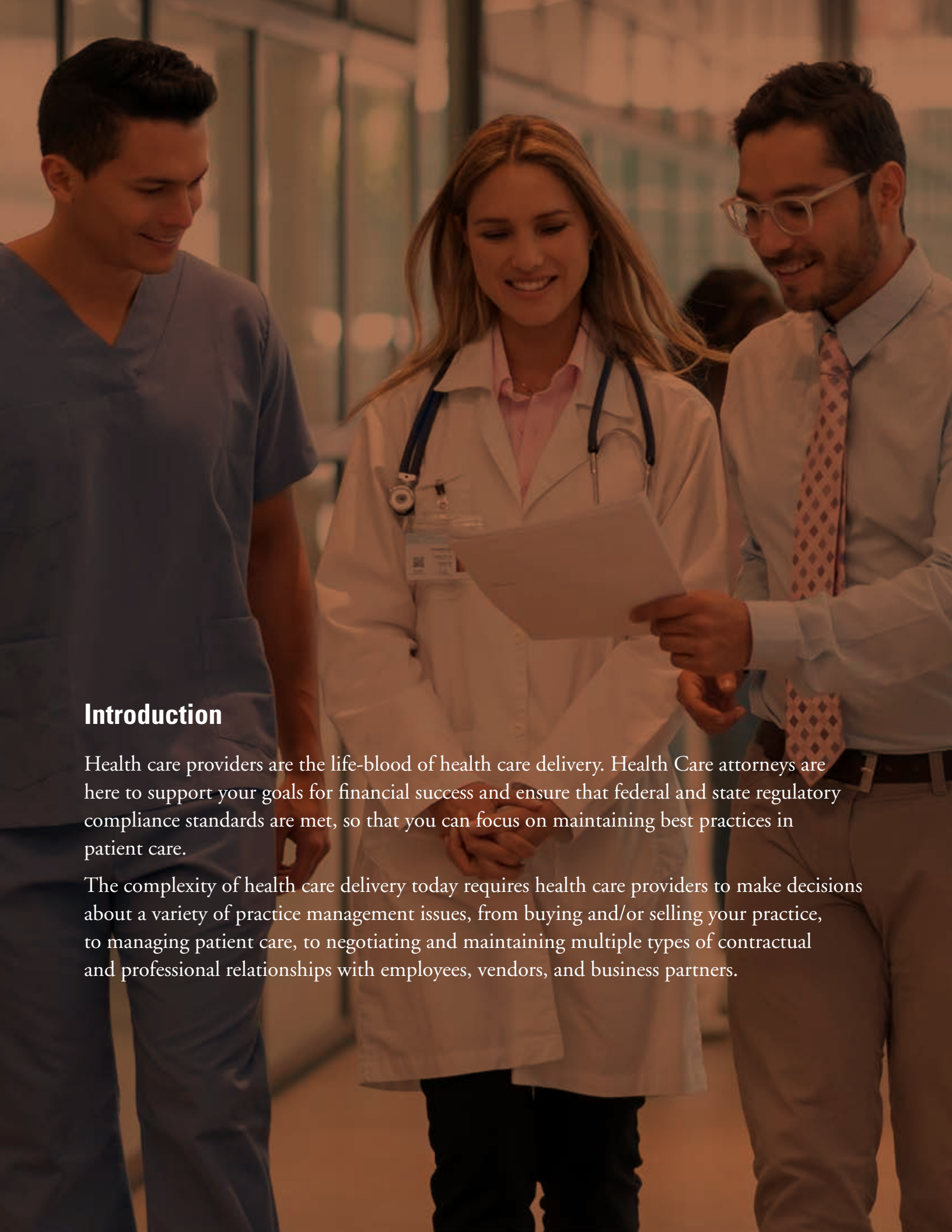
To The Point

Health Care

DAVIS | AGNOR RAPAPORT | SKALNY® Attorneys at Law



Introduction

Health care providers are the life-blood of health care delivery. Health Care attorneys are here to support your goals for financial success and ensure that federal and state regulatory compliance standards are met, so that you can focus on maintaining best practices in patient care.

The complexity of health care delivery today requires health care providers to make decisions about a variety of practice management issues, from buying and/or selling your practice, to managing patient care, to negotiating and maintaining multiple types of contractual and professional relationships with employees, vendors, and business partners.

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The well-prepared health care practitioner today is acutely aware, not only of the changing nature of the practice of medicine, but sadly, the seemingly endless demand for data. Data drives reimbursement rates, quality measures, and the analytics used for clinical decision making. To meet the demands of this data driven delivery model, you likely have ceded over more and more time to competently manage administrative and legal matters that can have a profound impact on your practice.

Moreover, making decisions about your medical practice will never be a one-and-done choice. There are simply too many moving parts and changing regulatory and practice standards that must be considered, planned for, successfully implemented, and continually revised.

