50% or more of the counties within the state are "frontier," i.e., counties in which the population per square mile is less than six. This would apply to North Dakota, South Dakota, Montana, and Wyoming which currently are below the 1.0 floors.

The "frontier states" amendment would have a substantial financial impact and go far beyond any other proposals for addressing the Medicare payment disparity issue for North Dakota. Sen. Dorgan reports, based on *Milliman* and CBO estimates, that the "frontier states" amendment would result in a $16.5 million annual increase for physicians services (18.5%) beginning January 1, 2011. The amendment would also result in a $51.7 million increase for hospital inpatient (12.8% increase) beginning January 1, 2011, and outpatient services (9.9% increase) beginning October 1, 2010. Over the ten-year period, this equates to $650 – 660 million. Overall for the states included, the CBO scored the amendment at $2 billion over ten years.

The majority of the Medicare geographic adjustment is due to practice expense GPCIs derived from alleged practice expense differences. *What's new is that we now have proof those alleged differences and prejudices against rural physicians and states are wrong.*

The basis for the practice expense GPCI adjustment has been the use of proxies of apartment rental rates in rural America and only four wage categories for staff expenses. On the other hand, survey data, not proxy data, has been used for many years by CMS to adjust RVU amounts for the practice expense portion of all fees. For 2010, the CMS rule made major adjustments to RVU amounts and therefore made significant payment changes to various specialties on the basis of the latest AMA Practicing Physician Information (PPI) Survey.

Our GEM (Geographic Equity in Medicare) Coalition in 2008 requested that the AMA geographically analyze that same nationwide PPI survey that CMS and almost all specialty societies have gone on record as supporting the validity. The geographic analysis results came out November 5, and they show conclusively *that there are no practice expense differences from region to region, rural, urban, or inner city.* Previous surveys by Medical Economics magazine and MGMA of practice expenses showed that rural areas had greater patient loads and, therefore, physicians needed more staff and space so their total practice costs were no less than urban areas.

So, now we have the proof; and health system reform must include significant Medicare payment reform.

The disparity in Medicare payments for North Dakota physicians and hospitals is addressed in several other provisions in the Senate bill. HR 3590, in addition to the "frontier states" amendment, would extend the temporary physician work geographic adjuster floor of 1.0 through the end of 2010, and reduce physician practice expense geographic adjustments by one fourth in January 2010 and then by one half in 2011. Additionally, during the next two years, CMS would be required to analyze and ensure that any geographic practice expense adjustments are accurate, or the 2011 changes would continue. This reanalysis and adjustments to the geographic practice expense cost index would take important steps to close the gap between Medicare reimbursement and the cost of providing services in predominantly rural areas, on a national basis.

NDMA also supports the development and application of a cost/quality index modifier as proposed in the Senate bill, to eventually replace the geographic adjusters.

The House bill, HR 3962, provides a $300 million windfall to California by redesignating GPCI payment localities in that state, and that state only. North Dakota would also likely benefit from House provisions requiring the Institute of Medicine to study geographic adjustment factors and geographic variation. The HHS Secretary would

be authorized to implement the IOM recommendations of one study, on geographic adjustment factors in Medicare payment. The Secretary also would be authorized to implement the recommendations of the second study, on geographic variation in health spending and promotion of high-value health care in Medicare, unless Congress votes to disapprove it.

Medicare SGR Fix

Both the House and Senate passed a 2-month extension of expiring appropriations for the Department of Defense that included a 2-month extension of the sustainable growth rate (SGR). In other words, the legislation stops the 21% Medicare pay cut scheduled take effect on January 1 for a period that will expire March 1, 2010. Importantly, the SGR issue has been taken off the main health system reform legislation and will be addressed separately.

According to AMA, Sen. Majority Leader Harry Reid stated his intent to pass legislation to permanently repeal the SGR formula. The House already passed a separate bill in HR 3961 which would provide a permanent fix to the SGR formula.

A permanent repeal of the sustainable growth rate (SGR) is critical to the goal of ensuring security, stability, and access for seniors, and to provide the essential foundation for the development of any new payment models and delivery reforms.

Health System Reforms

Health system reform is more than just payment reform. NDMA's letter of Dec. 14 to Senators Conrad and Dorgan identified other areas of the legislation NDMA supports and opposes with respect to insurance coverage and health system reforms.

