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PROTECTOR

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Dear Medical Protective healthcare provider:

These are confusing times for the healthcare professions! Physicians and dentists are wondering what effects the newly passed healthcare legislation will have on their practices. The economy struggles to recover. Federal regulations increase at every turn but lack the clarity and guidance that might help to facilitate compliance. And, doctors everywhere are trying to care for their patients, keep costs down, and stay solvent!

It's no surprise that more and more doctors are turning to Medical Protective for help with the kinds of liability concerns that seem to multiply in tough economic times. In this issue of Protector, we discuss just a few:

- Reduction of staff that may put patients at risk;
- Job assignments that force staff to assume duties for which they are not licensed or qualified;
- Budgetary cutbacks for training and education;
- Scrimping on availability of supplies and materials;
- Improper use/maintenance of materials, devices, and equipment; and
- Risks arising out of patient self-rationing of healthcare.

Some of these articles may be relevant to challenges that you and your staff are grappling with today. Or, they may identify potential risks that you haven't recognized. In either case, we hope they will help you and your staff protect your practice, as well as your patients.

As always, your questions and suggestions are most welcome!

Sincerely,

Kathleen M. Roman

Kathleen M. Roman
Editor

P.S. We hope you enjoy Protector's new, smaller format.
The same useful information – in a more compact and easier-to-read layout!

Economy Forcing Patients to Self-Ration Medical and Dental Care;

Are Doctors Aware – and if so, What Can Be Done?

Hospitals are reporting an increase in the number of uninsured patients who are showing up in Emergency Departments. Until recently, many of these patients did have insurance. But now their finances are in disarray; they may already have run up out-of-pocket expenses with their personal physicians or dentists and, embarrassed to admit that they have no money, they turn to the local hospital ED.

According to a Kaiser Family Foundation poll conducted in February 2009, nearly half the respondents reported that someone in their family had delayed receiving needed medical care by postponing checkups, failing to undergo recommended tests or procedures, or cheating on prescription medications, e.g., not filling prescriptions, cutting pills, or skipping doses.

According to the same Kaiser report, nearly one in three Americans now has trouble paying medical bills and one in five reports medical debt of at least $1000.

What can physicians and dentists do to help patients who are self-rationing care?
First of all, healthcare professionals should notice signs of non-compliance. For example, a diabetic who is faithful about coming in for checkups suddenly isn't scheduling appointments or is skipping appointments. Find a diplomatic way for a staff person or for the doctor to inquire about financial matters. During appointments, always ask if the patient is taking prescription medications according to directions – especially if the patient's condition seems to have deteriorated recently.

When prescribing, have some idea about what drugs cost. Have a staff member call nearby pharmacies. Find out the costs for the name brand medications you most frequently prescribe. Then check to see what the generics cost. Find out if there are over-the-counter drugs that patients might use in a pinch. Give the patient a prescription for a few doses of the generic to see if he or she tolerates it well. If you have samples for generics, these may provide an option. Sometimes just being aware of the retail costs for drugs can be an incentive to doctors to help their patients look at other options.

Obtain contact information and service updates on local or national organizations that provide support for patients who have a specific condition or disease. Stay aware of charitable organizations that may underwrite needed medical services on a case-by-case basis. Ask a staff member to "own" this information and to keep it updated. (See Resources List).

According to the American Association of Retired Persons (AARP), seventy (70) percent of patients who ask their hospitals for a discount, do receive one. In tough economic times, the provider who is willing to work with his or her patients to help them get the best financial deal possible, may find that such initiatives have marketing benefits in the form of word-of-mouth customer satisfaction.

Finally, the doctor's guidance and support are critical in helping some patients weather the numerous challenges of their lives. It is not uncommon, for example, for many people to have to decide if they have enough money to pay for groceries or for their medications. According to the AARP, Americans report more stress directly related to the economy and, at the same time, delay any kind of medical interventions that they perceive might put their jobs at risk.[1]

Doctors need to explain to their patients that some forms of scrimping may actually be dangerous over the long haul and ultimately end up costing the patient more money, possibly even endangering her life. If the patient trusts the doctor, perhaps together they can find ways to alter doses, change prescriptions, try other kinds of therapies, and search for additional resources. But, none of these things can happen if the doctor isn't considering whether or not the patient is rationing his medical and dental care. ■