Business and Practice Management

Buying or Selling a Medical Practice

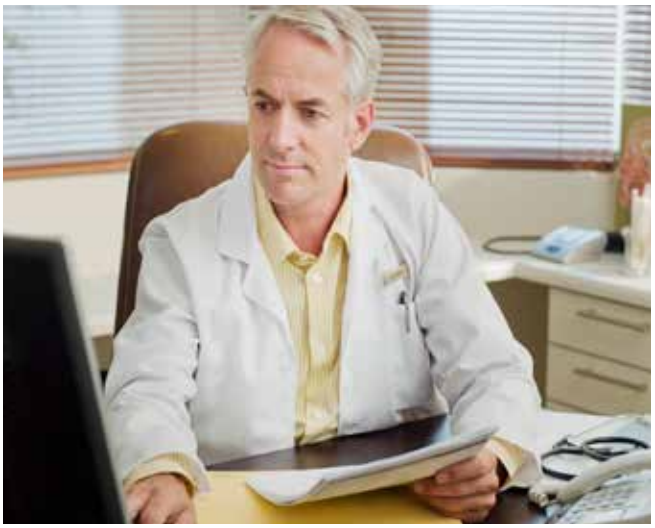
Your practice is an asset. When you decide to sell the practice many factors must be carefully considered to maximize your return on the sale. An established medical practice is built on the blood and sweat of your tireless care of patients, which earned their loyalty, and created an invaluable referral stream. But how much is that practice worth on the cold open market? The value assessment of a practice considers community-specific real estate factors, community demographics, established affiliations, patient payer mix, practice assets, cash flow, practice debt, and the regulatory environment of the practice location.

Health Care attorneys can also help connect an owner or purchaser of a practice with other professionals and experts who can provide valuation and brokerage services to help evaluate your unique practice characteristics and negotiate purchase and/or selling agreements.

Closing a Medical Practice or Separating from a Medical Practice

The decision to close or leave a practice demands planning to ensure all legal obligations are met and to avoid potential claims or complaints such as:

- Patient abandonment.
- Improper management of medical records.



- Safe Harbor violations.
- Improper or incomplete notification of practice closure.
- Violation of notification requirement to the Drug Enforcement Administration.
- Allegations of improper record keeping or nontherapeutic prescribing.

If, instead, you have decided to leave an active practice the focus shifts to confirm you meet contractual obligations and receive all reimbursements and considerations available to you.

Some key considerations while planning your exit from a practice will include:

- Process for terminating physician-patient relationship.
- Outline specific rights and obligations regarding non-compete restrictions.
- Identify your rights regarding an outstanding billing receipts.
- Clarify your malpractice tail insurance coverage for potential claims filed after departure.

- Identify your specific obligations regarding leaving contact information.

There are significant state and federal regulations that obligate physicians to a higher standard of responsibility which follows them through whatever practice model they choose and even into retirement. It is crucial that you navigate your professional decisions while meeting all legal and contractual obligations.

Business Contractual Agreements

Partnership Agreements

Most physicians, unfortunately, earn their business acumen only after entering the business of health care delivery. Too often that lack of professional business experience can have a devastating impact on your practice, expose you to avoidable regulatory violations, and impact your competitive standing within the limited talent pool of experienced physicians in your field of practice. Misinterpretations or assumptions about the intention and enforceability of contractual language can have real and lasting consequences.

When considering entering into a Partnership Agreement as a health care professional, know that the scope and language of these agreements will impact virtually every aspect of your professional life. And, for some, personal assets and quality of life can be put at risk. Partnership agreements can limit autonomy, impact risk exposure, undercut earning potential, and

unfairly tie business development targets to compensation. A skillful negotiation and informed draft agreement will consider the current business environment including legal, regulatory, and competitive considerations.

Employment Agreements

As with Partnership Agreements, crafting Employment Agreements for professional staff positions can be a powerful tool in defining the unique goals and priorities of your practice environment. Today, many medical offices or health systems have a diversified practice with a mixture of medical professionals that could include physicians, physician assistants, nurse practitioners, registered nurses, and para-professionals. Boilerplate contractual language can describe position, responsibilities, salary, and renewal options, but often fail to capture the unique nature and scope of practice of your office's professional staff. Ideally these agreements will reflect a thorough review of your business objectives, risks, and limitations.

Employment agreements have the power to define expectations, creatively structure compensation to incentivize proactive support of organizational goals and provide contractual default parameters.

Locum Tenens Physician Agreements

Practice patterns continue to evolve as the shortage of physicians, especially primary care providers, continues to force innovation to meet patient needs. The use of Locum Tenens physicians and other health care professionals has become a sustained component of health care delivery. This trend also responds to a growing preference among younger physicians to minimize responsibility for administrative tasks inherent to a full-time practice, while facilitating mobility and practice options, including part-time preferences of a diversified physician work force.

Employment contracts for any type of temporary staff creates administrative burdens. Locum tenen practitioner contracts are no exception, creating unique challenges to your practice. From your patient's perspective Locum Tenens are indistinguishable from practice partners or associates. It is therefore critical to perform exhaustive background and credentialing checks before offering any professional staff position regardless of the anticipated length of employment.