We pointed out there are provisions in the bill NDMA supports that expand insurance coverage and improve access to medical care, including those provisions that:

• Reform the health insurance market to provide *more choice and access to affordable coverage* for individuals and small businesses, including provisions relating to guaranteed issue, guaranteed renewability, modified community rating, pre-existing condition limitations, nondiscrimination based on health status, adequacy of provider networks, and transparency;

• Provide *tax credits* that are inversely related to income, refundable, and payable in advance to low-income individuals who need financial assistance to purchase private health insurance;

• Establish health insurance exchanges that offer more affordable choices;

• Reduce overpayments to Medicare Advantage plans;

• Enhance Medicaid coverage;

• Provide coverage for prevention and wellness initiatives without co-payments or deductibles; and

• Create an independent comparative effectiveness research entity that will develop information to enhance patient-physician decision making about treatment options.

The provisions on health system reform in HR 3590 do not provide a "master plan" for reducing health care costs. What they offer are pilot programs and studies.

Congress is listening to those who suggest that pilot programs are what is needed since each area of the country has its own health care history and traditions, its own gaps in infrastructure, and its own distinctive patient population. "To figure out how to transform medical communities, with all their diversity and complexity, is going to involve trial and error. And this will require pilot programs – a lot of them." Atul Gawande, *Testing, Testing,* The New Yorker (December 14, 2009)

The system reform initiatives in HR 3590 include, among others: a national strategy to improve health care quality including quality measure development and public reporting (Section 3013 – 3015); a hospital value-based purchasing program (Section 3001); "improvements" to the physician quality reporting initiative (Sections 3002, 3003); establishment of a CMS Innovation Center (Section 3021); a shared savings program for accountable care organizations (Section 3022); a national pilot program on

payment bundling (Section 3023); a hospital readmissions reduction program (Section 3025); a community-based care transitions program (Section 3026); creation of an interagency council to establish a national prevention and health promotion strategy (Section 4001) and outreach and education program (Section 4004); creation of a national commission to review health care workforce and projected workforce needs (Section 5101) including competitive workforce development grants (section 5102); grants for primary care training programs including faculty development (Section 5301); creation of a primary care extension program (Section 5405); and creation of a nonprofit Patient-Centered Outcomes Research Institute for comparative outcomes research (Section 6301).

NDMA told the ND Delegation that while these strategic initiatives test almost every approach that leading healthcare experts have suggested (except proven medical liability reforms), it is unknown at this time how these initiatives will develop, making it difficult to comment on their potential impact in North Dakota. Many of the principles we enunciated in our Medicare Payment Task Force address directly how any payment initiatives might be structured to better suit North Dakota, including the negative implications of applying the current geographic adjusters to initiatives to incent quality (PQRI) and technology (e-prescribing, HIT) or being locked in to current baseline expenditures. We need to ensure that North Dakota hospitals and physicians are not penalized for providing services more efficiently and at higher quality, or penalized for the teamwork and accountability that has created value in our North Dakota healthcare system.

We also said the Senate bill is wholly inadequate in addressing one of the major cost drivers in healthcare, that being the costs of defensive medicine. The costs of practicing defensive medicine are not merely anecdotal; the CBO has recently estimated that comprehensive tort reform could save the federal government $54 billion over the next 10 years. Other studies suggest medical liability reforms could result in national savings of $242 billion a year, more than 10% of America's health expenditures.

Other Issues

NDMA's letter of Dec.14 addressed many other issues in the Senate bill. These are summarized below.

NDMA opposes the hospital productivity adjustments that will reduce Medicare payments to ND hospitals.

NDMA supports establishing a mechanism to test innovative payment methods for medical homes that provide patient-centered coordinated care and for accountable care organizations that assume responsibility for quality and cost across the continuum of patient care, but expressed concerns regarding the need for adequate resources for ND to participate in these initiatives.

NDMA opposes a provision that would empower an independent commission to mandate payment cuts for physicians, who are already subject to an expenditure target and other potential payment reductions under the Medicare physician payment system.

NDMA supports efforts to strengthen primary care services financed by savings rather than across-the-board payment reductions in other physician services. This was corrected in the Senate amendment.

