



RHODE ISLAND

# MEDICAL NEWS

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## The 2010 General Assembly session: One for the record books

### – But not because it was unusually productive . . .

The 2010 session of the Rhode Island General Assembly was remarkable for two unheard of events: the mid-session election of a new House Speaker, and the Senate's rejection of the supplemental budget proposed by the House. It was unremarkable for legislation passed, aside from a new school funding formula.

The looming November general elections and the State's intractable fiscal straits combined to put a damper on legislative exuberance and may have killed whatever appetite House Speaker William Murphy (D-Warwick, Coventry) might still have had for a fifth term at the rostrum. In March the 47 year-old Murphy announced that he was stepping down from the Speakership and would retire from the General Assembly altogether at the end of this, his ninth term in the House. He thus paved the way for the rare mid-session election of House Majority Leader Gordon Fox (D-Providence) to the Speakership. Usually, the election of a Speaker is the first order of business in the January of odd-numbered years, when the Assembly begins a new two-year session. January 2011 will be no exception, but now Fox will face that election as the incumbent Speaker with enhanced prospects for reelection, this time to a full, two-year term.

### Dropping the budget ball

The other curiosity was perpetrated by the Senate, which broke with a 30-plus year tradition when it rejected the House's supplemental budget for the fiscal year that ended June 30. Constitutionally, it is the responsibility of the House to formulate the budget and send it to the Senate for concurrence. House Finance

Committee members generally rely on collaboration from their Senate counterparts in developing the budget, so Senate acceptance is normally preordained and free of intrigue. Thus, the rejection of the 2010 supplemental spending plan left veteran State House observers scratching their heads. Ultimately, the 2010 supplemental budget was rolled up with the 2011 budget and passed by both chambers in that form.

Aside from these two novelties – the new mid-session Speaker and the budget surprise – the legislative year was memorable for little other than an early adjournment and stampede for the doors.

Among the relatively few bills left standing to become law were two initiated by RIMS. House bill 7450 Sub A, and its Senate twin, S-2806 Substitute-A, introduced by Representative Frank Ferri (D-Warwick) and Senator Rhoda Perry (D-Providence), respectively, allows physicians, physician assistants and nurse practitioners to treat the partner of a patient for certain sexually transmitted diseases without first examining the partner. Twenty-two other states already permit "expedited partner therapy," which is consistent with the guidelines established by the Centers for Disease Control.

The second successful piece of RIMS legislation is a re-write of the licensing statute for radiological technicians (House 7273-Aaa, by Pollard, and its companion bill, Senate 2130-A, by Gallo). Rad techs have been licensed in Rhode Island since 1994 under a statute co-authored by the techs and RIMS. Given advances in technology in the intervening years, RIMS saw the need to work with the Rhode Island Radiological Society and the Department of Health to update the statute. *continued p.8*



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#### RHODE ISLAND MEDICAL NEWS

is the newsletter of the  
Rhode Island Medical Society  
235 Promenade Street, Suite 500  
Providence RI 02908  
Phone: 401-331-3207  
Fax: 401-751-8050  
Email: RIMS@rimed.org  
Website: www.rimed.org

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#### EDITOR

Newell E. Warde, PhD

#### GRAPHIC DESIGNER

Marianne Migliori

The Rhode Island Medical Society  
was founded in 1812 to promote  
the art and science of medicine.  
RIMS is the eighth oldest state  
medical association in the country.

In cooperation with the Brown  
University School of Medicine,  
the Rhode Island Department  
of Health, and Quality Partners  
of Rhode Island, the Society also  
publishes a monthly magazine,  
*Medicine and Health Rhode Island*.

#### RIMPAC NEWS

## The new federal legislation raises the stakes for doctors and patients in this fall's primary and general elections

2010 is an election year in Rhode Island. That means that all statewide general offices (Governor, Lieutenant Governor, Treasurer, Secretary of State and Attorney General), as well all 113 General Assembly seats, Rhode Island's two seats in the U.S. House of Representatives (Patrick Kennedy and James Langevin are the incumbents) and many mayors, town councils, school committees, etc. will be in play on November 2. Primary elections for all the intra-party contests will take place on Tuesday, September 14.

Rhode Island must elect a new governor and a new attorney general because the current incumbents are term-limited. Rhode Island will also elect a new general treasurer because the incumbent is running for governor. The First Congressional District is an "open seat" (i.e., no incumbent is running for reelection this year) for the first time in decades, because Congressman Patrick Kennedy will be retiring from Congress when his eighth term in the House of Representatives ends this year. With more than a dozen retirements in the General Assembly and with a sharp increase in the number of candidates who have filed for offices at all levels, this year's general election promises to be one of the most interesting and momentous in memory.

The new federal health care reforms raise the stakes for this year's fall elections, because the new law places much authority for implementation in the hands of the states. The general officers and the General Assembly who assume office at the start of 2011 will bear historic responsibility for shaping the future of Rhode Island health care.

Accordingly, RIMPAC, under the leadership of its Chair, former RIMS President and former General Assembly member Nick Tsiongas, MD, MPH, is especially active this year. A full listing of candidates who have received contributions from RIMPAC is available on the homepage of RIMS' website, [www.rimed.org](http://www.rimed.org). Below are brief notes on some of the key races this fall.

**GOVERNOR** The gubernatorial race became a little simpler with the withdrawal of Democratic candidate Patrick Lynch, Rhode Island's current Attorney General, but five candidates remain in the race as of this writing: Kenneth Block of the Moderate Party; current General Treasurer and former state senator Frank Caprio, a Democrat; former U.S. Senator Lincoln Chafee, running as an independent; and former state representative Victor Moffit and John Robataille, both Republicans. RIMPAC has made the maximum allowed contribution of \$1,000 to the Caprio and Chafee campaigns.

**LT. GOVERNOR** The incumbent, Elizabeth Roberts, is seeking re-election and faces a primary challenge from Red Sox advisor Jeremy Kapstein. Several Republicans are competing in the September 14 primary for the privilege of running against Kapstein or Roberts. RIMPAC has made the maximum allowed contribution of \$1,000 to the Roberts Campaign.

**ATTORNEY GENERAL** This seat is an open because the incumbent is term-limited. Democrats competing in the primary are Steven Archambault, Joseph Fernandez and State Representative Peter Kilmartin. Christopher Little is running on the Moderate Party ticket. Erik Wallin is the lone Republican in the race. Two independents have filed papers: Keven McKenna and Robert Rainville. The role of the Attorney General, as the state's chief consumer protector and anti-trust enforcer, has become increasingly important to health care in the past two decades.

RIMPAC has made the maximum allowable contribution of \$1,000 to the Kilmartin campaign and a \$500 contribution to the Little campaign.

**SECRETARY OF STATE** and **GENERAL TREASURER** RIMPAC generally does not make contributions to candidates for these offices.

**GENERAL ASSEMBLY** A substantial number of new faces may grace both chambers of the General Assembly come January. Some fifteen seats are open (i.e., no incumbent is seeking reelection), and most incumbents are facing challenges – in some cases multiple challenges.

Voters in the following five districts have a chance this year to vote for a physician or a nurse to represent them in the General Assembly:

**Senate District 35** (East Greenwich/North Kingstown/Warwick): The Honorable Mark Schwager, MD, a two-term member of the East Greenwich Town Council, is the endorsed Democratic candidate for this seat, which became open when the incumbent retired. Dr. Schwager faces a stiff primary battle on September 14, and whoever prevails in that contest will face a well-funded, business-supported Republican rival in November. RIMPAC has made the maximum allowed contribution of \$1,000 to the Schwager campaign. More information on this critical race is available at [www.doctormarkforsenate.com](http://www.doctormarkforsenate.com). Supporters can also contact the campaign at [doctormarkforsenate@gmail.com](mailto:doctormarkforsenate@gmail.com) or 401-884-1388.

**Senate District 11** (Bristol/Portsmouth): Christopher Ottiano, MD, is making his third run for the seat held by Senator Charles Levesque. Sen. Levesque is a member of the Senate Committee on Health and Human Services and has sponsored legislation on behalf of RIMS during his three terms in the Senate and previously during his eight years in the House of Representatives. RIMPAC has contributed \$250 to Senator Levesque's campaign.

**House District 3** (Providence): Daniel Harrop, MD, is making another run against the incumbent, Rep. Edith Ajello. Rep. Ajello has long been a solid RIMS ally and has sponsored many bills on RIMS' behalf. RIMPAC has contributed \$300 to Rep. Ajello's campaign.