Lease Agreements

The physical environment in which a medical practice operates creates a sense of professionalism and serves as the physical backbone of your practice. Typically, practice location leases are long-term multi-year agreements. As such, a successful lease negotiation will leverage

every tenant advantage that the market and specific location will permit. It is important to understand and calculate your costs associated with structural maintenance, repairs, and responsibilities and improvements. Additionally, terms and conditions related to rent increases, renewal clause options, and maintenance of common areas must be reviewed through the prism of your practice objectives.

Medical practices have unique demands that must be protected in lease agreements. The ideal lease considers;

- Practice demographics.
- Parking demand.
- Availability of uninterrupted quiet areas.
- Hazardous waste volume and disposal options.
- Infrastructure demands for specialized equipment.
- Power back-up options.
- Opportunities for expansion.

Medical Practice Business Management Agreements

On-going monitoring of your medical practice's stable of providers, vendors, and supplier agreements is recommended to ensure compliance with regulatory requirements and alert you to any changes likely to impact those agreements. New and innovative business structures can drive your reliance on third-party entities to seamlessly integrate practice services, products, and structures, provide legal counsel and professional services such as physical therapy or laboratory testing services.

Ideally, Practice Management agreements define and codify product or service expectations, targets, compensation, terms and exclusions, while meeting all applicable regulatory requirements. As a covered entity, subject to Health Insurance Portability and Accountability Act (HIPAA) rules, medical practices must protect the privacy and security of each patient's health information. Every support entity's access to Protected Health Information (PHI) must be defined to ensure adherence HIPAA regulations.

Business Associate Agreements

Protected Health Information (PHI) is the heartbeat of your medical practice. Many services provided by external associates depend, to some extent, on access to your practice's PHI. To maximize the value of your practice's data power, defend against claims of malpractice, and ensure appropriate billing for services provided, these associate's access to PHI is vital. In order to extend Health and Human Services (HHS) Rules for patient privacy and security to those associates, you must establish Business Associate agreements with all individuals or organizations that provide these services. When your practice engages the services of non-covered entities, Business Associate agreements ensure that the security of shared PHI is in compliance with HHS guidance. These agreements also serve to specify each business associate's function, expected deliverables, and terms of payment.

A well-crafted business associate agreement protects you from potential sanctions or fines that result from the enforcement of HHS privacy and security rules by the Office for Civil Rights (OCR). Fines can range from $100 per record violation to a maximum of $1.5 million/year/violation. A comprehensive Business Agreement will protect your practice in the event of an unauthorized PHI disclosure or use by a third-party entity with whom you have an in-force business associate agreement.

Ancillary Service Provider Agreements

Ancillary service providers to whom your practice elects to refer are essentially, an extension of your practice. Referrals to external diagnostic and treatment providers are a routine part of your practice. And, like your practice, these providers are covered-entities, removing the need to establish a business associate agreement to cover Protected Health Information (PHI). Instead Ancillary Service Provider agreements are subject to several other federal and state statutes intended to

protect against ethical violations and protect patient's rights within the referral process. Ancillary Services agreements include federal and state mandated protections related to payments and incentives and identify safe harbor exceptions under The Centers for Medicare and Medicaid (CMS) federal anti-kickback regulations. These laws prohibit physician self-referrals to providers, labs, or other health services in which the referring physician or immediate family member would benefit financially.

Each Ancillary Service Provider agreement should clearly outline every aspect of the referral encounter and feed-back loop process that ensures continuity of care for your patients.

Vendor Agreements

Your medical practice likely engages a variety of in-house and/or third-party service organizations that provide material support for your practice such as office equipment suppliers, payroll services, Electronic Health Records (EHR) vendors, and IT help desk support. These non-covered service providers are unlikely to encounter Protected Health Information (PHI), and as such may not require contractual language in the Vendor Agreement that extends Health and Human Services (HHS) compliance requirements.

However, given the ubiquitous nature of PHI within your practice environment, Vendor Agreements should consider the process details for each contracted vendor to determine risk level for unintentional release of PHI identified risk should inform contractual language that holds the contracted vendor responsible to immediately disclose any unintended or inadvertent contact with PHI materials.

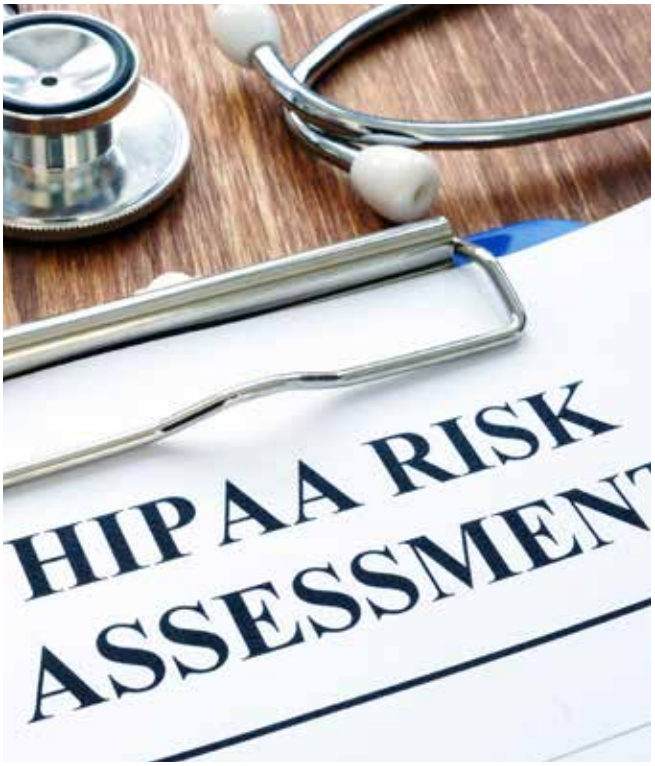
Electronic Health Record Software Agreements