1. S. Kirshheimer. Economic Distress: Patients Delay Doctor Visits, Skimp on Meds. *AARP Bulletin*. December 29, 2009.

Resources:

Organizations that provide financial help to uninsured (and sometimes underinsured) people with chronic conditions include:

- American Kidney Fund, 1-800-638-8299
- Caring Voice Coalition, 1-888-267-1440
- Chronic Disease Fund, 1-877-968-7233
- HealthWell Foundation, 1-800-675-8416
- National Cancer Information Center (American Cancer Society), 1-800-227-2345
- Patient Access Network Foundation, 1-866-316-7263
- Patient Advocate Foundation, 1-800-532-5274
- Patient Services Inc., 1-800-366-7741

For help obtaining low- or no-cost prescription drugs, contact:

- NeedyMeds
- Partnership for Prescription Assistance, 1-888-477-2669
- National prescription chains, CVS, Walgreen's, Wal-Mart, etc.

Agency for Healthcare Research and Quality (resources for services/information available to help low income populations)
http://www.ahrq.gov/populations/lowincix.htm

Kaiser Health Tracking Poll: Public Opinion on Health Care Issues, February 2009
http://www.kff.org/kaiserpolls/upload/7866.pdf

Cutting Corners in a Tough Economy: A Risk Assessment

By now, the media have told the entire nation about the Las Vegas endoscopy clinics where 150 patients are believed to have contracted hepatitis C allegedly because of unsafe injection practices. In addition, there are allegations that these clinics may have exposed an additional 40,000 patients to blood-borne diseases.

According to numerous news reports, nurse anesthetists employed by the clinics purportedly admitted to reusing single-dose medicine vials, equipment, and supplies as cost-saving measures. The nurses claimed that they were ordered to cut corners by a physician who was one of the principal investors in the clinics.

As a result, hundreds of former patients have sued the physician, his clinics, and some of the manufacturers of products used during the colonoscopies performed by the clinics. A concomitant criminal case includes charges against the physician and at least four other employees. According to news reports, charges already filed include insurance fraud and patient neglect. Others may follow.

Media commentators and reporters gauging public reaction have found the public outraged at the blatant greed that seemed to be the sole reason for the violation of the patients' safety. And yet, as more and more health services have moved into the ambulatory setting, patient safety advocates and quality experts are warning about an increase in similar patient safety violations, often associated with cost-cutting measures. While they aren't as blatant as the Las Vegas case, other patient safety violations arise out of the same disregard for the one of the oldest tenets of healthcare: first, do no harm. Healthcare professionals everywhere are likely to agree that this case is a violation of what they stand for and, if this is true, then why are similar short-cuts, oversights, and cost-cutting measures popping up in many healthcare facilities? Whether the cause is malicious or merely thoughtlessness, the potential for harm is unchanged.

"In tough economic times, it is wise to find ways to increase efficiencies and be creative with resources. But when that 'creativity' ignores the potential for harm, all kinds of bad things can happen."

For every medical and dental procedure, there is a standard of care. It requires thought, competence, accuracy, and consistency. In other words, every patient is entitled to care that conforms to the ethical and legal duties of the healthcare professions.

In tough economic times, it is wise to find ways to increase efficiencies and be creative with resources. But when that "creativity" ignores the potential for harm, all kinds of bad things can happen. In monitoring cost-cutting behaviors that have caused patient injuries, Medical Protective has come across numerous examples, in the media, in public data, and in some malpractice lawsuits. Here are just a few:

- The ophthalmology practice that rinses surgical equipment with alcohol and sterile water between procedures and sterilizes equipment just once, at the end of the day.

- The endodontist who keeps "forgetting" to order spore strips to challenge the effectiveness of the office's sterilizer. The CDC states that a best practice would require weekly testing – but that may not be often enough, depending on the medical or dental specialty and on the state requirements (which may vary) where the doctor practices.

- Persistent reports of disposable instruments being autoclaved. Manufacturers typically use lighter materials for these tools. As a result, they don't have the tensile strength to withstand repeated sterilizations. They may break when in use, injuring patients or the doctors/staff. And for this reason, they are less expensive than heavier-weight tools – and the manufacturers' instructions designate them as single use only.