**House District 49** (Woonsocket): Stuart Gitlow, MD, is making his first run for office challenging the incumbent in the Democratic primary. Supporters can contact Dr. Gitlow's campaign at [drgitlow@aol.com](mailto:drgitlow@aol.com) or 401-338-0493.

**House District 20** (Warwick): David Bennett, RN, is seeking to oust the incumbent in a democratic primary. Mr. Bennett narrowly lost a Senate primary in an open district in 2008. RIMPAC has contributed \$100 to the Bennett campaign. His campaign website is [www.joinbennett.com](http://www.joinbennett.com).

## RIMS 198th Annual Member Banquet

**Saturday, October 2, 2010**

**Squantum Association, East Providence**

**Look for your invitation in the mail**

The following new leadership team was duly elected by the RIMS Council on June 6, 2010, and will be installed in office on October 2:

Gary Bubly, MD	<i>President</i>
Nitin S. Damle, MD	<i>President-Elect</i>
Alyn L. Adrain, MD	<i>Vice President</i>
Elaine C. Jones, MD	<i>Secretary</i>
Jerry Fingerut, MD	<i>Treasurer</i>
Marlene Cutitar, MD	<i>Councilor at Large</i>
Scott E. Wang, MD	<i>Councilor at Large</i>
Steven R. Fera, MD	<i>Councilor at Large</i>
Martin R. Papazian, MD	<i>Councilor at Large</i>
Joel M. Kaufman, MD	<i>Adjunct Councilor at Large</i>
Ira M. Singer, MD	<i>Adjunct Councilor at Large</i>
Michael E. Migliori, MD	<i>Delegate to AMA</i>
Peter A. Hollmann, MD	<i>Alternate Delegate to AMA</i>

RIMPAC is a non-partisan medical political action committee that seeks to promote the election and re-election of state and local public officeholders who are friendly to medicine and knowledgeable about health care. Neither RIMS nor RIMPAC endorses candidates for any office. RIMPAC advises AMPAC (the American Medical Political Action Committee of the AMA) on potential support for candidates for federal office representing Rhode Island.

RIMS and RIMPAC encourage physicians to be politically engaged. RIMS routinely supports its members' involvement in political campaigns by helping physicians reach out to other physicians in support of candidates of their choosing.

While the political arena is decidedly not for everyone, political competition does affect everything and everyone (and everyone's children), for better or worse. Much is always at stake for physicians and their patients in the political arena, and even more than usual is at stake in this time of change.

It has long been a basic tenet of medical ethics that physicians' dedication to human wellbeing implies a professional responsibility for political awareness and political action. Professional associations like RIMS and the AMA, and medically-oriented political action committees like RIMPAC, AMPAC and many national and state specialty PACs, make it relatively easy and painless for physicians to fulfill this special responsibility to society. ❖



## What were they thinking?

### Reflections on recent history, U.S. health care policy and the role of organized medicine

As part of the ongoing national debate over health care reform, hefty discussion continues within the medical profession, much of it under the aegis of the AMA and its 500+ member House of Delegates.

The AMA House has long been the most representative and comprehensive policy-making body in American medicine. Over many years and decades, the AMA House has developed, revisited and refined a comprehensive body of policies that form the basis for AMA'S legislative and regulatory initiatives, and for the AMA's responses to legislative and regulatory proposals put forth by others. The final national health reform legislation signed by President Obama in March 2010 includes the following salient features that the AMA found to be consistent with established AMA policy:

- Coverage extended to 32 million currently uninsured Americans
- Ban on insurers' denial of coverage for people with pre-existing conditions
- Ban on lifetime insurance caps

- Ban on cancellation for illness
- Mandate that parents' coverage be available to children up to age 26
- Measures to sharpen competition in the insurance marketplace
- Requirements for transparency and accountability of insurance companies
- Tax credits to enable small businesses to purchase coverage
- Subsidies for low-income individuals and families to purchase coverage
- Streamlined insurance claims processing
- Elimination of the Part D coverage gap ("the donut hole")
- Protections against government and third-party misuse of comparative effectiveness research to dictate treatment decisions or coverage
- Disease prevention and wellness promotion
- A floor for primary care Medicaid payments at Medicare levels

The AMA was also successful in improving the bill by removing a provision that would have imposed an arbitrary 5% cut in payments to high-end physician outliers in utilization and another that would have extended Medicare coverage to people as young as 55. The original bill included Medicare and Medicaid "enrollment fees" for physicians and would have taxed elective medical procedures. The AMA was able to eliminate all of these problematic elements from the bill before it became law. Officially, the AMA remained neutral on the "public option," which did not survive in the final bill.

#### Liability and anti-trust remain unaddressed

Of course, the final legislation is still inconsistent with AMA policy in important respects. Most notable is the absence of anything beyond lip service to liability reform. While the new law does provide still more funding for "demonstration projects" in liability reform, these provisions can hardly be taken seriously. They are transparently a sop to those many, including the Rhode Island Medical Society and the AMA, who believe that liability and anti-trust are the two principal forces distorting American health care – driving up costs, restricting access and confounding important efforts to improve quality and patient safety.

Despite the substantial shortcomings that persist in the bill, however, the AMA did not impose any litmus test or walk away from the table. Walking away was an untenable option, tantamount to voluntary self-disenfranchisement on behalf of all physicians. Instead, the AMA recognized that in a negotiation, getting 75% of your ask up front is something to affirm and accept in good faith as a basis for further negotiation.

#### The road ahead

National health system reform will remain a work in progress for at least several more years. The official timeline set forth in the bill itself for implementation stretches through 2019. Much has yet to be codified in regulation, and a good deal of responsibility and discretion for the ultimate shape of health reform is left to the individual states.

These realities constitute a challenge to doctors, medical societies and the AMA to be vigilant, organized and engaged, now and for years to come.

For news and information on health system reform, visit the AMA's special site [www.hsreform.org](http://www.hsreform.org). For state advocacy and public policy information visit [www.ama-assn.org/go/arc](http://www.ama-assn.org/go/arc), the site for the AMA's Advocacy Resource Center (ARC). ❖



**AMA National Advocacy Conference in Washington, DC, March 2010**

*Gary Bubly, MD, RIMS President-Elect; J. James Rohack, MD, then-President of the AMA; and Vera A. De Palo, MD, RIMS President*

### Useful links for health system reform and federal regulations

#### From the AMA

[www.hsreform.org](http://www.hsreform.org)  
The AMA's comprehensive site on national health system reform.

[www.ama-assn.org/go/arc](http://www.ama-assn.org/go/arc)  
Presents state perspectives on health reform and other aspects of public policy from the Advocacy Resource Center of the AMA.

#### From the U.S. government

[www.healthcare.gov](http://www.healthcare.gov)  
Includes a tool for consumers to enter profile information and find which insurers are offering individual coverage in their state. This

portal will be a platform for other information as well, and includes an "Implementation Center" link (at the bottom under "Resources") that provides easy access to pending health reform regulations.

#### From the U.S. Department of Health and Human Services Office of Consumer Information and Insurance Oversight

[www.hhs.gov/ociio](http://www.hhs.gov/ociio)  
This portal includes a tab for "Regulations and Guidance" that provides links to regulations, fact-sheets, information on grants, etc.

### AMA House of Delegates: Chicago, June 12–15, 2010

While strong and diverse opinions persist within the AMA House over national health system reform and the AMA's posture in the long process to date, the actual voting at this year's Annual Meeting, held in Chicago, June 12–15, amounted to a solid affirmation of recent AMA positions and actions – even more so than was true at the Interim Meeting last November, where a trend toward consolidation and consensus was already evident.

At the heart of this more subdued and sober mood in the House seemed to be a pragmatic sense that the world has changed, that we need to move forward from where we are, and that where we are is in many ways better for our patients than where we were before March 23. In addition, there was a largely unspoken realization that the AMA's careful navigation over the past eighteen months had succeeded in preserving a positive public image for doctors this time around, in contrast, say, to 1964–65.

Cecil B. Wilson, MD, an internist from Winter Park, Florida, was inaugurated President of the AMA at this meeting; and Peter W. Carmel, MD, a pediatric neurosurgeon from Newark, New Jersey, was chosen President-Elect. Dr. Carmel had two strong competitors in the election, one of whom was a New Englander, Dr. Joe Heyman, an obstetrician-gynecologist in solo practice

in Amesbury, MA, whom we have known for many years through his long participation and leadership in the New England Delegation.