Selecting the right Electronic Health Record (EHR) software system for your practice will have direct impact on productivity, accountability, reimbursement, and user satisfaction or frustration levels within your practice. Researching, vetting, and negotiating with EHR vendors can be a daunting task. Arriving at the contract phase of the EHR selection process presents a whole new set of technical, operational, and regulatory hurdles. EHRs, a fast evolving technology, has regulators struggling to keep pace with oversight controls. For example, gag clauses, pervasive in commonly used EHR software provider contracts, has been a recognized problem for years. Effectively preventing health care providers from sharing EHR error patterns, issues of concern, or even user-designed error patches can put patient safety at risk. Regulatory bodies including CMS and the Office of the National Coordinator of Health Information are expected to issue new rules that will ban gag clauses.

Keys to building a successful EHR contract will include considerations such as:

- Vendor responsibilities for system performance.
- Data ownership.
- Limitations, known as a gag clause, that restrict authorized users from disclosing software issues or problems with any non-authorized entities.
- System support for the integration of third-party technologies intellectual property licensing.

HIPAA and Medical Records Compliance



HIPAA Compliance

Health Insurance Portability and Accountability Act (HIPAA) privacy regulations set forth detailed compliance requirements that you and your staff must consistently practice. These regulations are frequently amended, creating new obligations for Electronic Health Records (EHR) users. It is highly recommended that your practice consult regularly with qualified HIPAA compliance experts. Annual HIPAA compliance training should be incorporated into your practice's policies.

Medical Record Risk Management Services

Although digital health care records are easily shared, archived, and combined with other electronic data sources, Electronic Health Records (EHRs) are clearly not a solution. Undeniably, EHRs have created an enormous body of data ripe for research, patient care improvements, and real-time analytics directed at informing continuous improvement efforts. But the current state of EHRs creates serious challenges to your time management demands.

The maturation process of EHR software integration into every facet of health care delivery clearly presents liability risks for providers. For example, EHRs are inching up the list of primary exhibits in medical malpractice claims due to problems associated with common digital format issues such as auto-fill, cut-and-paste errors, and digital time-stamped entries versus the actual sequence of events documented in the EHR. Developing EHR utilization habits and protocols that recognize risks can dramatically minimize your practice's exposure to claims of negligence, falsified documentation, and malpractice.

As your medical practice continues to adapt and refine its utilization of EHRs, there are risks uniquely created by EHRs. They include:

- Inter-operational failures.
- Data security breaches.
- Cut and paste overuse.
- Over utilization of templates.

Appropriate malpractice risk mitigation associated with EHR utilization starts with awareness and is sustained by maintaining best practice policies and procedures. EHR-related risk mitigation requires a continuous loop of training, updates, feed-back, and confirmation that all state and federal compliance standards are met.

Patient Care Issues

Access to Care Regulatory Requirements

A key component of any health care provider's risk management efforts requires compliance with federal and state regulations that protect vulnerable groups of patient's access to health care. Regulatory rules have evolved over the past 50 years. The regulations prohibit discrimination based on age, disability, and sex. And in 2010, Section 1557 of the Affordable Care Act (ACA) put in place sweeping anti-discrimination rules.

Protections under the ACA incorporate prior anti-discrimination laws and expands protections to include:

- Sex-based discrimination. Sex stereotype-based, non-binary gender identity discrimination.
- Expanded meaningful access to include Limited English Proficiency (LEP) support.
- Expanded disability-based discrimination to include access to medical equipment.

Providers are required to file an assurance of compliance form. The form establishes documentation that your practice has implemented the anti-discrimination rules outlined in Section 1557.

These expanded anti-discrimination regulations, though codified in federal and state laws remain controversial, with judicial decisions that both uphold and block various sections, including the protections extended to non-binary patients. However, judicial challenges not-withstanding, patients can still sue, in federal court, any covered provider who violate Section 1557. The OCR final rule also clarifies that compensatory damages are available in Section 1557 actions. Prudent risk-adverse practices should be in compliance with existing federal and state laws, thereby avoiding the uncertainty of judicial challenges.

Managing Non-Compliant and Disruptive Patients

It is likely that, at some point, your practice will encounter patients that are non-compliant with medical management recommendations or present with such volatile behavior that your staff and/or other patients are put at risk. The Centers for Medicare and Medicaid (CMS), in recognition of this patient care

phenomenon, has now activated four ICD10 reimbursement codes for specific types of non-compliance.