NDMA opposes any tax on medical services, including the five percent excise tax on elective cosmetic surgical and medical procedures in the Senate bill. This was removed in the Senate amendment.

NDMA supports the proposed improvements to the Physician Quality Reporting Initiative (PQRI) but opposes mandatory PQRI participation or the imposition of penalties on physicians who do not successfully participate. *In addition, in North Dakota, we have consistently expressed our dismay at the notion that our PQRI bonus payments are reduced by geographic adjusters – the same geographic adjusters that have resulted in some of the lowest Medicare payments in the country for North Dakota physician services.* It is ironic that one of the states with the highest quality of care like North Dakota receives a reduced bonus payment in the federal government's physician quality reporting initiative.

NDMA opposes the imposition of Medicare provider enrollment fees on physicians. These were removed in the Senate amendment.

NDMA, like AMA, does not believe a new public health insurance plan is essential to ensuring competition in a reformed insurance market that provides access to, and choice among, a variety of private plans. The Senate amendment removed the public option.

NDMA supports additional resources for quality improvement processes, but has strong concerns about the requirements for public reporting of performance information given the problems with the existing PQRI.

NDMA supports specific requirements to standardize and simplify health care administration in order to eliminate billions of dollars of unnecessary costs and administrative burdens from the current system.

There is a wide array of fraud and abuse provisions in the Senate bill that NDMA opposes because they would penalize all physicians, casting a wide net in order to find a select number of individuals who are intent on defraud-

ing public health care programs. Most troubling are provisions that would penalize physicians where they had no intention of defrauding federal health care programs and any wrongdoing was the result of an honest mistake.

NDMA also opposes the expansion of the Recovery Audit Contractors (RAC) program as it is currently structured.

NDMA supports several provisions on healthcare workforce initiatives, although more could be done.

NDMA generally supports the graduate medical education (GME) provisions in the bill but points out that filling vacant GME resident slots alone will not be enough to address the predicted physician shortages that are estimated at 85,000-124,000 in multiple undersupplied specialties. NDMA supports the inclusion of GME provisions that would redirect unfilled Medicare-supported GME positions and expand the number of Medicare-supported GME positions by 15 percent, with preference given to primary care, general surgery, non-hospital community based settings, and other areas of need.

Under the bill, health plans may not discriminate against any health care provider, acting within their state scope of practice law, who want to participate in the plan. NDMA is urging clarification that this provision does not allow *expansion* of the scope of practice for non-physician allied health practitioners.

The imaging cuts provided in the bill and the 2010 CMS final rule on physician Medicare payments may have a serious effect on access to these services in North Dakota. NDMA opposes the bill's utilization rate provision for advanced imaging equipment as too broad. It should allow medical specialties that represent users of the various imaging modalities to submit data to CMS to determine an appropriate assumption for utilization, and this revised provision should override recent regulatory changes to the utilization rate announced under the final physician fee schedule rule for 2010.

Clearly, the good, the bad, and the ugly are evident in both the legislation and process being used in deliberating on health system reform. The resolution of many outstanding issues will be necessary in the final conference agreement. The debate is not over. As Senate and House leadership now focus on reconciling the bills passed in both chambers, NDMA will continue to advocate for you and your patients.

Looking to the 2011 Session

While 2010 is a year of preparation for the 2011 ND legislative session, the state's interim committee process is a very active one for healthcare. There are many interim studies, including studies by the ND Legislative Council's interim Industry, Business & Labor Committee, Health & Human Services Committee and other committees focusing on unmet health care needs, access to psychiatric services and mental health commitment procedures, factors impacting the cost of health insurance, the needs of pregnant minors and whether additional education and social services would enhance the potential for a health child and a positive impact for the minor, consideration of workers compensation laws with respect to prior injuries, preexisting conditions and degenerative conditions, and others.

These studies are important – we continue to put our testimony and other documents on the NDMA website and work with our physician leadership and organizations as necessary to ensure that physicians are well represented in the interim. The interim IB&L Committee has been particularly active in focusing in on federal health reform implications for North Dakota, and will meet for the fourth time on January 7 at the UND School of Medicine.

The NDMA Commission on Legislation, chaired by Dr. Fadel Nammour, will soon begin work on developing a preliminary NDMA agenda for the 2011 session.