Governance continues to be an unsettled discussion for the AMA House, in the sense that two-thirds the 500+ Delegates favor continuing with two big, policy-making meetings a year, but 52% think the interim meeting should be combined with another regularly occurring AMA meeting, most likely the National Advocacy Conference, which currently takes place in March.

As always, the scope of AMA House business, as well as the thoroughness, efficiency and openness with which the House accomplishes its enormous work, represent an impressive model of democratic process. The entire handbook for the June 2010 meeting (resolutions, council reports, reference committee reports, etc.) is publicly available online ([www.ama-assn.org](http://www.ama-assn.org)), as is a preliminary agenda for the Interim Meeting, which is coming up in early November.

At this past June meeting, RIMS' Executive Director Newell Warde was reelected by his state medical society peers to another two-year term on the Executive Committee of the AMA Litigation Center. The Center's Executive Committee subsequently elected him Chair. ❖



## Reform brings opportunity



VERA A. DE PALO, MD  
PRESIDENT

On March 23, 2010, an act entitled “The Patient Protection and Affordable Care Act” was signed into law by President Obama and became Public Law Number 111-148. The following week

the president signed “The Health Care and Education Reconciliation Act of 2010.” Together these laws offer the opportunity for the most sweeping reform in health care that has occurred in decades.

For years, we looked to the inefficiencies in the health care system with a desire to make things better. Many involved in health care’s different aspects, whether it be paying for, delivering, or consuming it, hoped for solutions which would streamline care and rein in costs. The health care reform bill now gives us that opportunity.

Rhode Islanders in health care have a long history of collaborating, whether it be on a state level using quality initiatives as the driving force, like the Rhode Island Chronic Care Collaborative and the Rhode Island Safe Transitions Program, or in initiatives launched by the Office of the Health Insurance Commissioner like the Chronic Care Sustainability Initiative (also known as CSI, Rhode Island’s multi-payer Patient-Centered Medical Home project). Insurers have collaborated with the process not only by funding quality initiatives but also by working with hospitals and medical practices to develop an extension of the medical home model of care. Quality measures in a Pay for Performance Program has yielded very positive results in some initiatives.

Through the demonstration of a collaborative environment, the Rhode Island Quality Institute was awarded the federal Health Information Exchange grant, which will assist in implementing an integrated, informative exchange to improve health outcomes, reduce medical errors and make our health care delivery system more effective and efficient. Additionally, the Institute was awarded the Regional Extension Center contract to assist providers in integrating effective HIT systems and to provide technical assistance to doctors, hospitals, and other health care

providers. To complete the trifecta of awards, the RIQI was selected as a Beacon Community which will use IT resources as a foundation for bringing doctors, hospitals, community health programs, federal programs and patients together to design new ways of improving quality and efficiency to benefit patients and taxpayers.

Earlier this year, Lieutenant Governor Elizabeth Roberts invited Rhode Islanders in government, in the health care field, in business, and on behalf of patients and families to plan for the challenges and opportunities of implementing national health care reform. She formed “The Healthy Rhode Island Task Force for National Health Reform Implementation.” Stakeholders in the health care discussion have met throughout the summer to discuss important topic areas like insurance market

reforms, coverage expansion, the design and building of the health insurance exchange, long-term care, payment and delivery system reform, prevention, pilots and reform initiatives, and workforce development.

On July 14, RIMS’ leadership and staff were among some 90 Rhode Islanders who participated in a Rhode Island Health care Stakeholders Meeting in Washington DC organized by Senator Sheldon Whitehouse. To face

the new and complex challenges as the implementation phase of reform begins, this forum gave Rhode Islanders an opportunity to discuss the provisions of the reform bill with Secretary of Health and Human Services, Kathleen Sebelius; Nancy-Ann Min DeParle, Director of the White House Office of Health Reform; and senior Senate staff.

The implementation phase of health care reform offers many opportunities for Rhode Island. The Healthy Rhode Island Task Force has tried to identify pilots and initiatives that can build on the current collaborative activities in the state. The Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 will change the landscape of our practice environment. Physicians and other health care stakeholders have the possibility to shape reform. We must come to the table to shape our future and the care that will impact our patients. The time to get involved is now, the opportunities are many! Together we can shape Rhode Island’s health care landscape. ❖

***“We must come to the table to shape our future and the care that will impact our patients.”***

## Dr. Edwin Forman on the nature and practice of medical ethics



*The following remarks were delivered by Dr. Forman upon his receipt of RIMS’ Rakatansky Award for Medical Ethics and Professionalism on September 26, 2009, at the Dunes Club. The Rakatansky Award was established by vote of the Council in 2008. Dr. Forman was the second recipient of the Award.*

Thank you, Dr. Siedlecki, for your over-kind remarks. I am deeply appreciative of this honor and grateful to the Rhode Island Medical Society for giving me this award. I also want to thank my wife, Sylvia, for her support, and in particular for the innumerable and valued discussions with me about the essence of patient care. And I must express gratitude to my friends – mentors – colleagues, the philosophers John and Rosalind Ladd\* who guided me in the field of ethics.

The gracious introductory remarks spoke of my efforts in research and development of the pediatric oncology program in Rhode Island. But my primary focus has always been on the cure of the afflicted children and the support of their families. People ask, “Why do you work in such an

agonizing field?” My best answer, after years of reflection, is that I thrive on, and need, the intense relationships that develop. Sometimes there are terrible, intolerable losses, other times wonderful achievements, but always a rich and enduring closeness.

There is an ancient Greek saying which I learned from a colleague and well-known pediatric ethicist – Dr. Lainie Friedman Ross: “A doctor has opportunities for studying human nature which are given to no one else, wherefore a philosopher ought to begin his life as a doctor, and a doctor should end his life by becoming a philosopher.” It was in 1974 that I faced a problem with one of my patients – a fourteen-year-old young man I was treating for acute myelogenous leukemia. After a few remissions, the disease became resistant to standard therapy. His mother, desperate to keep him alive, urged me to try one experimental drug after another – each producing only a transient response and moderate toxicity. My patient indicated, indirectly but clearly, that he wanted no further treatment. Who was I to serve? The answer was not in medical textbooks or literature. The question concerned values, and, as I was to learn, required moral reasoning. At that time, a Brown University program to study medical ethics was

just beginning. I joined the endeavor, and a new element in clinical practice was opened to me.

A word about what Ethics is – “no small matter but how we ought to live,” said Socrates. While morality is what we have been taught and believe is right, and law is codified morality with sanctions, ethics – as a branch of philosophy – is actually a method for determining the right thing to do. Although not achieving final proofs like calculus, the position with the best arguments – which involve highly-prized human values as well as scientific facts – ought to prevail. Thus ethics requires moral reasoning, utilizing principles such as right, utility, and fairness. To explore what great minds have written on these subjects and to engage in open-minded discussions with one’s peers is an extraordinary experience.

I believe that moral reasoning, which gets better with practice, has several rewards. It makes an individual a better listener and communicator and, by giving “reasoned recommendations” which take into account a patient’s values as well as the medical facts, more effective in persuasion. It enhances the physician-patient relationship. And, finally, it enriches one’s professional and personal life. To paraphrase the eminent philosopher Bertrand Russell: “Ethics is to be studied, not solely for the sake of any final answers to such questions, since no such answers may, as a rule, be known to be true, but rather for the sake of the questions themselves, because these questions enlarge our conception of what is possible, enrich our intellectual imagination and diminish the dogmatic assurance which closes the mind against speculation.”

I invite you to study, reflect on, and involve yourself in medical ethics. Try it – I’m sure you will like it!

Thank you for the opportunity to speak with all of you. ❖

\*John Ladd is professor emeritus at Brown University and author of a paper entitled “The Good Doctor and the Medical Care of Children.”



**JOSEPH LIFRAK, MD**, is President of the Rhode Island Orthopedic Society. **RICHARD TEREK, MD**, is Vice President. **GREG AUSTIN, MD**, is Secretary/Treasurer. Members At Large are **ANTHONY MECHREFE, MD**, **SIDNEY MIGLIORI, MD**, and **ERIC WALSH, MD**.

**DIETER POHL, MD**, is President of the Rhode Island Chapter of the American College of Surgeons. **STEVEN MIGLIORI, MD**, is President-Elect. **JENNIFER GASS, MD**, is Treasurer. **ERIK ENQUIST, MD**, is Secretary. **MARLENE CUTITAR, MD**, is Immediate Past President.