- A trend in both medical and dental offices to take shortcuts with staff training for sterilization processes. Possible patient exposures have been reported concerning staff members who hadn't followed (or known about) process requirements. As an example, staffers have reported that they didn't think they needed to use a chemical indicator during the sterilization process. They assumed (but did not ask) that if the packet changed color, they'd reviewed the chemical indicator. This is not correct. When the dot on the autoclave packet changes color, this means only that the autoclave ran, but it does not tell if the sterilization process was correct and complete.

- A dermatologist's office that stores tissue samples in the same refrigerator where employees keep food. "But it's OK because we keep the food on a separate shelf." An oral surgeon's office that does the same thing – and may also store floral arrangements to keep them fresh over the weekends.

- Significant confusion about (or disinterest in) which instruments must be autoclaved, e.g., those that touch mucous membranes or open incisions or wounds. General care offices can get away with using low-level disinfectants, as approved by the environmental Protection Agency (EPA). However, for invasive procedures, such as colonoscopies, high-level disinfectants which are approved by the Food and Drug Administration (FDA), must be used. It can be confusing that two separate agencies publish lists of acceptable chemicals for approximately the same purposes, but lack of information about the differences, and failure to stay abreast of the recommendations of these two agencies, can lead to harm to staff as well as patients and result in a variety of sanctions, fines, and professional disciplinary actions.

- The pediatric practice that markets a "nurse education" call center where parents can call for advice. In a cost-cutting move, the administration eliminated the jobs of the RNs who operated the center. However, the practice continued to operate the center, adding these duties to the group's medical assistants' job descriptions.

Patient safety isn't the place to cut corners. Equipment needs to be adequate to the task. It needs to be in good repair and staff need to know when and how to use it properly – and when to take it out of service for maintenance or repair. One of the most difficult malpractice lawsuits to defend is the suit in which a patient sustains a serious injury caused by a piece of equipment that the staff had reported as malfunctioning but that was not removed from service.

Another type of economy-focused injury occurs when supplies and materials needed for patient treatment aren't available in adequate inventories, so that there is no worry about the possibility of running out.

In his excellent book, *The Checklist Manifesto*, Dr. Atul Gawande reported on the results of a research project designed to reduce the number of central line infections in hospitalized patients. The research group discovered that critical supplies, such as chlorhexidine soap, which reduces line infections, was available in less than a third of the participating hospitals' ICUs.

While clinicians clearly saw the need for these supplies and were frustrated by their lack of availability, those charged with hospital budgets weren't supportive and, according to Gawande, in some hospitals the researchers "encountered hostility," from the financial watchdogs.[1]

Penny wise and pound foolish? It's more dangerous than that, because such cost-cutting measures clearly show that the organization has deviated from the core mission of any medical or dental practice: the compassionate provision of sound care. From a liability perspective, it poses a much bigger potential loss than poor budgeting. ■

1. Gawande, A. The checklist manifesto: how to get things right. Henry Holt and Co. 2009. pp. 43-44.

As More Medical and Dental Teams Focus on a Culture of Safety, Consider Including Patients as Allies

Patient safety is the underpinning of good medical and dental care. Regardless of their specialties, physicians and dentists try to address the many patient safety risks that might occur in any healthcare setting. Some risks don't change much over time; e.g., a child runs across the waiting room and falls. But occasionally, new risks emerge or escalate, e.g., a patient claims that she contracted an infection during a procedure that was performed in her physician's/dentist's office.

Medical and dental providers can incorporate a culture of safety into their practices in many ways. This article primarily focuses on infection control as a means of improving the culture of safety.

Consistency of Approach. Research is showing that consistency of approach improves outcomes. Something as elemental as a checklist can help doctors and their employees stay on the same page when engaging in everyday practice activities.

An example that has received international attention is the work of Peter Pronovost, MD, of Johns Hopkins School of Medicine and Department of Health Policy. His research has focused on the development and use of checklists. One of Pronovost's findings is that the lengthier and more complicated a checklist is, the less likely that staff will use it. Determined to devise checklists that were actually useful, Pronovost eventually came up with a simple five-point checklist to prevent central line infections.[1]

The checklist was designed to prevent staff from skipping, or overlooking, any of the five steps. The checklist also empowers any member of the team to stop the process if others participating in the procedure attempt to skip any of the steps. Hospitals that began using Pronovost's checklist noted significant reductions in the number of central line infections, with many plunging to near-zero. In one scenario, a hospital that implemented the checklist system reported that it had prevented an estimated forty-three infections and eight deaths, with a savings of $2 million.[2] If a simple five-step checklist can have this kind of effect in a high-risk hospital environment, how easily might office-based medical and dental teams be able to prevent patient injuries by devising their own checklists?