Other activities are ongoing as well. The process for determining the location of the Bismarck Center for Family Medicine continues, in implementing the appropriation of $5.4 million provided by the 2009 ND Legislative Assembly. The new ND Health Information Technology Advisory Committee established by the legislature is working on leveraging federal funds. The State Health Information Exchange Cooperative Agreement Program grant application was submitted on November 15 for $5.34 million. In anticipation of the receipt of the grant, a request for proposals was issued for strategic and operational planning services. NDMA established a "clinical workgroup" to assist in advising the committee work and the new state HIT office as we work to develop a health information exchange function for our state. There is also an effort ongoing to obtain federal funding for an HIT Regional Extension Center.

As the work continues, your help in supporting NDMA is critical in ensuring we have the resources and expertise to continue to be successful. I strongly encourage you to join or rejoin NDMA in 2010 along with your colleagues who see the value of our continuing to work together on policy issues.

Best wishes for the new year!

Medical Director Career Opportunity

Position located in Fargo

BlueCross BlueShield of North Dakota has an opportunity for a full-time Medical Director.

The director will provide leadership in credentialing, quality monitoring, physician reporting and policy development. This senior leadership position will also be responsible for physician clinical support for utilization management, case management, disease management and other general medical management activities. The ideal candidate will have an extensive knowledge of the healthcare industry.

Candidates must have a current North Dakota unrestricted license as a Medical Doctor and be Board Certified. Qualifications include a minimum of 5 years of clinical experience and strong communication skills. Administrative experience is preferred.

For prompt consideration, please complete an application on-line at *www.bcbsnd.com*.

An Affirmative Action/ Equal Opportunity Employer

BlueCross BlueShield of North Dakota

An independent licensee of the Blue Cross & Blue Shield Association

AMA House of Delegates Clarifies Position on Health System Reform

Report of the NDMA Delegate to the AMA House of Delegates, Gaylord Kavlie, MD

The AMA House of Delegates convened in Houston in early November on the heels of the AMA's indication of "support" for the House of Representatives' healthcare reform bill, HR 3692.

Alternate Delegate Robert Beattie and NDMA President Kimberly Krohn participated with me in policy deliberations of the House as well as in the work of our regional caucus, the North Central Medical Conference (ND, SD, IA, MN, NE, Wis) which is currently presided over by Dr. Beattie. The North Central has been instrumental over the years in furthering our goals for Medicare payment equity and continues to actively pursue a legislative resolution of the issue.

The AMA House of Delegates engaged in serious debate on AMA policy and on AMA's support for the House legislation, which resulted in changes to AMA policy and more specific articulation of AMA opposition to and support for specific health system reform proposals in the legislation as the debate continues in Congress.

AMA's Vision for Reform

Seven critical elements are needed, according to the AMA policy, to improve access to affordable, quality care and reduce unnecessary costs in the current system. Those are:

- Health insurance coverage for all Americans;
- Insurance market reforms that expand choice of affordable coverage and eliminate denials for pre-existing conditions or due to arbitrary caps;
- Assurance that health care decisions will remain in the hands of patients and their physicians, not insurance companies or government officials;
- Investments and incentives for quality improvement and prevention and wellness initiatives;
- Repeal of the Medicare physician payment formula that triggers steep cuts and threaten seniors' access to care;
- Implementation of medical liability reforms to reduce the cost of defensive medicine; and
- Streamline and standardize insurance claims processing requirements to eliminate unnecessary costs and administrative burdens.

The AMA decided that insurance coverage options offered in a health insurance exchange must be self-supporting, have uniform solvency requirements; not receive special advantages from government subsidies; include payment rates established through meaningful negotiations and contracts; not require provider participation; and not restrict enrollees' access to out-of-network physicians. The AMA also supports the right of patients and physicians to privately contract, without penalty to patient or physician.