**CHARLES PATTAVINA, MD**, will receive the prestigious James D. Mills Outstanding Contribution to Emergency Medicine Award of the American College of Emergency Physicians on Thursday, September 30, in the context of the ACEP's annual Scientific Assembly in Las Vegas, September 28–October 1. The award is named for one of the founders of the ACEP.

**L. ANTHONY CIRILLO, MD**, will become Chair of the State Legislative and Regulatory Committee of the American College of Emergency Physicians when the ACEP holds its annual Scientific Assembly in Las Vegas, September 28–October 1.

**PHILIP R. RIZZUTO, MD**, will receive the prestigious Secretariat Award of the American Academy of Ophthalmology in the context

of the AAO's Annual Meeting in Chicago, October 16–19. The Secretariat Award recognizes special contributions to the Academy and to ophthalmology. In particular, AAO will recognize Dr. Rizzuto for exemplary efforts as a member of the AAO's Secretariat for State Affairs, as President of the Rhode Island Society of Eye Physicians and Surgeons and as a teacher and mentor of residents, among other contributions.

**STEVEN R. DETOY**, RIMS' Director of Government Relations and Public Affairs, has been named to the fifteen-member Federation Staff Advisory Steering Committee of the AMA Practice Management Center. The Center provides advocacy on payment issues, practical assistance to medical offices, and timely information to medical society staff on medical practice issues. Mr. DeToy is also a founding member of the Executive Committee of the AMA's Advocacy Resource Center.

**NEWELL E. WARDE, PHD**, RIMS' Executive Director, was elected by his state medical society peers in June to chair the Executive Committee of the Litigation Center. The Center, a joint undertaking of the AMA and the medical societies of every state and the District of Columbia, was established in 1995 to advance physicians' rights through the judicial system. It has participated in more than 200 legal cases.



Senator Sheldon Whitehouse with RIMS President Vera De Palo, MD, at the Rhode Island Health Care Stakeholders meeting in Washington, DC, on July 14.

Budget – continued

RIMS vs. tanning salons and sugary drinks

RIMS initiated two other timely public health measures that failed narrowly because of the abbreviated Assembly session and will be back on RIMS' legislative agenda next year. One measure would have barred persons under the age of 18 from patronizing tanning salons. Jason Neustadter, MD, a resident in dermatology, led the charge for this legislation. His worthy efforts were the subject of a front-page feature article in the Providence Journal on July 5, 2010.

RIMS also introduced a bill to tax sugar-added drinks. This bill attracted support from more than twenty organizations that share the Medical Society's concern about American dietary habits and the related epidemic of obesity. It also attracted vehement opposition from the beverage industry, which launched a well-funded campaign of radio and print advertising and whipped up "anti-tax" chatter on the radio talk show circuit. RIMS' bill was given a lengthy hearing by the House Finance Committee. In the end, however, the opposition succeeded in killing the bill. RIMS and a growing coalition will bring it back in 2011.

Professional liability

This year's efforts on liability reform met with disappointment as well. One might have hoped that RIMS' legislation to protect open communication between doctors and patients when outcomes disappoint (commonly known as the "I'm sorry" bill) would have stood a good chance of passage this year in the wake of last summer's high-profile case involving the family of actor James Woods and Kent County Hospital. But while the bill did receive a reasonable hearing in House Judiciary Committee, the Senate did not deign to follow suit.

The usurious prejudgment interest rate that Rhode Island law applies to medical liability settlements and awards (12%) received diligent attention once again this year. Inappropriately frozen in law for decades now at an artificially high level, the prejudgment interest rate remains a significant driver of process delays and high cost. Unfortunately, much like RIMS' "I'm sorry" legislation, this year's interest bill received a serious hearing on the House side but met a firm stone wall in the Senate.

As always when liability reform bills are heard in the General Assembly, it can be impressive to observe the intellectual creativity, rhetorical elegance and mulish intransigence of the plaintiff bar as they fiercely defend their lush turf.

Drs. Aronson, Hamolsky receive national honors

The Federation of State Medical Boards has honored Dr. Milton W. Hamolsky and Dr. Stanley Aronson with Lifetime Achievement Awards for distinguished leadership in medical regulation.

The two Rhode Island doctors were only the third and fourth recipients in the entire history of the award, which is presented infrequently to outstandingly meritorious individuals. The previous presentations were made in 2002 and 2008.

The Federation is the professional association of state medical boards, the authorities that license and discipline doctors in the various states. Dr. Aronson and Dr. Hamolsky received their awards at the federation's 98th annual meeting in Chicago in April.

Dr. Hamolsky had just retired in 1986 from a long and distinguished career as a pioneering endocrinologist, professor of medicine at Brown and physician-in-chief at Rhode Island Hospital, when then-Director

of Health H. Denman Scott, MD, MPH, recruited him to be the first chief administrative officer of the new Board of Medical Licensure and Discipline. The BMLD officially replaced the old Board of Medical Review on January 1, 1987, with Dr. Hamolsky at the helm. Dr. Hamolsky led the new board from then until his second retirement in 2001.

Dr. Aronson served on Rhode Island's Board of Medical Licensure from 1992 to 2003. He is the Founding Dean of Brown's medical school, now the Warren Alpert School of Medicine, and served as Dean for 11 years. He is a former editor-in-chief of the Medical Society's monthly journal, *Medicine @ Health Rhode Island*. His popular, erudite commentaries on medicine and medical history appear regularly in that journal and on the editorial pages of the *Providence Journal* every Monday morning. ❖

Awards for Drs. Ettensohn, Troise

The Medical Society will bestow special honors upon David Ettensohn, MD, and Caroline Troise, MD, in the context of the RIMS Annual Member Banquet on Saturday evening, October 2, at the Squantum Association in East Providence.

Dr. Ettensohn will receive the Dr. Charles L. Hill Award in recognition of his energetic and eloquent leadership in a time of particular challenge and stress for the Rhode Island medical community. Dr. Ettensohn was President of RIMS 2002–2003.

Dr. Carolyn Troise will be the third recipient of the Dr. Herbert Rakatansky Award for Professionalism in Medicine. Dr. Troise has served as the medical director of the Rhode Island Free Clinic since its inception. ❖

*Members should have received invitations to the Annual Banquet by late August. Questions can be directed to Sarah Stevens at 401-331-3207. (See also p.2 of this newsletter.)*

Other health-related bills that did become law include the following:

- A bill to regulate "discount medical plans," which are typically scams promoted by small signs nailed to utility poles.
- A bill adopting the AMA's 6th edition *Guides to the Evaluation of Permanent Impairment* in workers' compensation cases. This bill also clarifies the statutory language pertaining to workers' compensation and Preferred Provider Networks (PPNs). (See also a related article on workers' compensation page 16.)
- A bill to allow the Director of Health to grant privileges to health care professionals licensed in other states to practice in Rhode Island during a declared emergency.
- A bill to allow the health care provider of a child who has been sexually assaulted to report that information to the appropriate regulatory agency.
- A bill to expand the role of the medical examiner's office to include making recommendations to decrease the incidence of preventable child deaths.

- A bill to require school districts to work with the Rhode Island Interscholastic League (RIIL) to develop guidelines for coaches and players of youth sports to reduce risks associated with concussions.
- A bill changing the name of the Department of Mental Health, Retardation and Hospitals (MHRH) to Rhode Island Department of Healthcare, Developmental Disabilities and Hospitals (DHDDH).

A more complete account of this year's health legislation is provided in the accompanying grid on pages 10–11.

The RIMS Public Laws Committee, chaired by Michael E. Migliori, MD, is comprised of physicians representing a full spectrum of medical specialties and subspecialties. Its meetings are open to RIMS members. Physicians are encouraged to contact RIMS' Director of Government Relations, Steve DeToy, with questions regarding the legislative process or with suggestions for potential future legislation (sdetoy@rimed.org). As usual, the Public Laws Committee invites participation and suggestions from members and specialty societies for its meeting in the autumn to formulate RIMS' legislative agenda for 2011. ❖

Health-related bills that became law in the 2010 session of the Rhode Island General Assembly

The complete text of the bills can be viewed at [www.rilin.state.ri.us](http://www.rilin.state.ri.us), search by bill number.