Review and update policies that have patient safety objectives. Policies should be reviewed and updated with an eye toward making them more realistic and useful, rather than more complicated and convoluted. Further, physicians and dentists who are serious about patient safety include their employees as partners in the patient safety initiatives.

In an effort to make such policies realistic, it might be helpful to conduct an imaginary patient visit with staff members included. This imaginary visit should be used to note possible areas of risk and to determine how the behaviors of doctors and staff resolve – or enable – these risks. After such visits, evaluate your findings and formulate any necessary action plans. Action plans may include assessments designed to determine:

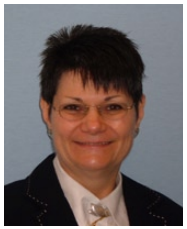
- whether policies need to be revamped,
- if staff training is adequate,
- if in-service education is needed,
- if job descriptions should be rewritten to include patient safety initiatives, and/or
- if patient safety is a key accountability for everyone associated with the practice.

In one dental office, a leaky sink went unrepaired for over two years – until a patient slipped and fell on the wet floor. In another example, a medical office kept discovering instances of sharps being wrapped up in paper exam table covers. The risky behavior was eventually attributed to a lone employee who was fired for her dangerous shortcuts.

"...it's...possible to infect the next patient or an employee even though those two individuals never come into direct contact."

Make a culture of safety a priority. The existence of a culture presumes that a group of individuals adhere to a common set of beliefs, customs, and traditions and pass these habitual behaviors along to ensuing generations. But cultures don't develop over night and they don't remain static. In 1847, Ignaz Semmelweis wasn't complying with current medical culture when he insisted that surgeons ought to wash their hands in order to prevent the transfer of infections. His comrades roundly rejected his theory and nearly 30 years went by before Louis Pasteur was able to convince the healthcare establishment that Semmelweis was right.

Today, 145 years after Pasteur's research discovery that germs do indeed spread disease, some healthcare environments still aren't "getting it," according to Marcia Patrick RN, MSN, CIC. In her role as director for infection prevention and control for the Multicare Health System in Tacoma, WA, Patrick is committed to ensuring that infection prevention is part of the organization's core commitment to patients, whether they are hospitalized or are being seen in their physicians' offices.



Marcia Patrick, RN, MSN, CIC, Director for Infection Prevention and Control, Multicare Health System, Tacoma, WA

"There are lots of ways to 'sell' patient safety to the team," Patrick told *Protector* in a January 2010 interview. Using examples within her own area of expertise, Patrick tells how her hospital utilizes research from the University of Pennsylvania Partners in Your Care hand hygiene program whose research established the number of expected hand hygiene episodes per occupied bed day for inpatient areas *and per office visit for outpatient areas* – as measured by the volume of soap and alcohol-based hand antiseptics used. According to Patrick, the Partners in Your Care program suggests that there should be six hand hygiene episodes *per outpatient visit.*

Knowing the volume of product dispensed with each push of the hand soap or gel dispenser, the medical or dental staff can calculate the number of hand hygiene events per month. All they have to do is measure the amount of soap and gel consumed and then divide by the volume dispensed per hygiene episode. If the number of hygiene episodes is less than six times the number of patient visits for the month, the results indicate a potential problem that warrants additional staff discussion. Even in a small medical or dental office, it ought to be easy to see if the exam room or operatory soap dispensers are full at the end of a busy day.

"During this seemingly year-long cold and flu season, we all need to find ways to break the chain reaction of infection," Patrick says. And one area that's been neglected in recent years is, "the idea that anything that touches the patient should be disinfected before it touches another patient," Patrick says. This means it's just as possible to infect the next patient or an employee even though those two individuals never come into direct contact. As examples, Patrick asks, "Got a vital sign chair? When was the last time

that it was cleaned? How often do you clean your blood pressure cuffs? Your pulse ox probe? All of your stethoscopes? Your cell phones?"