What the AMA Opposes

In accord with AMA policy, the HOD voted to oppose these provisions in any health system reform legislation:

- Reduced payments to physicians for failing to report quality data when there is evidence that widespread operational problems still have not been corrected by the Centers for Medicare and Medicaid Services (CMS);
- The Independent Medicare Commission (or other similar construct), which would take Medicare payment policy out of the hands of Congress and place it under the control of a group of unelected individuals;
- Medicare payment rate cuts mandated by a commission that would create a double-jeopardy situation for physicians who are already subject to an expenditure target and potential payment reductions under the Medicare physician payment system;
- Medicare payments cuts for higher utilization with no operational mechanism to assure that CMS can report accurate information that is properly attributed and risk-adjusted;
- Redistributed Medicare payments among providers

based on outcomes, quality, and risk-adjustment measurements that are not scientifically valid, verifiable and accurate;

• Medicare payment cuts for all physician services to partially offset bonuses from one specialty to another; and

• Arbitrary restrictions on physicians who refer Medicare patients to high quality facilities in which they have an ownership interest.

The House also reaffirmed its call for replacing the sustainable growth rate (SGR) with a Medicare physician payment system that automatically keeps pace with the cost of running a practice and is backed by a fair, stable funding formula. The body also reaffirmed its opposition to the creation of a new single payer, government-run health care system and its support for effective medical liability reform and appropriate "comparative effectiveness" research.

While health system reform dominated the House of Delegates meeting, other policy positions were taken on a variety of issues, which can be reviewed on the AMA website at *www.ama-assn.org*.

The House adopted HR 3962 and another bill, HR 3961 which would permanently eliminate the SGR Medicare physician payment system. Many physician organizations issued statements in opposition to, and support for, various provisions of the Senate version in HR 3590, the *Patient Protection and Affordable Care Act of 2009,* which passed as amended on December 24.

AMA Supports Senate Bill, As Amended

After evaluating the changes contained in the manager's amendment filed by Senate Majority Leader Harry Reid (D-Nev.), the AMA Board of Trustees voted to support passage of H.R. 3590. In a letter of support, the AMA noted the need for additional changes in the final conference committee agreement that reconciles the differences between the House and Senate bills.

According to the AMA, before Sen. Reid's manager's amendment was filed, the AMA succeeded in blocking a proposed Medicare "buy-in" for individuals ages 55-64 and eliminating a proposal to impose a 5 percent cut in Medicare payments to physicians in the top tenth percentile of resource utilization. The Senate proposal does not include a public option.

As a result of AMA lobbying, according to the AMA, the manager's amendment filed by Sen. Reid included the following changes:

• Eliminating the budget neutrality adjustment for the primary care and rural surgery bonuses. Other physician services will not be cut to pay for these bonuses as result of this change.

• Eliminating the proposed tax on elective cosmetic surgery and medical procedures.

• Eliminating the proposed Medicare/Medicaid enrollment fee for physicians.

• Modifying provisions to establish an independent comparative effectiveness research entity to secure greater representation for physicians on its governing board and to clarify that this entity cannot issue practice guidelines or make coverage, payment or policy recommendations.

After the Senate vote, AMA reiterated key elements in legislation that it supports:

• Health insurance reforms to provide more choice and access to affordable coverage for individuals and small businesses (e.g. eliminate denials based on pre-existing conditions, discrimination based on health status and gender, annual and lifetime limits)

• Advanceable, refundable tax credits, inversely related to income, for low-income individuals to purchase health insurance

• Creation of health insurance exchanges to stimulate competition and offer more affordable choices

• Additional federal funding to improve the Medicaid safety net

• Coverage for prevention and wellness initiatives without co-payments or deductibles

• Administrative simplification provisions to streamline, standardize and lower the cost of processing health insurance claims

The AMA urged the removal of a one-year patch to the Medicare physician payment formula in HR. 3590 that would have provided a 0.5 percent increase in 2010 but would also have led to a 23 percent cut in 2011. Eliminating the one-year patch freed up funds to offset the cost of removing the provisions dealing with budget neutrality, the cosmetic surgery tax and the enrollment fee.

A separate Department of Defense (DOD) appropriations bill passed by the House and Senate averts a Jan. 1 cut of 21 percent. The DOD bill provides for a 60-day extension of the 2009 conversion factor.

A permanent repeal of the sustainable growth rate (SGR) formula is essential to the stability of the Medicare program and to the success of any health reform initiative. According to AMA, the Obama administration, the House leadership and the Senate leadership are committed to passage of a permanent repeal of the SGR before the current two-month extension of the 2009 conversion factor expires on March 1.

On Dec. 19, Sen. Reid stated that after the holidays he

will renew efforts to pass a permanent repeal of the SGR.