**Bold and underlined** indicates RIMS-Sponsored  
***Bold and italicized*** indicates of particular RIMS interest

BILL	HOUSE BILL NO. SPONSOR	HOUSE STATUS	SENATE BILL NO. SPONSOR	SENATE STATUS
<b>RELATING TO EDUCATION</b> This act would require school districts to work with the Rhode Island interscholastic league to develop guidelines for educating coaches and players in youth sports about the risks associated with concussions. This act would also limit the liability of school districts and others for such injuries, provided certain insurance coverage is provided. This act would take effect upon passage.	H 7036 A aa Gallison	PL 10-022	S 2034 A aa Felag	PL 10-021
<b>RELATING TO BUSINESSES AND PROFESSIONS – RADIOLOGIC TECHNOLOGISTS LICENSING</b> This act would repeal the existing radiologic technology licensing act and adopt a revised radiologic technology licensing act. This revised act would allow the director of health to appropriately license radiologic technologists in accordance with current standards of practice established by national professional associations which examine, register, certify or approve individuals and education programs relating to operators of sources of radiation. This act would take effect upon passage.	<b><u>H 7273 A aa</u></b> Pollard	<b><i>PL 10-137</i></b>	<b><u>S 2130 A</u></b> Gallo	<b><i>PL 10-139</i></b>
<b>MAKING APPROPRIATIONS FOR THE SUPPORT OF THE STATE FOR THE FISCAL YEAR ENDING JUNE 30, 2011</b>	<b><i>H 7397 A aa</i></b> Watson	<b><i>PL 10-023</i></b>		
<b>RELATING TO HEALTH AND SAFETY – MEDICAL EXAMINERS</b> This act would increase the responsibilities of the medical examiner’s office to make recommendations to decrease the prevalence of preventable child deaths, and to help establish community intervention strategies through the use of a child death review team. This act would take effect upon passage.	<b><i>H 7417 A</i></b> Naughton	<b><i>PL 10-143</i></b>		
<b>RELATING TO EDUCATION – HEALTH EDUCATION CURRICULUM</b> This act would require that the department of elementary and secondary education develop a Lyme disease awareness and prevention course for public school students and all health education classes include instruction on Lyme disease prevention and treatment. This act would take effect upon passage.	<b><i>H 7418 A</i></b> Jackson	<b><i>PL 10-087</i></b>	<b><i>S 2265 B</i></b> DiPalma	<b><i>PL 10-081</i></b>
<b>RELATING TO HEALTH AND SAFETY – SEXUALLY TRANSMITTED DISEASES</b> This act would permit physicians, physician assistants and nurse practitioners to prescribe prescription drugs to a patient’s sexual partner or partners for the treatment of sexually transmitted diseases.	<b><u>H 7450 A</u></b> Ferri	<b><i>PL 10-175</i></b>	<b><u>S 2806 A</u></b> Perry	<b><i>PL 10-166</i></b>
<b>RELATING TO INSURANCE - DISCOUNT MEDICAL PLANS</b> This act would establish standards for discount medical plan organizations, protect consumers from unfair and deceptive marketing practices and facilitate consumer understanding of discount medical plan organizations. This act would take effect upon passage.	<b><i>H 7606 A</i></b> Kennedy	<b><i>PL 10-158</i></b>	<b><i>S 2632 A</i></b> Sheehan	<b>PL 10-156</b>

BILL	HOUSE BILL NO. SPONSOR	HOUSE STATUS	SENATE BILL NO. SPONSOR	SENATE STATUS
<b>RELATING TO HEALTH AND SAFETY – DISTRESSED ESSENTIAL COMMUNITY HOSPITALS</b> This act would allocate a quarter percent (.25%) of the taxes on the premiums of health insurers to assisting a distressed essential community hospital. This act would take effect upon passage.	<b><i>H 7654 A</i></b> Fierro	<b><i>PL 10-154</i></b>	<b><i>S 2417 A</i></b> Picard	<b><i>PL 10-155</i></b>
<b>RELATING TO INSURANCE</b> This act would add a trend test to the risk based capital statutes governing insurers and health organizations, financial health determinations. This act would take effect upon passage.	<b><i>H 7711 A</i></b> Marcello	<b><i>PL 10-065</i></b>	<b><i>S 2714 A</i></b> Lynch	<b><i>PL 10-049</i></b>
<b>RELATING TO BUSINESSES AND PROFESSIONS – CONFIDENTIALITY OF HEALTH CARE COMMUNICATIONS AND INFORMATION ACT – HEALTH CARE COMMUNICATIONS AND INFORMATION</b> This act would require the health care provider of a child who has been sexually abused to report the abuse to the appropriate law enforcement entity. This act would take effect upon passage.	<b><i>H 7865 A</i></b> McNamara	<b><i>PL 10-085</i></b>	<b><i>S 2220 Aaa</i></b> Perry	<b><i>PL 10-082</i></b>
<b>RELATING TO HEALTH AND SAFETY – HEALTH CARE SERVICES – UTILIZATION REVIEW ACT</b> This act would repeal the sunset provision regarding the statutory variances the department of health is allowed to issue. This act would take effect upon passage.	H 7907 A Kilmartin	PL 10-190		
<b>RELATING TO LABOR AND LABOR RELATIONS – WORKERS’ COMPENSATION</b> This act would make changes in the medical review procedure for claimants receiving workers’ compensation benefits. This act would take effect upon passage with paragraph 28-29-2(3)(ii) and section 28-33- 4 18 applicable to all injuries sustained on or after January 1, 2011.	<b><i>H 8114 A</i></b> Williams	<b><i>PL 10-121</i></b>	<b><i>S 2083A</i></b> P Fogarty	<b><i>PL 10-095</i></b>
<b>RELATING TO MOTOR AND OTHER VEHICLES – THE DIESEL EMISSION REDUCTION ACT</b> This act would add new provisions with respect to diesel emissions control in public projects, and would exempt diesel emissions control technology from the sales tax. This act would take effect upon passage.			S 2440 Aaa Miller	PL 10-184
<b>RELATING TO INSURANCE – EXTENDED MEDICAL BENEFITS</b> This act would provide that dental and vision benefits be included for individuals eligible for extended medical benefits. This act would take effect upon passage.			<b><i>S 2629</i></b> DeVall	<b><i>PL 10-053</i></b>
<b>RELATING TO HEALTH AND SAFETY</b> This act would give authority to the director of health to certify out-of-state health care professionals in times of emergency. This act would take effect upon passage.			<b><i>S 2631</i></b> Tassoni	<b><i>PL 10-051</i></b>



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## Tar Wars® Rhode Island: Annual Poster Contest

CATHERINE NORTON  
ASSISTANT DIRECTOR OF PROFESSIONAL  
AND COMMUNITY SERVICES FOR RIMS

While the heavy rain made for a soggy mess outside, it was quite a different story inside the school gymnasium at Wakefield Hills Elementary School on Saturday, May 8. A colorful array of wonderful works of art were on display as 36 fifth-grade students and their families gathered for the Rhode Island's seventeenth annual state-wide Tar Wars® poster contest, the culmination of the Academy of Family Physicians and Academy of Pediatrics yearly tobacco education program for middle schoolers.

"The weather didn't dampen our spirits. It was a great turnout," noted Arthur Frazzano, MD, chairman of the Tar Wars® program and emcee for the day.

Before announcing the winners of the 2010 contest, Dr. Frazzano thanked all the students for their participation in the 2010 Tar Wars® program, telling them they were all winners and congratulating them for a job well done. "This was one of our most competitive contests to date,"



he explained to the audience as they anxiously waited for the judges to emerge from their lengthy deliberation.

First-place went to Alexandria Nogueras (*left*) from Marieville Elementary School in North Providence, who received an all-expenses paid trip for her and her family to travel to the National Tar Wars® competition in Washington, DC, in July. The second-place winner and recipient of a \$75 American Express gift card was Maria Spagnolo from George Peters School in Cranston; the third-place winner and recipient of a \$50 American Express gift card was Keia DePina from Kingston Hill Academy in Saunderstown.

RIMS extends a hearty thanks to the 2010 Tar Wars® celebrity judges, who were presented with a very challenging task of picking a winner among this year's 36 entries. "It was very tough choosing a winner this year," explained Channel 10 health reporter Barbara Morse Silva, who has been judging Tar Wars® competitions for the past five years. Her sentiments were echoed by the four other judges, who were Gary Bubly, MD, President-Elect of the Medical Society; Nitin Damle, MD, Vice President of the Medical

Society; Larry Lamothe, Director of Human Resources & Compliance for the West Warwick Public Schools; and Priya Gupta, MD, of the Rhode Island Academy of Family Physicians.