Infection control research shows that these materials can be prime sources of contamination – and there are lots of ways to deal with them, Patrick says. One example is pop-up disinfectant wipes, such as SaniCloth or CaviWipes, easily dispensable cloths that can be used by staff who are obtaining patients' vital signs or to prepare a dental or medical exam area before the next patient enters.

"Especially with multidrug-resistant organisms, we need to be careful that we're not taking MRSA from one patient to the next. Now, if a patient becomes colonized with MRSA in the office during a pre-op visit, that individual could be at risk for a surgical infection at a later date." The patient's increased clinical risk may also increase the doctor's liability with the convergence of several factors.

First, the public is aware of the possibility that infections have become more serious in recent years. There is a heightened expectation that, regardless of the venue of care, providers are doing all they can to prevent infections.

Second, as scientists track and analyze various strains of viruses and other pathogens, it is becoming easier to identify the source of some types of infections. So, that patient who claimed that she got MRSA from her physician's or dentist's office might be able to produce some evidence that would support her contention, especially if other patients of the same practice have also contracted a similar strain.

And third, the public expects to see visible evidence that medical and dental practices are putting in to place the kinds of infection and contamination prevention processes that are getting a lot of press coverage. Doctors and their employees who don't update their safety processes may be inviting patient complaints. According to recent media reports, some of these reports are filed with the doctors' offices – but some of them are taken directly to public health departments or state medical or dental boards.

Include patients as partners. In order to meet patients' expectations and heighten their level of trust, physicians and dentists should find ways to include their patients as partners in patient safety initiatives. If patients actually see their providers washing their hands and engaging in other infection prevention activities, their sense of confidence in the quality of care is positively affected. "There are lots of ways to include patients in the process," Patrick suggests. And, as a result of these collaborative efforts, patients feel more reassured about the competence of their providers while doctor and staff compliance increases.

Include patients on the front end, Patrick says. "For elective procedures, encourage people to reschedule their appointments if they have a cold or the flu. "That's not to say that someone who may have been vomiting for several days, or who has a child who's refusing to drink, should be given the impression that they can't come to the office. Patrick notes that the patient who has a serious condition, such as congestive heart failure, may still need to be seen because, for this individual, a bout with flu may have more serious complications.

Doctors' offices can use their appointment reminder calls to encourage patients to reschedule if they have the sniffles. It places the onus on the patient to make the decision about rescheduling and it doesn't take any additional staff time to accomplish the request.

One busy OB practice tells patients as they sign in that if their doctors don't wash their hands in their presence, they will receive a gift certificate!

In many offices, patients' entrance areas have undergone infection prevention updates with signs posted on the doors encouraging patients to use hand gels and wipes which are available at the reception desk and also to ask for masks if they have coughs or upper respiratory infections. If the office waiting room is big enough, Patrick advises sequestering patients with coughs and sneezing in a separate area. This is especially effective in offices where children are treated since the contamination rate increases with little patients who are too young to cover their mouths when they cough or sneeze – and who are unlikely to cooperate with having masks placed over their noses and mouths!

Hand cleaning stations can be located in a number of places in the waiting room, Patrick says, including the free-standing dispensers that patients encounter immediately upon entering the office. Aside from gels and masks being available at the registration desk, gels and tissues should also be available throughout the waiting area and in operatory and exam rooms as well. One family practice office has posted a sign over its scales. As patients weigh in they see:

Please join us in our efforts to provide a safe environment for our patients. Feel free to use these germ-killing towelettes – and thank you!

A number of practices are also asking patients to help the staff be mindful about hand cleaning. In a process called, "Tag – You're It!" one busy OB practice tells patients as they sign in that if their doctors don't wash their hands in their presence, they will receive a gift certificate! What the patients don't know is that the non-compliant doctor must pay for the certificate. Once this policy was implemented, doctor compliance with the hand-washing policy soared.

Collaborative efforts can improve infection control. Doctors, their staffs, and patients can make infection control a part of any medical or dental office's culture of safety. Infection control is just one example of patient safety initiatives that can be more effective and more easily implemented when medical and dental practices incorporate processes: a) that work; b) that aren't onerous; c) and that do improve the organization's overall approach to culture change.