Your practice can control only a limited number of the possible reasons for non-compliance or behavioral issues. Chronically non-compliant or volatile patients can often prevail in malpractice claims despite your practice's attempts to encourage compliance, investigate cause, or intervene, but are not thoroughly documented in the medical record. Your culpability will be judged, not by your intentions or even your repeated attempts to encourage compliance. Instead, your care will be judged by the patient's medical record.

It is the burden of your practice to comprehensively document efforts aimed at improving compliance with recommended treatments, especially when the continued non-compliance is linked to demonstrable deterioration of the patient's health.

Comprehensive documentation can scuttle attempts to use he-said-she-said testimony to demonstrate allegations of your failure to meet standard of care. Documentation must include the details of patient encounters; recommendations, rationale, and patient response/inquires.

Terminating Physician-Patient Relationship

Knowing when and how you can safely terminate the physician-patient relationship is key to minimizing claims of negligence. When done correctly, your practice is protected from legal repercussions.

A certain amount of belligerence, anger, obfuscation is expected, accommodated even, but there are limits. Sometimes the best solution, or maybe the only solution, is to dismiss a patient from your practice. Where and when you choose to draw the line is a tough decision to make, never to

be made in haste or precipitously. It is a decision fraught with legal pitfalls.

Charges of patient abandonment, breach of health system contractual obligations, complaints to your licensing board, and cyber-bashing or trolling, are all serious potential consequences of your decision to fire a patient. A comprehensive approach to ensuring that all patients served by your practice are optimally managed requires practice-wide awareness with a clear process for reporting warning signs of impending or potential problems. Early recognition and policy-based responses can significantly reduce risks and avoid on-going unproductive negative encounters with patients and provide guidance as to whom and when a patient can be legally discharged.

Establishing a termination policy and procedure must consider;

- Payor, statutory, and regulatory limitations.
- Establish a termination documentation process.
- Create patient focused version of termination policy.
- Define criteria for appropriate patient termination which include:
  - Any non-discriminatory reason.
  - Written notification to the patient.
  - Patient's current care is not at an acute stage.
  - Patient is not in the third trimester of pregnancy.

As a preemptive measure distributing the patient focused brochure to all new patients firmly establishes expectations regarding payment of bills, in-office behavior, appointment cancelations, and policies regarding non-compliance with recommended medical treatments.

Physician Rights to Refuse Patient Care

Generally, physicians have a fiduciary relationship with their patients. Physician education, training, and experience creates an obligation to recommend and provide care that is in the best interest of patients. Accepting a patient into your practice's schedule signals your intention to treat and thereby initiate a physician-patient relationship. Likewise, once you have actually seen the patient, a relationship is established. Once established the physician-patient relationship can only be terminated as described under Terminating Physician-Patient relationship section above.

Although there are regulatory parameters that limit your ability to terminate or refuse to treat a patient(s), the following list provides a guideline of acceptable circumstances for refusing to treat patients:

- No health care insurance or independent means of payment.
- Anticipated or requested care and treatment that you judge to be ethically inappropriate or contrary to your religious beliefs.
- Patient request specific treatment or medication for their condition or disease that you deem to be inappropriate.
- When your practice has reached capacity.

Knowledge of prevailing laws, enforcement factors, potential fines, and documentation requirements can make all the difference when making the choice not to treat some patients.

Transgender Care Issues

Currently a little less than 1% of the American population identifies themselves as transgender. However, this population has a disproportionately high rate of illness and death when compared to the general non-transgender population. Health disparities among the transgender community include high incidence rates of depression, substance abuse, sexually transmitted diseases, and suicide attempts.

From the perspective of a medical provider, care for transgender individuals is generally indistinguishable from care provided to other patients. The exception is the provision of whatever support and care a transgender individual may request when seeking medical and/or surgical solutions to achieve physical alignment with their gender identification.

Discrimination on the basis of sex is illegal under federal and state laws. Section 1557 of the Affordable Care Act (ACA), as signed into law, prohibits sexual discrimination, including gender-identity discrimination by health insurance companies and providers that receive federal funding or have at least one plan on a federal or state marketplace. This means that insurance companies cannot exclude transition-related care and protects transgender individual's right to treatment according to their gender identity. Generally, that means any health care treatments or procedures that are covered for non-transgender patients would also be available to transgender patients.

Although the antidiscrimination section of the ACA is under judicial challenge, organizations like the American College of Physicians (ACP), the American Medical Association (AMA), and the American Academy of Family Physicians (AAFP) all oppose discrimination against transgender persons, and have made great strides toward creating a welcoming clinical environment.

Telehealth

The Telehealth infrastructure has deeply penetrated the health care market place. Telehealth, by its most comprehensive definition accomplishes a spectrum of tasks that range from off-site staff training programs to consultative and diagnostic communications between patients and providers. The integration of telehealth services into your practice model must consider regulatory oversight for patient safety and privacy, on-going cybersecurity

measures with monitoring and response policies, and on-going assessment of liability exposure.