Special acknowledgement is also in order for this year's Tar Wars® sponsors, whose support made the event possible: the Rhode Island Academy of Family Physicians, the Rhode Island Chapter of the American Academy of Pediatrics, the Rhode Island Medical Society Foundation, and the West Warwick School Department.

Most of all, RIMS thanks the many volunteer presenters who gave their personal time to visit area schools and engage students in discussions about the dangers of tobacco use and teach them to think critically about tobacco advertising.

For more than 22 years, Tar Wars® has been the sole youth tobacco education program offered by a medical specialty organization in the United States. Tar Wars® is a program of the American Academy of Family Physicians (AAFP) and reaches approximately 400,000 students annually nationwide. In Rhode Island, the Tar Wars® program operates routinely in dozens of school districts across the state and involves more than 2800 students each year.

To become a Tar Wars® presenter or receive more information about the program, contact Catherine Norton, 528-3286 or cnorton@rimed.org. Volunteer presenters are always needed and no experience is necessary. RIMS provides all program materials, including "How To Present" guidelines and PowerPoint presentation. ❖

### 2010 Tar Wars® Presenters

Nathan Beraha, MD  
Jeffrey Borkan, MD, PHD  
Maureen Bowman, MD  
Gillian Breslin, MD  
Stephanie Chow, MD  
Robert Crausman, MD  
Paul Del Guerico, MD  
Suzanne DeLaMonte, MD  
Kate Eldridge, MD  
Keivan Ettetfagh, MD  
Marissa Fast, MD  
Roger Fazio, MD  
Sarah Fessler, MD  
Jacqueline Firth, MD  
America Foster, MD  
Arthur Frazzano, MD  
Arnold Goldberg, MD  
Donald Hebb, MD  
Peter Hollmann, MD  
Yamini Howe, MD  
Mae Igi, PA-C  
Katja Karrento, MD  
Martin Kerzer, DO  
Anita Kestin, MD  
Elizabeth Lange, MD  
Sheldon Lidofsky, MD  
Anthony Lombardi, Jr., MD  
Patty Lynch-Gadaleta, MS, PA-C

Mary Lyster, MD  
Tim Manown, MD  
Leslie Morris, MD  
Meg Murray, MD  
Brian Pickett, MD  
Herb Rakatansky, MD  
James Schwartz, MD  
Russell Settipane, MD  
Craig Woda, MD  
Raymond Zarlengo, MD

### Alpert Medical School (Brown University) medical student Tar Wars® Presenters

Ross Beckman  
Eugene Cone  
Pamela Escobar  
Richa Mishra  
Alejandro Navarro  
Reshma Ramachandran  
Arkady Rasin  
Devin Smith  
Ina Soh

## 2010 Bike helmet distribution to RlTeCare kids

Thanks to the generosity of its physician members and to the volunteer energy of several Brown University medical student members of RIMS, the Rhode Island Medical Society gave away about 225 new bike helmets and other bike safety paraphernalia to children who are beneficiaries of RlTeCare. This year's event took place Wakefield Hills Elementary School in West Warwick on Saturday morning, May 8.

The Medical Society sincerely thanks medical students Andrew Matson, Matthew Reilley, and Ina Soh for donating their time and talent, engaging the children and individually fitting each helmet that day.



RIMS thanks the following individuals and medical practices for their generous support of this year's bike helmet give-away:

American College of Emergency Physicians, Rhode Island Chapter Consultants in Urology, Inc.  
East Bay Pediatrics and Adolescent Medicine Associates, Inc.  
East Greenwich Pediatrics  
ENT and Allergy, Inc.  
Medical Associates of Rhode Island, Inc.  
Orthopaedic Associates, Inc.  
Orthopedic Group, Inc.  
RI Colorectal Clinic, LLC  
RI Neurological Association, Inc.



Sadaf Ali, MD  
Rebecca H. Allen, MD  
Charles F. Allendorf, MD  
Cynthia M. Alves, MD  
Robert H. Andler, MD  
Pamela M. Antoniuk, MD  
Stanley R. Balon, MD  
Peter E. Baziotis, MD  
Linda J. Berman, MD  
Jack R. Bevivino, MD  
Jacques L. Bonnet-Eymard, MD  
Lawrence P. Bowen, MD  
Elizabeth A. Cadoret, PA-C  
Joseph F. Callaghan, MD  
Linda L. Carpenter, MD  
David P. Carter, MD  
Heather A. Chapman, MD  
and Andrew Sucov, MD  
Nathan T. Connell, MD  
Michelle M. Daniel, MD  
Vincent A. DeConti, MD  
Stuart V. Demirs, MD  
Candace L. Dyer, MD  
Frank J. Faltus, MD

Jerry Fingerut, MD  
David R. Gifford, MD, MPH  
James F. Griffin, DO  
Daniel S. Harrop, MD  
Melvin Hershkowitz, MD  
James K. Herstoff, MD  
Peter A. Hollmann, MD  
Martin I. Holzman, MD  
Harold M. Horwitz, MD  
Ian M. Jacobson, MD  
Beth Lange, MD  
and Raymond Zarlengo, MD  
David E. Leibowitz, DO  
Otto Liebmann, MD  
Mary D. Lekas, MD  
Patrick R. Levesque, MD  
Foong-Yi Lin, MD  
Mary L. Lussier, MD  
Terrie A. Mailhot, MD  
Roland C. Merchant, MD  
Frank Merlino, MD  
Joseph L. Migliori, MD  
Stephen J. Migliori, MD  
and Sidney P. Migliori, MD



E. James Monti, MD  
John F. Murphy, IV, MD  
Adelaide G. Nardone, MD  
Hung Nguyen, MD  
Patricia A. Nolan, MD  
James A. O'Brien, MD  
Martin R. Papazian, MD  
John J. Przygoda, MD  
Albert J. Puerini, Jr., MD  
Diane Reali Marini, MD  
Kenneth C. Rickler, MD  
Norman E. Rudolph, MD  
Warren K. Russell, MD  
Virginia Schmidt Parker, MD  
Nicole P. Somvanshi, MD

and Rahul A. Somvanshi, MD  
Sonia Sprung, MD  
Gregory J. Steinmetz, MD  
Elizabeth M. Sutton, MD  
Patrick J. Sweeney, MD, MPH  
Keiko M. Tarquinio, MD  
John M. Tarro, MD  
Carole V. Toselli, MD  
Nancy Y. Tsai, MD  
James J. Turanski, MD  
Sui-Yen Wang, MD  
Lewis R. Weiner, MD  
Elizabeth A. Welch, MD  
and Stephen E. Glinick, MD  
Richard J. Zienowicz, MD



WORKERS' COMPENSATION

Beacon Mutual's divorce from Blue Cross generates confusion

Late in 2009, Beacon Mutual Insurance Company, Rhode Island's largest writer of worker's compensation insurance, informed the Medical Society that Beacon wanted to have closer relationships with the physician community and assume more direct management of workers' compensation cases. With those purposes in mind, Beacon moved this year to terminate its long-standing arrangement with Blue Cross & Blue Shield of Rhode Island for administrative and network services and to replace that arrangement with a new, three-part strategy: Beacon is now performing more care management in-house, contracting with Mitchell Health Services for billing, and ceding to Prime Health Care responsibility for managing Beacon's provider network.

Unfortunately, some communication glitches with Beacon's new partners marred the transition, and some confusion persists.

For physicians, the questions began

to arise in May 2010, when many Rhode Island physicians received correspondence from Prime that indicated – misleadingly – that physicians would have to join a Prime PPO in order to be included in Beacon's Preferred Provider Network (PPN).

PPN vs. PPO

PPN is a term of art that is unique to the language of Rhode Island's workers' compensation law and is not interchangeable with the more familiar term PPO (Preferred Provider Organization). Rhode Island law guarantees injured workers complete freedom of choice in their initial selection of a treating physician and does not allow insurers to limit workers' initial choice to any particular network. Moreover, if a treating physician refers the patient to a specialist for treatment or consultation, the referring physician and injured worker retain the right of free choice for that initial referral. However, a subsequent change in an injured worker's treating physician or referrals must be made within the insurer's approved Preferred Provider Network (PPN), and that PPN must be on file with the Workers' Compensation Medical Advisory Board.

The participating agreement Prime offered to Rhode Island physicians for its PPO raised concerns at RIMS, because the Prime PPO was all-purpose, not limited to workers' comp, and it included a substantial discount in reimbursement from the standard workers' compensation fee schedule. Such discounting threatens a linchpin of Rhode Island's highly successful workers' compensation act, which has been a national model since its passage in 1992. Integral to Rhode Island's success is the mandate that physicians and other health care professionals must be reimbursed at a rate that ensures injured workers timely access to care by the doctor of their choice and fairly compensates physicians for the

additional administrative requirements of the workers' comp system.