Once everybody's on board with a sound hand washing program, there are other challenges to be met, Patrick says. An example?"Injection safety! One needle, one syringe, one patient. With multi-dose vials, not using them unless it's absolutely unavoidable (e.g., immunizations come in multi-dose vials), but never entering a multi-dose vial unless the needle and syringe are both new!"But that's a topic for a future *Protector* article! ■

1. Culture change needed to cut HAIs, says Johns Hopkins professor. *Materials Management in Healthcare*. January 2010.
2. Gawande, A. The Checklist. *The New Yorker*. Dec. 10, 2007. @ http://www.newyorker.com/reporting/2007/12/10/071210fa_fact_gawande. p. 4

RAC Audits Coming to a Location Near You

The Medicare and Modernization Act of 2003 established the Recovery Audit Contractor (RAC) as a three-year demonstration project to detect improper Medicare payments. Section 302 of the Tax Relief Health Care Act of 2006 gives the RAC program permanent federal status and mandates its implementation in all 50 states.

During the demonstration project, which ran between 2005 and 2008, over $900 million in Medicare overpayments were returned to the Medicare Trust Fund and providers received underpayment adjustments of nearly $38 million.[1]

With completion of the demonstration project, recovery audits are the first of several initiatives that CMS has announced it will roll out over the course of the next several years with the goal of improving the efficiency and payment processes for U.S. healthcare services.

The RACs essentially divide the nation into four separate regions. Each of these entities has authority to review payment processes in its multi-state area. Audits will include two types of reviews:

- Automated reviews: Use of existing database files to analyze claims and coding methods and to identify billing errors such as inappropriate claims bundling/unbundling and duplicate billing; and,
- Complex medical review: Selected medical records and billing documentation will be reviewed by auditors, with the intent to identify records that deviate from Medicare payment guidelines. These would include billing errors and payment denials with triggers such as incomplete documentation or care that fell outside the definition of medical necessity.

Healthcare providers should review their data files to ensure that billing and documentation procedures comply with CMS requirements. Records of periodic audits that show oversight of compatibility between clinical services and billing processes will be helpful in the event of a RAC audit, if for no other reason than they show the intent to comply and take appropriate corrective actions.

Staff training for billing and coding is essential because the demonstration projects revealed that, not only were many healthcare providers violating the law by up-coding services, but there were also many instances of providers losing legitimate reimbursement because of incorrect coding for charges that CMS would have paid.

During the demonstration project, which ran between 2005 and 2008, over $900 million in Medicare overpayments were returned to the Medicare Trust Fund and providers received underpayment adjustments of nearly $38 million.

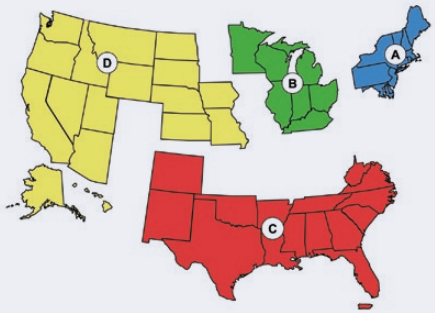
While hospitals are able to dedicate multiple resources to ensure accurate coding and billing practices, many small medical and dental offices may have difficulty complying with these rules simply because of staff shortages or lack of adequate training and oversight. This is not an area in which it is advisable to skimp on preparedness – especially in light of the RAC data indicating that so many practitioners may be under-coding their services, thus losing substantial income.

A certified billing/coding expert may be worth every penny of his or her salary if they can keep the practice on the right track in its billing and coding practices. Practices should have certain policies and procedures in place, such as periodic review and updates, support for staff training and compliance oversight, even without the threat of a RAC audit looming over their shoulders. And besides, in these tough economic times, a sound billing and coding system may be of real value if it ensures that the practice receives all of the reimbursement to which it is legally entitled! ■

1. Centers for Medicare and Medicaid Services. CMS Announces New Recovery Audit Contractors to Help Identify Improper Medicare Payments. Monday, October 6, 2008. http://www.cms.hhs.gov/apps/media/press/factsheet.asp?Counter=3292&intNumPerPage=10&checkDate=&checkKey=&srchType=1&numDays-3500&srchOpt=0&srchDate-&keywordType=All&chkNewsType=6&intPage=&showAll=&pYear=&year+&desc=&cboOrder=date