Regulatory oversight is certainly routine to your practice. But telehealth is a fast moving technology. Since 2017, the U.S. Congress has introduced forty-one bills that would require Medicare to reimburse for the use of telehealth in caring for a cluster of health conditions. In February, 2018 Congress enacted the Creating High-Quality Results and Outcomes Necessary to Improve Chronic (CHRONIC) Care Act of 2017. The new law removes restrictions that had limited reimbursement for telehealth by Accountable Care Organizations (ACOs) that use telehealth to monitor and treat patients, and expands telehealth's use to more patient populations. There are several bills working their way through both federal and state-level legislative bodies that will impact the practicality of telehealth as a routine tool of your medical practice.

Telehealth regulations vary between states and as it continues to evolve, practitioner's need to be aware of regulatory requirements and limitations, such as state-line restrictions, credentialing requirements, and inadequate liability and malpractice coverage for telehealth services.

A technical barrier may be limited reliable internet connectivity. In 2017 the Federal Communications Commission (FCC) eliminated net neutrality rules that had required internet providers to treat all web traffic equally. With the removal of that restriction, broadband providers can now charge fees for high-speed internet service, which is often required for effective and robust telehealth services. The impact of the loss of net neutrality on the practicality of telehealth services remains unclear.

The specter of a cyber security breach with the loss of Patient Health Information (PHI) can have a catastrophic effect on patient confidence and willingness to participate in telehealth applications. Establishing comprehensive reliable cyber security will always be a challenge, with ever increasingly sophisticated challenges. Through the Cybersecurity Act of 2015, Congress established the Health Care Industry Cybersecurity (HCIC) task Force to identify and address risks faced by health care providers to ensure cybersecurity. In June 2017 HCIC released its first report that outlines cybersecurity priorities, which include:

- Increase security and resilience of medical devices and health IT.
- Increase health care industry readiness through improved cybersecurity awareness and education.
- Improve information sharing of industry threats, risks, and mitigations.

There are several federal, state, and professional organizations that have committed significant resources to improve all manner of IT-based service tools. Cautious development of organizational telehealth services will consider the obvious advantages these systems offer, while remaining vigilant for privacy threats, changes in reimbursement requirements, and the ever-changing needs associated with maintaining information integration and sharing functions.

Regulatory requirements and standards of care will continue to evolve as telehealth practice models mature. Telehealth is the natural progression of our increasingly digitized world, offering limitless tools to achieve continuity of care.

Medical Practice Human Resource Issues

Background Checks

Office personnel will always be your most important asset, but they can also be your worst nightmare. Approaching the recruitment and hiring process in a rigorous way, using a policy that reflects current best practices, can protect you from the nightmare of a bad hire. And in some settings, on-going and periodic targeted checks prove equally valuable.

Objectives of a comprehensive background check include:

- Source candidate information from third-party entities to substantiate and/or verify candidate provided responses.
- Acquire confirmation of candidate's qualifications.
- Determine/confirm candidate history regarding criminal convictions, motor vehicle violations, credit history, educational achievements, and work history.

To avoid bias in your hiring process, your practice's policies should reflect consistent and equal measures are applied to every candidate within defined categories of employment. For example, the depth of character references and/or job performance background checks you deem as important in hiring associate physicians is likely to be different than what you need for hiring a front desk receptionist. Whatever the investigative depth is for each positions, your records need to reflect that the level of scrutiny applied to one candidate in a job category was also applied to all other candidates.

The U.S. Equal Employment Opportunity Commission (EEOC) requires that employers who use background information, regardless of how it was obtained, to comply with federal laws established to protect candidates from discrimination. And if your practice engages a third party to conduct background checks you are required to comply with the Fair Credit Reporting Act (FCRA). Accordingly, to ensure compliance you must:

- Provide written disclosure to the candidate or employee of your intention to conduct a background check and obtain written

consent from them prior to initiating the background check.

- In the event of a negative background check report, send candidate/employee a Pre-Adverse Action Notice before deciding not to hire or to fire the candidate/ employee based on the background checks findings. Provide candidate/employee a copy of the background report. Notify the candidate or employee that they have the right to dispute the accuracy of the report.
- Provide the candidate or employee contact information of the third-party that performed the background investigation. Inform candidate or employee that the third-party investigator did not make the decision to hire or fire them, and therefore cannot provide specific reasons that lead to decision.
- Once adverse background content is confirmed to be accurate and candidate/ employee has had adequate time to dispute the findings, employers can send an Adverse Action Notification to formally decline to hire an applicant/or to fire an existing employee.

Other state laws governing background checks generally are refinements of existing federal laws. For example, Maryland law excludes listing most criminal convictions older than 7 years on criminal record reports, while the District of Columbia extends felony conviction reporting to 10 years and Virginia criminal record reports prohibits listing any expunged convictions.

Social media, as a legitimate resource for background investigations, is an evolving consideration. State laws generally protect the individual's right to privacy for their personal social media accounts, but are trending toward allowing limited access when reasonably warranted.