RIMS immediately sought a meeting with representatives of Beacon, the Medical Advisory Board (MAB), and the Worker's Compensation Advisory Council (WCAC). Beacon subsequently instructed Prime to rescind its all-purpose PPO provider agreement offer. In addition, the Worker's Compensation Advisory Council drafted legislation to remove any possible ambiguity about the key provisions of the 1992 reforms, including the subordinated function of the PPN. This new statutory language affirms that "any contract proffered or maintained which restricts or limits the health care provider's ability to make referrals pursuant to the provisions of this section, restricts the injured employee's first choice of health care provider, substitutes or overrules the treatment protocols maintained by the medical advisory board or attempts to evade or limit the jurisdiction of the worker's compensation court *shall be void as against public policy*" (emphasis added).

The Medical Advisory Board has also explicitly warned that "any effort to amend the PPN because a caregiver has refused to participate in a PPO will be strenuously resisted by the Board."

Prime subsequently offered physicians the opportunity to join a workers' comp-specific PPO (again with a discount of the workers' compensation fee schedule), which will presumably become a basis for replacing Beacon's current PPN with a new Prime PPN early next year. Beacon's current approved PPN is valid through February of 2011.

Each individual medical practice must make its own decision with regard to participation or non-participation in Prime's PPO and the possibility that it may evolve into the workers' comp PPN next year. One factor for consideration would clearly be an assessment of the value to the particular practice of being a member of the PPN,

bearing in mind that the PPN becomes relevant only when an injured worker switches from his or her original choice of physician.

Workers' comp fee schedule COLA

In 1999 RIMS was successful in promoting the addition of an annual cost of living adjustment (COLA) to the workers' compensation fee schedule. A COLA has been applied every year since, with the sole exception of 2009; in that year the indices would have provided a COLA of less than 1%. For 2010, a COLA of 2.8% should become effective in October; however, the Workers' Compensation Division of the Department of Labor and Training informs RIMS that the 2010 COLA may not be applied uniformly to all services. This year's COLA is more likely to be applied to the fees that are close to Blue Cross payment levels and less likely to be applied to fees that are already well in excess of what Blue Cross has been paying for a given service.

AMA 6th Edition now the law

The 2010 changes to the workers' compensation act also include the adoption of the 6th Edition of the American Medical Association's *Guides to the Evaluation of Permanent Impairment*. This standard will now be used to determine the earnings capacity of an injured worker as a percentage of an uninjured worker's capacity, based on the AMA *Guides*.

The Workers' Compensation Advisory Council has invited the AMA and RIMS to make a presentation on the 6th Edition *Guides* on September 29th. In addition, RIMS and the AMA will be available to offer training programs on the 6th Edition, if there is sufficient demand.

More information about the 6th Edition *Guides* is available through RIMS' Director of Government and Public Affairs, Steve DeToy (sdetoy@rimed.org). ❖



Rhode Island Medical Society at the Gamm!

A Night of Theater with RIMS

You are invited to attend the Rhode Island premiere of "Mauritius" on Thursday, November 4, 2010 at the Sandra Feinstein-Gamm Theatre.

Pricing includes a ticket to the show and a pre-show cocktail hour with hors d'oeuvres. The cost is \$35 per person. Reservations need to be made by October 18, 2010 and will be made on a first-come, first-served basis.

Reception 6:30–7:30 pm

Performance 8:00 pm

Gamm Theatre, 172 Exchange Street, Pawtucket, 401-723-4266

Located in the historic Pawtucket Armory just 2 blocks from exit 29 off I-95 (and 5 minutes from downtown Providence), The Gamm is easy to find and offers plenty of free parking.

The Rhode Island Medical Society gratefully acknowledges the support of RIMS Insurance Brokerage Corporation

About "Mauritius"

Mom has died, leaving half-sisters Mary and Jackie with a rare stamp collection. Mary wants to keep it for its sentimental value. Jackie wants to sell it for the fortune it might be worth. Enter three foul-talking shady stamp dealers determined to get the sale, and an elaborate con game over the dubious inheritance unfolds. At once a gripping family drama and a delightfully sinister comedy, veteran playwright Theresa Rebeck's 2007 Broadway hit twists and turns and takes you for a ride until its final shocking scene.

Reservation Form

Please respond by October 18, 2010.

Name \_\_\_\_\_

Number of Tickets \_\_\_\_\_

Total Enclosed \_\_\_\_\_ \$35 per ticket

Phone \_\_\_\_\_

Email \_\_\_\_\_

You may pay by check, payable to "Rhode Island Medical Society", or by credit card. Return this form with payment to the Rhode Island Medical Society, 235 Promenade Street, Suite 500, Providence RI 02908.

If you have any questions, please contact Sarah at RIMS' office, 401-528-3281.

AMA "Therapeutic Insights" series is:

- free and online
- highlights one disease condition per issue
- features state and national pre-scribing data from IMS Health and evidence-based treatment guidelines
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### PRACTICE MANAGEMENT

#### New "Regional Extension Center" (REC) offers doctors free, practical help with EHRs

The federally funded Rhode Island Regional Extension Center (RI REC), a new function of the Rhode Island Quality Institute, wants physicians to know that it is open for business. That business is putting millions of new federal dollars to work in Rhode Island to help "priority primary care physicians" achieve "meaningful use" of electronic health records (EHRs). The RI REC is a vendor-neutral resource.

The REC's definition of "priority primary care physician" includes solo physicians and small group practices of ten or fewer primary care professionals, community health centers, rural health clinics, public and critical-access hospitals, and any other primary care settings that serve uninsured, underinsured or medically underserved populations.

Those who meet the federal definition of "priority primary care physician" incur no cost to enroll for REC services.

#### The Rhode Island REC provides the following services to medical practices:

- Subsidies of up to \$2,500
- Direct, individualized, on-site support
- Access to a pre-screened marketplace of approved vendors
- Pre-negotiated discounts from vendors
- Advice on best practices for efficient adoption and use of EHR technology for consistently optimal patient care

The RI REC portal is DocEHRTalk.org. The REC is ready to provide interested medical practices with a Process Manager who can offer unbiased, individualized support in moving the practice toward "meaningful use." DocEHRTalk.org provides a list of REC-approved, pre-qualified vendors as well as updates on relevant state and federal initiatives.

The REC's services include helping practices measure and document their progress toward "meaningful use" to help them qualify for federal, state, and payer incentives.

The Centers for Medicare and Medicaid Services (CMS) define "meaningful use" of health information technology (HIT) as capturing health information in a standardized, coded format; using that information to track and manage key clinical conditions; coordinating care by communicating that information; and reporting clinical quality measures and public health information electronically. ❖

#### Useful links for practice management and health information technology

##### From the AMA

[www.ama-assn.org/go/pmalerts](http://www.ama-assn.org/go/pmalerts) Physicians and their office staff should sign up through this link for email alerts from the Practice Management Center of the AMA, with timely information on unfair payer practices, tips on addressing them, and new practice management resources and tools.

[www.ama-assn.org/go/pmssoftware](http://www.ama-assn.org/go/pmssoftware) The Medical Group Management Association (MGMA) collaborated to develop a new online toolkit, which is free to members. The toolkit, "Selecting a Practice Management System," helps you select and purchase the most appropriate software for your practice. The toolkit resources include:

- A five-step guide to practice management system software selection.
- A comprehensive checklist that helps you determine which practice management system software features and functionalities are essential to your practice and which will enhance your revenue cycle management.
- A sample "request for proposal" that you can employ in your communications with practice management system software vendors.

[www.ama-assn.org/go/ucrssettlement](http://www.ama-assn.org/go/ucrssettlement) Last year's massive UnitedHealthcare settlement made \$350 million available to compensate physicians for underpayments received for out-of-network services provided between 1994 and 2009. This link is a key to submitting a claim, which physicians must do by October 5, 2010. (See related article on back page.)

##### From the Rhode Island Quality Institute

[www.docEHRTalk.org](http://www.docEHRTalk.org) is the portal for Rhode Island's new federally funded Regional Extension Center (REC), a function of the Rhode Island Quality Institute and a resource for primary care physicians in achieving "meaningful use" of health information technology. (See related article on the new Rhode Island REC in the column to the left.)