RAC Regions, Agencies, and States:

- **Region A: Diversified Collection Services, Inc., Livermore, CA:** Initial state assignments include: Maine, Massachusetts, New Hampshire, New York, Rhode Island, and Vermont.
- **Region B: CGI Technologies and Solutions, Inc., Fairfax, VA:** Initial state assignments include Michigan, Indiana, and Minnesota.
- **Region C: Connolly Consulting Associates, Inc., Wilton, CT:** Initial state assignments include: Colorado, Florida, New Mexico, and South Carolina.
- **Region D: Health Data Insights (HDI), Inc., Las Vegas, NV:** Initial state assignments include: Arizona, Montana, North Dakota, South Dakota, and Utah.



Update your Business Associate Agreement with Medical Protective:

In keeping with current revisions to the HIPAA provisions, Medical Protective encourages all insured clients to update their Business Association Agreement with the company. The 2010 agreement has been updated to reflect the new requirements of the HITECH rules.

To access the Medical Protective Business Association Agreement go to www.medpro.com, scroll to the bottom of the page and click on HIPAA.

Federal Trade Commission Delays Implementation of Red Flags Rule:

Congress May Reconsider Requirement Based on Practice Size

In October 2009, the Federal Trade Commission (FTC) announced its intention to delay the enforcement deadline of the Red Flags Rule from November 1, 2009 to June 1, 2010.

At almost the same time, the U.S. House of Representatives passed a bill that would exempt certain small businesses (including most small medical and dental practices) from the definition of "creditor," which generally requires compliance with the Red Flags Rule. The purpose of this legislation may be, in part, due to the negative effect the Rules might have on the ability of these entities to conduct business. However, the exemption doesn't currently address the issue that caused so much consternation for physicians and dentists – whether or not they should be classified as "creditors" in the first place.

American Dental Association President Dr. Ronald Tankersley said, "...the original Red Flags legislation was not meant to apply to small businesses like the vast majority of dental practices, but rather it was intended to encourage large businesses like banks, credit firms, and national retailers to implement best practices to protect customers from identity theft."

The Red Flags legislation is intended to require those who proffer credit to customers to implement a written Identity Theft Prevention Program designed to detect the warning signs– or "Red Flags" – of identity theft in their day-to-day operations, take steps to prevent the crime, and mitigate the damage it inflicts. This Program may include incorporating a higher level of security in various transactions in which customers' confidential information might be shared, stored, and protected.

In March 2009, the American Dental Association launched an initiative to obtain clarification on the type of business that should fall within the definition of "creditors" in the FTC requirements. In response to this initiative, and those of numerous other healthcare organizations, the House passed HR 3763, which, in part, excluded businesses with a specified number of employees from the definition of "creditor," and, as such, they are exempted from compliance.

In response, American Dental Association President Dr. Ronald Tankersley said, "…the original Red Flags legislation was not meant to apply to small businesses like the vast majority of dental practices, but rather it was intended to encourage large businesses like banks, credit firms, and national retailers to implement best practices to protect customers from identity theft."[1]

Over a year later, the bill remains in the Senate. Without passage of the bill into law, healthcare providers remain confused by the FTC's assertion that it will continue to enforce the Red Flag Rules, utilizing a standard of "reasonable compliance."[1] The FTC asserts that "healthcare providers are creditors if they bill consumers after their services are completed." Further, the FTC says that providers who accept insurance "are considered creditors if the consumer ultimately is responsible for the medical fees."[2]

With the passage of legislation in the House that would seem to specifically exclude the small medical or dental practice from compliance with the Red Flags Rule, it would be useful if there was further information about to what extent, and from what size of healthcare entity, the FTC expects "reasonable compliance." Stay tuned for updates from the FTC and on the bill's status in the Senate.[3] ■

1. Palmer, C. U.S. House passes ADA-backed Red Flags exemption legislation. *ADA News*. October 21, 2009. Found at: http://www.ada.org/prof/resources/pubs/adanews/adanewsarticle.asp?articleid=3799

2. Red Flags Rule: http://ftc.gov/bcp/edu/microsites/redflagsrule/more-about-red-flagsrule.shtm

3. Op cit.

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