Overtime Policies

Your practice's overtime policy must incorporate all federal, state, and local jurisdictional laws and regulations. Professional staff, which includes physicians and other licensed clinical professionals, and highly compensated administrators *(total annual compensation of $100,000 or more),* are, in most cases, exempt from overtime requirements.

Nurses are generally considered a member of the learned professional employee category, and are therefore likely to be exempt from the Fair Labor Standards Act (FLSA)

overtime requirements. Licensed practical nurses and lab technicians however generally do not meet the learned professional exemption requirements based on their educational training, and are therefore eligible to earn overtime pay. Your practice's overtime policy must reflect federal and state regulations, as they apply to each category of practice staff.

Work Place Safety Requirements

The United States Department of Labor is the primary regulatory body that dictates occupational health and safety regulations. The Occupational Safety and Health Administration (OSHA) promulgates safety standards (Standards – 29 CFR) that are utilized across the spectrum of employment environments, except most federal agencies and departments, that operate in the United States, including the District of Columbia, and U.S. territories.

Applicability of OSHA regulations within the health care delivery system will vary widely, depending on services and equipment involved for the provision of those services. As a general rule, medical practice offices will have relatively few significant safety risks, but what there are can be quite lethal. Proper risk management protocols for needle use and disposal, radiation exposure, handling of tissue and fluid specimens, and any other risk related job function, must meet OSHA standards.

OSHA regulations require detailed scrutiny when designing or reconfiguring your practice's physical space and access to that space.

Professional Negligence Claims and Disciplinary Complaints

Malpractice and Professional Negligence Claims

The specter of a malpractice or negligence lawsuit is ever present in the practice of health care delivery. The percentage of your income spent on malpractice insurance can vary wildly, depending on your specialty, location, participation rules of health care insurance carriers, and state laws that govern malpractice requirements and payment caps. Not all states require that you carry malpractice insurance, including Washington D.C., Maryland and Virginia. However, most physicians do carry some amount of malpractice insurance to shield against the financial jeopardy posed by a lawsuit. In Washington D.C. litigation risks

are heightened because of the lack of tort reform that would limit or cap monetary payouts. But regardless of the financial risk that accompany malpractice claims, whether they are warranted or not, the burdens imposed on your time and the disruption to your practice cannot be overstated.

Medical malpractice claims move through the judicial system at a pace completely out of your control. The adjudication of a single lawsuit can last years, demanding time and focus away from your practice. Lawsuits can place demands on your practice's administrative staff to locate and produce every bit of salient office records including, patient's medical records, call logs, third-party transaction reports, such as contact with pharmacies and diagnostic testing centers, and billing records. Your direct involvement in the case will likely require preparation for and participation in depositions and/or court appearances.

Though malpractice insurance carriers assign counsel after a covered claim is filed, retaining personal counsel to anticipate legal risk can often avoid claims through proactive management of risks, minimize demands on your time, and protect your rights.

Licensing Issues

Each state has a medical board that serves as a regulatory body to ensure patient safety and the professional competency of physicians and other allied health professionals licensed within its jurisdiction. Boards are responsible for issuing licenses and certifications, enforcement of criminal and disciplinary provisions of the Medical Practice Act, determination and implementation of licensing status, and monitoring the quality of medical practice as performed within its jurisdiction.

Protecting your license to practice may

sometimes require you to respond to complaints. Complaints risk damage to your reputation and your right to practice medicine. The complaint process is intentionally streamlined, allowing consumers unfamiliar with practice standards for physicians to easily file a complaint. There are no restrictions on who or when a complaint can be filed with appropriate jurisdictional Medical Boards or federal agencies like the Office of Civil Rights (OCR). Most complaints are resolved with facilitated communication between provider and patient. For those that are not easily resolved, each state's Board of Medicine has established procedures by which complaints are investigated, violations, if any, are identified, and consequences are determined. Judgement regarding whether a violation has been adequately demonstrated, physician's culpability identified, and the severity of the breach in terms of risk to patient safety, and prior licensure sanctions all contribute to what actions are taken following the administrative hearing phase of complaint investigations.