The manager's amendment included a provision that authorizes $50 million over five years for state demonstration programs for alternative medical liability reforms. This provision would allow for a broader array of demonstration projects than the provision in the House bill.

The amended bill also includes a Government Accountability Office study to determine if quality and payment policies create potential new causes of action or legal liabilities for physicians.

Outstanding Concerns

The AMA was not able to solve all of its concerns with the manager's amendment and says it will work vigorously during the House-Senate conference committee negotiations on a number of issues. Of primary concern is the establishment in the Senate bill of an independent payment advisory board.

The AMA expressed opposition to the proposed board, noting that physicians are already subject to a spending target under the Medicare physician payment formula. The proposed board would establish a new spending target that could subject physicians to multiple cuts in a given year. In addition, the Senate bill exempts hospitals and other providers from potential cuts in the first four years the board is in operation. The manager's amendment also expanded the scope of the board and authorized it to make advisory, nonbinding recommendations for private payers.

The AMA says additional changes are needed to allow adjustments for legitimate increases in Medicare spending as well as to assure that there is adequate accountability, transparency and physician input for this new body.

Legislation passed by the House does not include an independent payment advisory board, and several key House members recently signed a letter opposing the creation of such a board.

The AMA has said to the White House, the Senate leadership and the House leadership that its support for a House-Senate conference agreement is contingent upon:

- Movement on a clear pathway for passage of legislation to permanently repeal the SGR by the end of February
- Modifications of the proposed Independent Payment Advisory Board
- Refinements of the quality improvement and Medicare data release provisions
- No new major problematic provisions surfacing in conference

According to the AMA, its strategy of constructively working for changes at each stage of the process has put it in a position to have significant influence in the House-Senate conference committee negotiations. The AMA retains the ability to withhold support for a conference committee agreement if it fails to achieve its priority objectives.

AMA Advocates for Delaying Medicare Consultations Policy Change

In the 2010 Medicare physician payment final rule, CMS finalized its proposal to eliminate Medicare payment for consultations and use the money from these services to increase payments for visits. In its comments on the proposed rule, the AMA urged CMS to take more time to consider this proposal and to not finalize it for implementation in January. Furthermore, during the Interim Meeting, the AMA House of Delegates passed a resolution calling for the AMA to oppose the new policy. Nonetheless, CMS finalized the proposal.

AMA's advocacy efforts on the issue are ongoing. Recently, the AMA met with senior CMS staff to discuss the technical and practical concerns this policy presents, and the serious consequences it will have on physicians and their patients if the agency moves forward on Jan. 1. In addition, AMA pointed out that a January implementation date will likely result in substantial confusion and claims processing problems. In follow up to this meeting, AMA urged the director of CMS' Center for Medicare Management and Health and Human Services Secretary Kathleen Sebelius to delay implementation of the new consultation policy.

AMA Working for You

Recent events make clear the value of AMA in steering medicine through a difficult policy debate. We do not all agree on either the language or pace of health system reform. Yet, most of our national specialty societies are consistent with AMA in articulating our concerns and opposition to many parts of the proposed legislation. While there is considerable concern among physicians over the AMA role, it is evident that AMA and our other physician organizations remain at the table in addressing the major issues in Congress' work toward health system reform. Whether reform passes in one form or another, this has been a historic time for all of us and a historic role played by your AMA, your NDMA and your national specialty societies.

The University of North Dakota seeks the Vice President for Health Affairs & Dean of the School of Medicine and Health Sciences (VP/Dean SMHS) reporting to the President of the University. As North Dakota's only medical school, operating in multiple communities and clinical campuses, SMHS is uniquely positioned to make an important difference to the health of the population of the state and the region and to contribute to the historic dialogue about the direction of health care reform nationally.

The SMHS offers academic excellence and diversity in a full range of educational programs in the health sciences and is one of the nation's most respected community-based medical schools. The medical school is recognized nationally for its curricular innovation and patient-centered learning and has developed a deserved reputation for leadership in inter-professional health care education and promotion of a strong understanding of the health care professional team. The SMHS is a leader in rural medicine, community based education and health services research. For additional information: www.und.edu

The University seeks candidates who are invigorated by the opportunity to build on the school's mission and proud traditions; to advance the SMHS's leadership in basic science and clinical and translational research; to support the medical and health science education; to enhance the health care training and clinical service that are community-based and dispersed geographically; and, to support the promotion of health professions and medical careers in primary care and rural medicine in North Dakota and beyond.