##### From the U.S. government

[www.cms.gov/EHRIncentivePrograms/](http://www.cms.gov/EHRIncentivePrograms/) This is the official CMS website for the Medicare & Medicaid EHR (Electronic Health Records) Incentive Programs – who is eligible for the programs, how to register, "meaningful use," upcoming EHR training and events, etc.

[www.hhs.gov/news/press/2010pres/06/20100618d.html](http://www.hhs.gov/news/press/2010pres/06/20100618d.html) provides information on the recently issued "final rule" on temporary certification for EHR (Electronic Health Record) technology from the Office of the National Coordinator for Health Information Technology (ONC). ❖



## AMA's new liability survey: Eye-popping, but not surprising

More than 60% of doctors over the age of 55 have been sued at least once, according to a survey released by the American Medical Association (AMA) in August.

Although most of those claims are dropped or dismissed, the survey indicates that most physicians will be sued for malpractice at some point in their careers, and while some physicians will experience a greater frequency of litigation than others, the overall trend is for a total of 95 medical malpractice lawsuits to be filed for every 100 physicians now in practice, according to AMA.

"This litigious climate hurts patients' access to physician care at a time when the nation is working to reduce unnecessary healthcare costs," said AMA immediate past president J. James Rohack, MD, in a prepared statement.

For the report, AMA surveyed 5,825 physicians from the 2007–2008 Physician Practice Information (PPI) survey, which is used to update the practice cost data to develop practice expense relative value units (RVUs) for the Medicare Physician Fee Schedule. The measure of malpractice claims was determined by survey questions that asked doctors about the number of claims filed against them in their career and over the previous year; the survey did not ask about the outcome of those claims.

While physicians are likely to be served with a lawsuit at some point in their careers, only about 5% of physicians are sued in any given year, the report found.

Certain specialties – including general surgeons and obstetricians/gynecologists – were more than five times as likely to be sued as pediatricians and psychiatrists, according to the report. About half of Ob/Gyns under the age of 40 have already been sued, and 90% of surgeons ages 55 and older have been sued.

In contrast, less than 30% of pediatricians and psychiatrists surveyed had been sued, and almost no one in either specialty had had an adverse claim filed in the previous 12 months.

The report goes on to say that while 65% of claims are dropped or dismissed, all claims are costly. Even dropped or dismissed claims on average incur defense costs between \$22,000 for cases dropped early to more than \$100,000 for cases that go to trial before being dropped or dismissed, according to data in the report from the Physician Insurers Association of America.

"Even though the vast majority of claims are dropped or decided in favor of physicians, the understandable fear of meritless lawsuits can influence what specialty of medicine physicians practice, where they practice, and when they retire," Rohack said.

The report also found that men were twice as likely

to be sued as women. The report author suggests that the difference might be in part because male physicians are concentrated in the specialties with the highest numbers of claims. In addition, women physicians are generally younger than male physicians, and older doctors are more likely to have been sued at some point in their careers, simply because they've been working longer.

Also, the survey found that practice owners and those who work in single-specialty group practices were more

likely to be sued than doctors who work in hospitals and multispecialty group practices, largely because they work in liability claims-heavy specialties. Ob/Gyns are a special case, however: they do tend to practice in solo or single-specialty practices, but unlike other specialties who get sued the most often, the work Ob/Gyns usually are sued for – childbirth – is done in the hospital.

The survey was funded by the AMA and more than 40 national medical specialty associations. ❖

### MANAGING PROFESSIONAL RISK

## Tips for Steering Clear of Problems with Pain-Med Prescribing

MARY-LYNN RYAN  
RISK MANAGEMENT, NORCAL MUTUAL INSURANCE COMPANY  
AND THE NORCAL GROUP

*The following tips are intended to help physicians prescribe narcotics/opioids appropriately to patients in chronic pain.*

**Obtain a thorough history and determine the specific cause of pain.** In an article on treating patients' pain, Eliot Cole, MD, a physician associated with the American Academy of Pain Management, advises, "Do not call [a patient's] pain a headache or backache but try to find a specific pathological process to explain why your patients hurt."1 Stephen Richeimer, MD, Chief of Pain Medicine at the University of Southern California, says, "Assessment is a key issue. The history and physical examination provides the information that allows the physician to judge if the patient is legitimately in pain or if the patient is improperly seeking drugs."2

**Document well.** Cole advises, "Chart everything you see, think, feel, and hear about your patients. Leave nothing to the imagination of the future reader... Explain what you are doing, why you believe opioid analgesics will be helpful or continue to be helpful, what alternatives have been considered, that your patient agrees to the treatment, and how you intend to follow your patient over time."1 Richeimer agrees: "Good record keeping is part of good medicine, and it is also your best protection from frivolous lawsuits," he says.2

### Ask chronic-pain patients to agree to use a single pharmacy.

Discussing pain treatment with the patient and getting the patient to agree to certain parameters associated with long-term pain management are mutually beneficial strategies: they help you avoid inadvertently supplying medication that might be diverted for street sale, and they reassure the patient in pain that he or she can count on obtaining needed medication. An especially useful rule is that the patient will use a single pharmacy for all pain medications.

**Make use of a written pain medication agreement with chronic-pain patients.** A signed agreement by the patient that he or she will follow rules for obtaining pain medication will improve the likelihood of appropriate behavior by the

patient. It discourages patients from seeking an unlimited supply of medication and helps staff members verify the legitimacy of refill requests.

**Monitor patients over time on their needs for and use of pain medication.** Richeimer observes that patient trustworthiness "can only be assessed by monitoring the patient over time."2 Cole suggests talking with patients periodically to reduce dosage appropriately, as well as periodically ordering "urine drug screens for...patients of concern to document that you are able to recover their prescribed medications."1

**If you keep controlled substances in your office, establish a reliable process for safeguarding and reconciling such medications and for tracking their distribution.** The federal Drug Enforcement Administration (DEA) requires physicians who administer or dispense controlled substances from their offices to have effective controls to guard against theft and diversion. Controlled substances must be stored in a securely locked, substantially constructed cabinet. Using a controlled substances inventory log can help you account for each and every dose of medication that goes through your office.

These strategies are aimed at fostering appropriate pain management within the limits of professional practice. Furthermore, they can help physicians and staff consistently meet regulatory requirements on the management of pain medications.

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*Managing Professional Risk is offered by the NORCAL Mutual Insurance Company and the NORCAL Group. More information on this topic, with continuing medical education (CME) credit, is available to NORCAL policyholders. To learn more, visit [www.norcalmutual.com/cme](http://www.norcalmutual.com/cme).* ❖

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## **October 5 is deadline for physicians to claim their share of UnitedHealthcare's \$350 million settlement for past underpayment of out-of-network services**

Thousands of physicians across the country who cared for subscribers of UnitedHealthcare (or for subscribers of some twenty-one affiliates and subsidiaries of United) on an out-of-network basis during the more than 15-year period from March 15, 1994, to November 18, 2009, may qualify to be compensated for underpayments from United.

Most physicians who qualify for compensation under the class action, including many doctors in Rhode Island, received a Settlement Notice and claim form by U.S. mail in early summer. The deadline for returning the claim form is Tuesday, October 5, 2010.

Additional copies of claim forms can be downloaded from the special AMA link, [www.ama-assn.org/go/ucrsettlement](http://www.ama-assn.org/go/ucrsettlement). This AMA site provides a wealth of information and resources to help physicians claim what is rightfully theirs.

The claim and recovery process is not as simple or quick as it might be. Physicians will find the above-cited AMA website indispensable. In addition, AMA members can receive hands-on, individualized help directly from AMA in filing their claim for compensation.

Depending upon the level of documentation a physician is able to assemble, his or her recovery of underpayments

may be based on 50%, 70% or 90% of the difference between what the physician billed and what was paid.

**Background:** The \$350 million dollars now available to compensate physicians and patients is one part of the historic class action settlement that took final form last year – after ten years of litigation by the AMA Litigation Center and the Medical Societies of New York State and Missouri.

This is the same settlement that New York State Attorney General Andrew Cuomo helped consummate during 2008–2009.

A second major piece of the settlement agreement eliminates United's systematically skewed database, Ingenix, as the health insurance industry's leading source of physician payment data. Most payers had used Ingenix' data for years to calculate "usual, customary and reasonable" ("UCR") payments for physician services provided out-of-network. United, Aetna and Cigna have provided an additional \$90 million to replace Ingenix with a new, independent, transparent, non-proprietary database, which is currently being constructed under the aegis of Syracuse University. ❖