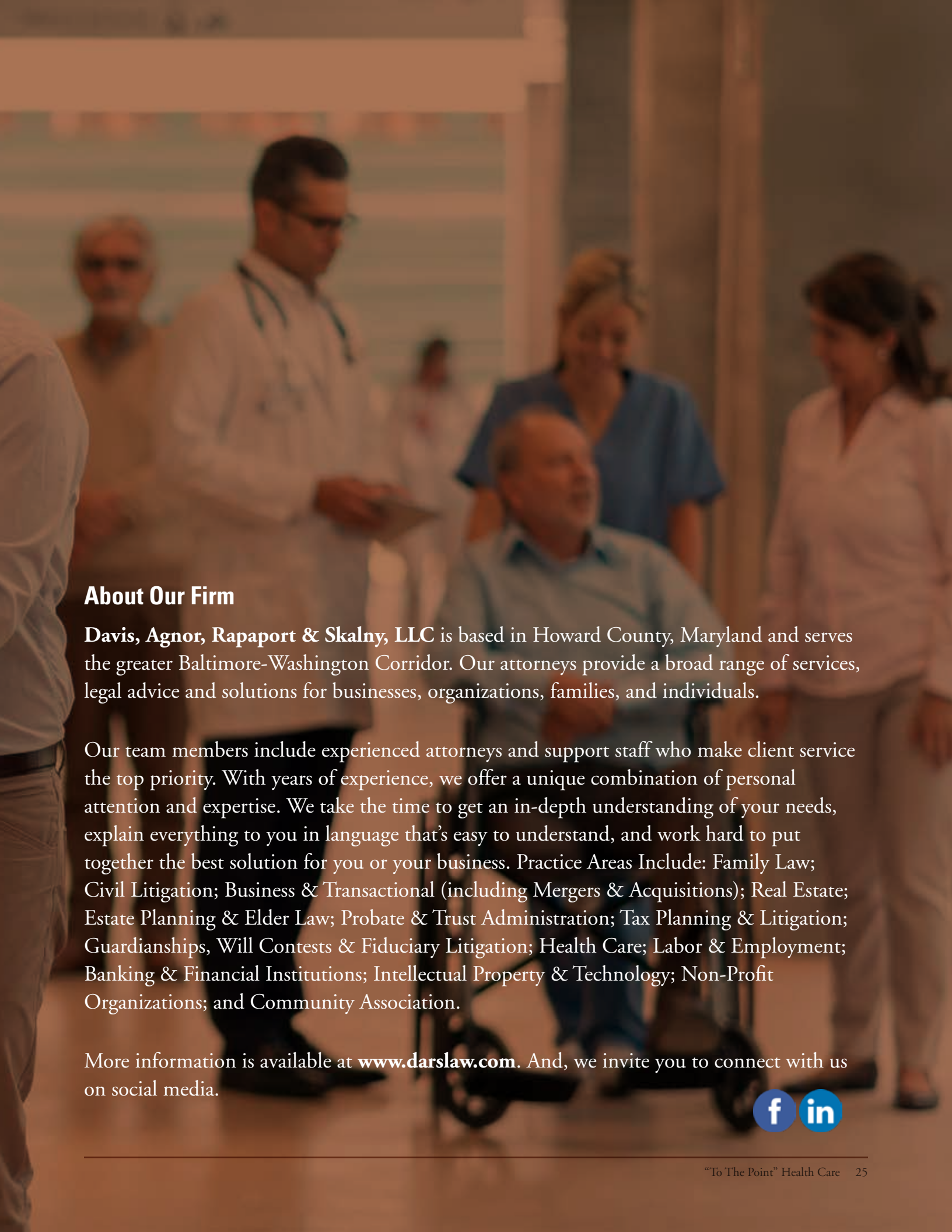
When an initial investigation finds substantive evidence of a violation of the Medical Practice Act, the process then moves to a formal administrative hearing with an administrative judge. It is critical, at this point, to seek legal representation, regardless of your assessment of the seriousness of alleged violations or risk adverse findings in the absence of proactive defense against a complaint. State Medical Boards that find against a physician publish all disciplinary and investigative actions taken. These findings remain accessible to anyone who searches a physician's practice record.

Another complaint avenue that is broadly available to consumers and can jeopardize your license, is through state quality improvement organizations (QIOs). These entities focus on issues involving Medicare and/or Medicaid patient care. Like state Board of Physician practices, QIOs respond to consumer complaints, resolve many with simple clarification support, but work with state Boards of Physicians for complaints requiring more investigation. If a complaint reveals possible violation of federal statutes like HIPAA rules, the OCR will perform the investigation. These investigations can result in decisions ranging from a simple correction to achieve regulatory compliance to civil money penalties (CMPs), based on the evidence presented. When CMPs are imposed, physicians are entitled to a hearing with a Health and Human Services (HHS) administrative judge who will decide what penalties will be imposed.

Conclusion

Health care law requires a great deal of knowledge, skill and experience with issues regarding standard of care, government regulation, compliance, ethics and administrative law, among others. There's often a lot at stake for health care professionals facing civil, criminal or administrative actions. Our firm is focused on finding the best solutions so you can focus on your critically important work.

If you have questions about your health care practice or law needs, please feel free to call us at 410-995-5800 or visit www.darslaw.com.



About Our Firm

Davis, Agnor, Rapaport & Skalny, LLC is based in Howard County, Maryland and serves the greater Baltimore-Washington Corridor. Our attorneys provide a broad range of services, legal advice and solutions for businesses, organizations, families, and individuals.

Our team members include experienced attorneys and support staff who make client service the top priority. With years of experience, we offer a unique combination of personal attention and expertise. We take the time to get an in-depth understanding of your needs, explain everything to you in language that's easy to understand, and work hard to put together the best solution for you or your business. Practice Areas Include: Family Law; Civil Litigation; Business & Transactional (including Mergers & Acquisitions); Real Estate; Estate Planning & Elder Law; Probate & Trust Administration; Tax Planning & Litigation; Guardianships, Will Contests & Fiduciary Litigation; Health Care; Labor & Employment; Banking & Financial Institutions; Intellectual Property & Technology; Non-Profit Organizations; and Community Association.

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