Required Qualifications: MD or MD/PhD or equivalent degree; board certification in the candidate's specialty/discipline; progressive and broad administrative leadership experience within an academic or similarly complex institution.

Preferred Qualifications: Nationally recognized achievement in clinical, educational and/or research pursuits that would warrant appointment as a tenured, full professor; broad understanding of national health policy and future challenges to academic health services; ability to effectively represent a public academic entity; broad understanding of the rural healthcare environment; expertise in management techniques, financial management, clinical operations and oversight of a large, distributed infrastructure; balanced commitment to educational, clinical and research missions; commitment to employee, environmental and patient safety and quality initiatives; philanthropy, alumni relations and development experience.

Nominations and/or letters of application and CV may be sent electronically to the Search Consultants assisting this search:
Karen Otto, Anthony Barbato, M.D. or Donna Padilla
Witt/Kieffer; 2015 Spring Road, Suite 510; Oak Brook, Illinois, 60523
UNDDeanMedicine@wittkieffer.com
Phone: 630-990-1370.

Consideration of candidates will begin mid January and will continue until the position is filled.

***Any submission regarding this opening is subject to the open records laws under North Dakota statutes.** The names of all candidates and nominees are a matter of public record under the open meetings-open records statutes and policies of the State of North Dakota. Prior to nomination or declaration of candidacy, individuals who may want information on the position are invited to call the Search Consultant.

The University of North Dakota is dedicated to academic and research excellence, achieved through building a culturally diverse community. The University of North Dakota is an equal opportunity/affirmative action employer and actively seeks and encourages expressions of interest and applications from women, persons with disabilities, and members of underrepresented populations.

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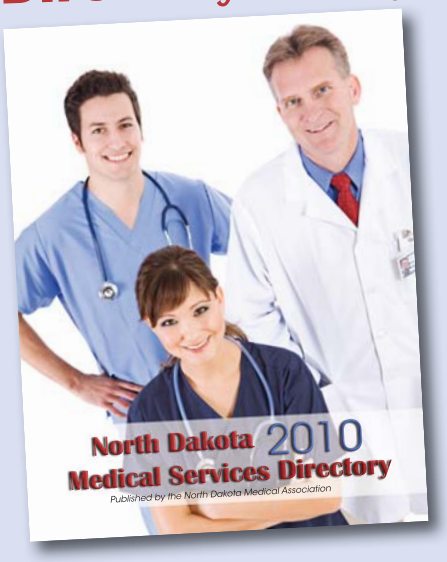

The Directory is an invaluable reference for anyone working with healthcare in North Dakota. With this up-to-date source of information, you can contact:

- Licensed Physicians Residing in North Dakota (pictorial)
- Physicians Licensed to Practice in ND Living Out-of-State
- Health Agencies & Organizations
- Ambulance Services
- Ambulatory Surgery Centers
- Basic Care Providers
- Clinics
- Home Health Care Providers
- Hospice Facilities
- Hospitals
- Nursing Homes
- Pharmacies
- Physician Assistants
- Public Health Units
- Social Service Providers

This concise, well-organized resource delivers it all to you in an easy-to-read format that's not available anywhere else in print.

Estimated delivery date: February 19, 2010

Directory data is also available electronically. Information is provided in Microsoft Excel. Other formats are available upon request. Please call the North Dakota Medical Association for further details.

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MINOT AIR FORCE BASE

Dinah Goldenberg
Past-President, NDMA Alliance
Director, AMA Alliance

Happy New Year! 2010 already, where has the last year gone? With Health Care Reform in the forefront this last year, it has been an interesting time. With any luck this year will bring some positive change to patients and to the physicians who care for them.

Today I would like to tell you about the inaugural year of the Carol Harding Memorial Scholarship to attend the North Central Regional Alliance (Illinois, Indiana, Iowa, Kansas, Minnesota, Missouri, Michigan, Nebraska, North Dakota, South Dakota and Wisconsin) meeting in St. Louis, February 5-7, 2010. Carol was a devoted Alliance member from Wisconsin who passed away a couple of years ago. She was a fixture at North Central meetings. As I'm sure many of you remember, she was the picture lady. In the days before digital cameras she was the picture taker and record keeper. After a meeting she would print copies of every photo for the individuals in the picture and send it to them. If it weren't for Carol I wouldn't have any photos of those meetings. Carol was also the one who took the new comers under her wing. She showed us the ropes, made sure we were looked after and having a great time. She instilled in us the importance of friendships within the Alliance. She was also committed to the work of the Alliance and shared her passion.

In 2009 we held a fundraiser at North Central to create a scholarship in Carol's memory. Many of Carol's friends also made contributions to the fund. The planning group was overwhelmed by the generosity of our members. As a result, with small additional fundraisers each year we will be able to offer the scholarship for many years to come. This year we will be offering three scholarships to first time attendees to the North Central Meeting. The scholarship will cover all registration fees for the participating individuals. This year one member from Kansas, Iowa and Illinois will receive a scholarship. Every year going forward three different states within the region will receive the scholarship. The North Central Regional meeting is a wonderful introduction to the broader Alliance membership. If anyone is interested in joining me in St. Louis please contact me.

I would also ask you to mark your calendars for the upcoming National Advocacy Conference to be held in Washington, DC March 1-3, 2010. For more information and to register go to *www.ama-assn.org/go/nac*

Dinah Goldenberg, Past President
North Dakota Medical Association Alliance
dinahgold@cableone.net

By Cinda Velasco, RN, JD, Attorney-Risk Management

MMIC Malpractice Claim Review

Specialty:
Family Medicine

Allegation:
Medication Error

Risk Management Focus:
Communication Failure

Details of Case:
A 29-year-old patient, married and mother of three children, arrived at her family physician's office without an appointment early one morning for the second of her three hepatitis B vaccine doses. She informed the receptionist that she was in a hurry to get to work. After waiting several minutes, she asked the receptionist if she could "just get her shot and go." The receptionist pulled the chart and attached a charge ticket to the front. The charge ticket said "Depo shot" and the nurse prepared an injection of Depo-Provera. After taking the patient back to the exam room, the nurse asked her if she was there for her Depo shot. The patient nodded her head up and down and the nurse gave her the injection. After the patient left, the receptionist realized she had pulled the wrong chart and attached the wrong charge ticket. The nurse notified the physician who called the patient to explain what had happened. He told her that she might experience slight side effects and instructed her to return to the clinic the next day to receive her hepatitis B vaccine and information about the side effects of Depo-Provera. Over the next several months, the patient reported menstrual irregularity and mood changes for which she sought treatment from another provider.

The patient filed a malpractice claim alleging a medication error causing pain and suffering, lost wages and subsequent physician visits.

Disposition of Case:
The case closed with a payment of $5000.

Risk Management Perspective:
The clinic staff made an error in pulling the wrong chart and giving the wrong injection. The nurse who gave the injection did not verify the correct patient and correct medication before administering the injection. The nurse testified she asked the patient if she was there for a Depo shot and the patient nodded yes. The patient testified that she did not know what Depo meant and assumed it was another name for the hepatitis vaccine. The patient stated she was too embarrassed to question the nurse and just nodded her head, assuming the nurse knew what she was doing. The patient alleged that after the mistake, the nursing staff appeared to blame her by saying things like, "you were in such a hurry," and "why did you nod your head yes?" The patient felt stupid and disrespected.

Low health literacy affects nearly one in every three people in the United States and can include anyone, regardless of age, race, education or income. All patients should receive clear communication about their health care treatment in words they can understand.

2010 Calendar of Upcoming Events

January 18-22	33rd Annual Family Medicine Update, Huntley Lodge, Big Sky, Montana. For more information contact Brandy Jo Frei at 701-772-1730 or email: brandy@ndafp.org
March 6-7	North Central Medical Conference, Minneapolis
April 30-May 1	ND-SD Chapters of the ACS Annual Meeting, Holiday Inn City Centre, Sioux Falls, SD. For more information contact the NDMA office.
September 9-10	NDMA Annual Meeting, Fargo Holiday Inn NDMA Alliance Annual Meeting, Fargo Holiday Inn NDMGMA Annual Meeting, Fargo Holiday Inn